Nplate® (Romiplostim) (for Indiana Only)

Policy Number: CSIND0214.02
Effective Date: November 1, 2022

Instructions for Use

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Related Policies
None

Application

This Medical Benefit Drug Policy only applies to the state of Indiana.

Coverage Rationale

Nplate is proven and medically necessary for the treatment of certain conditions outlined within the InterQual criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual guideline: Specialty Rx Non-Oncology Romiplostim (Nplate).

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J2796	Injection, Romiplostim, 10 micrograms

Policy History/Revision Information

Date	Summary of Changes
11/01/2022	**Coverage Rationale** • Revised language to indicate Nplate is proven and medically necessary for the treatment of certain conditions outlined within the InterQual criteria; for medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline: Specialty Rx Non-Oncology, Romiplostim (Nplate) **Applicable Codes** • Removed ICD-10 diagnosis code D69.3

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Date	Summary of Changes
	Supporting Information • Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections • Archived previous policy version CSIND0214.01

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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