

GUIDANCE STATEMENT

Generic eltrombopag for the early management of newly diagnosed and persistent immune thrombocytopenic purpura (ITP) in adult patients

PAC recommendations

- Generic eltrombopag is recommended as a second line treatment option in adult patients with newly diagnosed and persistent ITP, who meet the following additional commissioning criteria:
 - » Initiation by Consultant Haematologist only
 - » Platelets $<20 - 30 \times 10^9/L$
 - » Patient has failed to respond adequately or has relapsed following 1st line treatment with corticosteroids and/or IVIG.
- Current international standards classify the stages of ITP into acute or newly diagnosed (<3 months), persistent (2-12 months) and chronic ITP (>12 months).
- Patients should be reviewed at least at 6 - 12 months and if clinically appropriate, withdrawal of eltrombopag treatment should be considered.
- Supply arrangements should be agreed locally using the most cost-effective route e.g. via outsourced outpatient dispensing services where available.
- The use of homecare arrangements for the supply of eltrombopag is not supported by East of England commissioning pharmacists.
- Patients with newly diagnosed or persistent ITP who fail to respond to generic eltrombopag should be managed conservatively with first line treatments until eligible for treatment with other TPO-RAs in line with NICE TAs.
- ICBs should monitor the uptake of treatment and patient clinical progression e.g. via Bluteq or equivalent.

Background

Immune thrombocytopenia (ITP), also known as immune thrombocytopenic purpura, is a haematological disorder characterised by isolated thrombocytopenia (platelet count $<100 \times 10^9/L$ [$<100 \times 10^3/\text{microlitre}$]) in the absence of an identifiable cause.^{1,2} Primary thrombocytopenia is generally caused by an autoimmune response involving antibody destruction of peripheral platelets, thrombocytopenia can also occur secondary to other diseases such as leukaemia and lymphoma, as well as certain drug treatments; including but not limited to; NSAIDs, penicillin, quinine, anticonvulsants.^{2,3} Symptoms include fatigue, spontaneous bruising and regular bleeding episodes, including possible GI bleed, intracranial haemorrhages, severe epistaxis etc. Spontaneous, serious bleeding is rare ($<5\%$ of patients).^{2,4} Intracranial bleeding is reported in approximately 0.5% of children and 1.5% of adults.²

Treatment for ITP is usually introduced when the platelet count drops below $20\text{--}30 \times 10^9$ per litre and the patient is at risk of recurrent severe bleeding. Current international standards classify the stages of ITP into acute or newly diagnosed (<3 months), persistent (3-12 months) and chronic ITP (>12 months). Historically, patients with a platelet count which remained below $30 \times 10^9/\text{L}$ after 12 months were considered to have chronic ITP.¹

Asymptomatic patients, with platelet count $<30 \times 10^9$ do not require immediate treatment; observation is usually advised. Patients with life-threatening bleeding, regardless of platelet count, are considered for combination therapy with corticosteroids, intravenous immunoglobulin (IVIg), and platelet transfusion.²

Subsequent treatment with thrombopoietin receptor agonists (TPO-RAs), rituximab (unlicensed), the spleen tyrosine kinase (SYK) inhibitor; fostamatinib (adults only), or immunosuppressants such as mycophenolate, are considered in patients with persistent symptomatic ITP despite initial acute treatments.²

Splenectomy is an option and usually only used for patients with severe thrombocytopenia (e.g. $<15 \times 10^9/\text{L}$), in whom bleeding risk cannot be controlled with medical therapy or those whose disease persists after 12 months. Splenectomy can achieve complete remission in about two thirds of patients who relapse following initial treatment but results in an increased risk of thrombosis and infection. Patients require vaccination against *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Neisseria meningitidis*, ideally >2 weeks before the procedure.²

Whilst the NICE TAs for eltrombopag and romiplostim placed the use of these TPO-RAs after mycophenolate or rituximab, for patients with established chronic ITP,^{5,6} the more recently published recommendations regarding avatrombopag and fostamatinib have placed mycophenolate and rituximab as options after TPO-RAs treatment.^{7,8} Whilst this reflects a change in specialist opinion it has led to confusion over the optimum place in the ITP treatment pathway for these medicines leading to possible inequity of access to treatments and treatment delays between ICB localities.

Guidance issued by NHS England (NHSE) during the COVID-19 pandemic recommended the use of TPO-RAs as a first line early option for ITP, to reduce the risk from COVID infection with corticosteroids and immunosuppressive agents, in line with WHO pandemic policy.^{9,10} This guidance was withdrawn by NHSE in June 2022 and whilst systems were directed to return to pre-pandemic protocols, there remains a need to consider the most appropriate place in therapy for TPO-RAs in order to optimise outcomes for patients.^{10,11}

The UK patent for eltrombopag has also expired and generic eltrombopag versions are now available which has lowered the price and made treatment more cost effective.¹²

Evidence

Current international consensus guidance recommends corticosteroids as the standard initial treatment for adults with intravenous immunoglobulin (IVIg) reserved for patients with significant bleeding or at high risk of bleeding, requirement for a surgical procedure or if there is a lack of response to other treatment. Subsequent recommended treatments include TPO-RAs, rituximab (RTX) or fostamatinib, although no specific order of treatment is suggested. There is less robust evidence for mycophenolate and other immunosuppressive treatments.¹ Approximately 50% of patients will respond to first line treatment with corticosteroids.

The National Institute for Health and Care Excellence (NICE) have published technology appraisals (TAs) which recommend the use of the TPO-RAs avatrombopag ([TA853](#)), eltrombopag ([TA293](#)), romiplostim ([TA221](#)) and the spleen tyrosine kinase (SYK) inhibitor, fostamatinib ([TA835](#)) as treatment options for patients with primary chronic ITP.⁵⁻⁸

Comparative studies between agents for ITP are lacking. Several systematic reviews and meta-analyses have attempted to confirm the comparative status of the TPO-RAs.¹³⁻¹⁵

One review by Wang et al identified 13 randomised controlled trials involving 1,126 ITP patients with persistent or chronic ITP. Ten of the included studies reported the incidence of any or severe bleeding events. The pooled results demonstrated that TPO-RAs significantly reduced the incidence of any or severe bleeding events (RR: 0.80, 95% CI: 0.67–0.95, $p = 0.013$; RR: 0.52, 95% CI: 0.27–0.99, $p = 0.048$; respectively) and in eight studies indicated that there was a significant reduction in the proportion of patients needing rescue medications in the TPO-RA groups compared with the control groups (RR: 0.50, 95% CI: 0.42–0.59, $p = 2.0 \times 10^{-15}$).

Subgroup analysis based on TPO-RA regimens indicated that romiplostim did not substantially decrease the incidence of any or severe bleeding events (RR: 0.93, 95% CI: 0.72–1.21; RR: 0.64, 95% CI: 0.31–1.35; respectively). However, there were substantial reductions in the incidence of any or severe bleeding events in eltrombopag treated patients compared with control patients (RR: 0.68, 95% CI: 0.51–0.90; RR: 0.27, 95% CI: 0.07–1.00); respectively.¹³

Conversely, the systematic review and meta-analysis by Liu et al reported that in terms of efficacy romiplostim is superior and avatrombopag had a better safety profile¹⁴ and therefore it is difficult to draw a definitive conclusion and until further data becomes available. No TPO-RA can be considered to be clinically superior to another.

A joint position statement on the use of generic eltrombopag has recommended that generic eltrombopag should be considered first when a TPO-RA is clinically needed and confirms that effectiveness of TPO-RA treatments is broadly similar.¹²

Evidence for TPO-RAs in early, newly diagnosed and persistent ITP

There is an increasing, albeit small, amount of evidence regarding the use of TPO-RAs in patients with early newly diagnosed but persistent ITP.

Eltrombopag

A systematic review published in 2019, identified 12 randomised controlled trials including 1,306 adult patients (>16 years; median age 42–60.5 years) with persistent ITP (3–12 months duration) or chronic ITP (>12 months), although outcomes in these 2 groups are not reported separately. and a median platelet count range was $9\text{--}33 \times 10^9/\text{L}$. No patient had a history of prior TPO-RA use. Romiplostim was used in four studies, eltrombopag in five, avatrombopag in one, rituximab in one trial and combined use of recombinant human thrombopoietin (rhTPO) plus rituximab in the final included trial.

The main outcomes were overall platelet response $\geq 50 \times 10^9/\text{L}$, incidence of bleeding episodes, necessity of rescue treatments and therapy related adverse events, including thrombosis.

Pooled results for both eltrombopag ($n=410$) and romiplostim ($n = 278$) showed higher overall response than placebo ($n=379$) (summary effect estimate or risk ratio (RR), 4.75; 95%CI, 2.49 – 9.07; $p < 0.01$ and RR, 4.21; 95% CI, 1.87–9.52; $p < 0.01$, respectively), and other arms such as RTX ($n = 93$) (RTX vs. eltrombopag, 0.28; 95% CI, 0.08–0.95; $p = 0.04$ and RTX vs. romiplostim, 0.31; 95% CI 0.08–1.18; $p = 0.09$). No significant differences were observed between eltrombopag and romiplostim (RR, 0.89; 95% CI, 0.33–2.41, $p = 0.82$). Compared with placebo, RRs were also higher (i.e. better overall response) for RTX, rhTPO + RTX ($n = 77$), and avatrombopag ($n = 59$). No statistical significance was demonstrated in these groups. More data is required for avatrombopag.

Eltrombopag and romiplostim reduced clinically significant bleeding episodes compared with placebo (eltrombopag: RR, 0.47; 95% CI, 0.27–0.84; $p = 0.01$, and romiplostim: RR, 0.56; 95% CI, 0.37–0.84; $p < 0.01$). The RR between the two TPO-RAs was not statistically significant (RR, 1.19; 95% CI, 0.59–2.41; $p = 0.63$).

For severe bleeding (WHO Grade ≥ 3) both eltrombopag and romiplostim reduced bleeding episodes compared with RTX, (for eltrombopag: RR, 0.05; 95% CI, 0.01–0.90; $p = 0.04$, and romiplostim: RR, 0.25; 95% CI, 0.04–1.58; $p = 0.10$) or placebo (for eltrombopag: RR, 0.11; 95% CI, 0.01–1.00; $p = 0.05$, and romiplostim: RR, 0.50; 95% CI, 0.23–1.06; $p = 0.06$) with no significant differences between the two

TPO-RAs (eltrombopag to romiplostim: RR, 4.38; 95% CI, 0.44–43.5; $p = 0.20$). Severe bleeding was nearly the same between the two. The review authors concluded that TPO-RAs can be first choices for the treatment of persistent to chronic ITP rather than RTX.¹⁶

Similar results were also reported in a second systematic review and network analysis which also identified 12 trials, including 1,313 adult patients with persistent ITP (9 studies were also included in the analysis by Arai et al with 3 different trials were identified). For all relevant treatment outcomes, eltrombopag and romiplostim were more effective than placebo, with the former reported to have a slight but non-significant advantage in terms of platelet response [RR = 1.10 (95% CI 0.46, 2.67)] Both romiplostim and eltrombopag were reported to be significantly more effective than rituximab and rhTPO plus rituximab, with corresponding pooled RRs of 4.56 (1.89, 10.96) and 4.18 (1.21, 14.49) for eltrombopag and 4.13 (1.56, 10.94) and 3.79 (1.02, 14.09) for romiplostim. The highest probability for bleeding was found in the placebo group, followed by romiplostim, eltrombopag and rituximab respectively.¹⁷

In relation to newly diagnosed patients, a retrospective analysis published in 2017, included 220 adult ITP patients who had received treatment across 30 Spanish centres. 30 patients were allocated to newly diagnosed, 30 patients to persistent and 160 to chronic categories and eltrombopag was administered at doses in accordance with the European Medicines Agency. 180 (90%) patients achieved a platelet response, 17 (75.9%) were complete responders (CR) after a 15 month follow up. There were no statistically significant differences reported regarding response and duration of response among the ITP groups. The analysis reported a trend towards greater efficacy in newly diagnosed ITP with 93.3% of responses and 86.7% of CR. Persistent ITP achieved 83.3% of responses and 80.0% of CR. Similarly, 79.4% of responses with 73.1% of CR were observed in chronic ITP. The relapse rates were also similar among groups: 29% ($n=8$), 20% ($n=5$) and 29% ($n=37$) in newly diagnosed, persistent and chronic ITP respectively.¹⁸

In a proof of concept open, single arm study, 12 adult patients with newly diagnosed ITP, bleeding manifestations, a platelet count of $<30 \times 10^9/L$ and no prior treatment, received dexamethasone 40mg/day by mouth for 4 days and eltrombopag 50mg by mouth once a day for 28 days beginning at day 5. Nine patients had grade 2 bleeding manifestations. Median platelets at diagnosis were $7 \times 10^9/L$ (range 2-28). Median follow up was 12.5 months (range 7-18 months).

After dexamethasone, five patients responded and five achieved CR. All patients achieved partial or complete response by the time eltrombopag treatment was completed. Six patients had platelets $>400 \times 10^9/L$ the day eltrombopag was stopped. Four patients relapsed in a median time of 14.5 weeks (range 6.3-29.7); two regained CR and one regained response after treatment with dexamethasone and rituximab, with the other patient seeking treatment elsewhere. The study authors reported at the time of write up, that four patients remained in CR and 4 in response. Bleeding manifestations disappeared in all patients. No adverse events were reported.¹⁹

In a multicentre, prospective cohort study 46 patients were identified as starting first line therapy, of these 27 patients (58.7%) were newly diagnosed and 19 patients (41.3%) had an acute relapse of remitting relapsing ITP with a median disease duration of 69 months. All 46 patients received first line therapy with prednisolone at a median starting dose of 1.0 mg/kg body weight. Fifteen patients received IVIG for 2 consecutive days and which was more frequently given in new patients than in acute relapse patients. The median duration of prednisolone treatment was 62 (39-122) days. Of the 38 patients who responded to first line treatment, 17 relapsed after a median time of 90 days, whereas 21 patients achieved long term remission with first line treatment. Overall, 23 patients (50%), 11 (40.7%) with new diagnosed ITP and 12 (63.2%) with relapsed ITP, received second line treatment. Of these, 19 patients received a TPO-RA; eltrombopag ($n=13$), avatrombopag ($n=4$) and romiplostim ($n=2$). Fourteen patients responded to TPO-RA treatment resulting in an overall response rate of 73.7%. Five (26.3%) patients did not respond to TPO-RA treatment after a median treatment duration of 39.6 (25-120) days. The majority of patients reported no adverse effects, with only 2 of 19 patients reporting headache or nausea.

Four patients received no TPO-RAs. One received rituximab, although treatment had to be stopped after 2 cycles due to an adverse drug reaction and three had splenectomy instead. Two splenectomised patients achieved CR, however one had no response.²⁰

A retrospective cohort study by Cuker et al, identified 8,268 patients with primary ITP. Of these, 7,327 (88.6%) did not use second line treatment during the first 90 days of treatment. The most commonly used second line agent was rituximab (n=400; 42.5%). 43.6% of patients received a TPO-RA (romiplostim n=222 (23.6%) and eltrombopag n=188 (20.0%) and 108 (11.5%) patients received multiple second line therapies. Median platelet counts increased, the proportion of bleeding events decreased in all groups.²¹

Romiplostim

A pooled analysis of subgroup data by ITP duration (ITP ≤ 1 year and ITP > 1 year) taken from 9 European and North American studies (published between 2002 and 2014), assessed romiplostim efficacy in adult patients with either newly diagnosed or persistent ITP for up to one year or patients with chronic ITP for more than one year.

1,037 patients were included; 277 patients with ITP ≤ 1 year and 634 with ITP > 1 year in the romiplostim group and 34 patients with ITP ≤ 1 year and 92 with ITP > 1 year in the combined placebo/standard of care group. The majority of patients were Caucasian, with a median age across the groups of 52 to 54 years. Of the patients with ITP ≤ 1 year, 155 (50%) had newly diagnosed ITP (< 3 months) and 156 (50%) had persistent ITP (3 to 12 months). The median duration of ITP was 3 months for those with ITP ≤ 1 year and 72 months for those with ITP > 1 year. Median baseline platelet count was $18 \times 10^9/L$.

The median time to first platelet response for romiplostim treated patients was 2 weeks in each ITP duration subgroup and 4 weeks for patients with ITP ≤ 1 year and 12 weeks for those with ITP > 1 year in the placebo/standard care arm. The number of patients who were able to discontinue treatment after 9 months and maintain platelet counts $\geq 50 \times 10^9/L$ without any ITP treatments for than ≥ 6 months (i.e. remission) was greater for those with ITP ≤ 1 year (16%; 95% CI; 11-21%) than for those with ITP > 1 year (6%; 95% CI 4-8%). For romiplostim patients, rescue medications were used in 44% of those with ITP ≤ 1 year and 50% for those with ITP > 1 year. Use of rescue medication decreased over time irrespective of ITP duration and the rate of decline of corticosteroid or IVIg use was similar between ITP duration subgroups.²²

In a single arm, retrospective, real world observational study, 100 adult (≥ 18 years) ITP patients who had received at least one dose of romiplostim were identified. The main study objectives were to describe the overall study population and application of romiplostim.²³

Further analysis in relation to the duration of ITP at romiplostim initiation has also been published. At romiplostim initiation, 22.0% of patients with newly diagnosed ITP, 17% had persistent ITP and 61.0% had chronic ITP. Baseline platelet counts were lowest in the newly diagnosed ITP group; (median $7.5 \times 10^9/L$; interquartile range (IQR) 4.0, 16.0). 68.2% of patients in the newly diagnosed group had experienced at least 1 bleeding event in the 6 months prior to romiplostim administration, with 41.2% of persistent and 29.5% of chronic ITP patients experiencing a prior bleeding event.

The percentage of patients achieving an initial platelet response exceeded 80% and did not differ according to response definition or ITP duration, ranging from 81.8% to 88.2% across groups. However, there were reported differences in durable platelet response between groups, 50% (95% CI 28.2 - 71.8%) of newly diagnosed patients, versus 35.3% (95% CI: 14.2 - 61.7%) in the persistent group and 31.1% (95% CI; 19.9% - 44.3%) in the chronic group. The percentage of patients able to discontinue all non-romiplostim ITP medications was highest in the newly diagnosed group (31.8%) compared with 17.6% and 16.4% in the persistent and chronic groups respectively. 13.6% of newly diagnosed patients, 5.9% of persistent patients and 4.9% of chronic ITP patients required emergency treatment for bleeding events.²⁴

In a small retrospective cohort study, 340 adult patients with primary ITP who received at least 1 dose of romiplostim were identified. Sixty four (19%) had newly diagnosed ITP, 50 (15%) had persistent ITP and 226 (66%) had chronic ITP at romiplostim initiation. Regardless of ITP duration, more than 80% of patients had achieved a platelet response at the 24 week follow up, with 32% of patients with newly diagnosed ITP, 53% of persistent ITP patients and 49% of chronic ITP patients achieved a durable platelet response. 45% of newly diagnosed patients received rescue treatment compared with 23% and 20% in the persistent and chronic groups respectively. 21-22% of patients experienced a bleeding event after romiplostim initiation, regardless of duration of ITP and hospitalised bleeding occurred in 6-7% of patients.²⁵

Rituximab

The use of rituximab in early persistent ITP is well described. It is intended to be used a short course to induce long term remission.²⁶

The short term response with rituximab has been documented as 40-60%, with a median time to response of 4-8 weeks, but more delayed responses have also been reported.²⁶

A meta-analysis of 5 trials showed complete response is more likely with rituximab than standard care and that rituximab improves platelet count responses at 6 months in ITP patients, however rituximab was not associated with reductions in bleeding or an increase in infections.²⁷

The 5-year outcomes of rituximab at the standard dose were assessed in 376 adults. This study revealed that 215 patients (57%) attained a remission (144 [38%] complete; 71 [19%] partial). Of the initially treated adult patients, only 38% maintained remission at 1 year, and 21% maintained remission at 5 years.²⁸

A sub-analysis of the EXTEND study has assessed whether eltrombopag efficacy and/or safety were different among patients with and without prior rituximab treatment.

EXTEND was a phase 3 open label extension study evaluating eltrombopag safety and efficacy for up to 8.8 years in adults with ITP. It included patients with an ITP diagnosis ≥ 6 months. Eltrombopag was dose-adjusted to achieve target platelet counts of ≥ 50 to $< 200 \times 10^9/L$. Of 302 patients in EXTEND, 70 (23%) had or were receiving rituximab [ritux(+)] and 232 (77%) had not [ritux(-)]. Higher proportions of ritux(+) than ritux(-) patients had undergone splenectomy, received ≥ 5 prior ITP therapies, and were more likely to have had a baseline platelet count of $\leq 15 \times 10^9/L$ in their prior eltrombopag trial, confirming that ritux(+) patients had more advanced ITP at baseline. In the full analysis set (FAS), 53/70 (76%) ritux(+) and 208/232 (90%) ritux(-) patients responded (platelet counts $\geq 50 \times 10^9/L$) at least once with a comparable mean average dose for both groups.

Among patients with $< 50 \times 10^9/L$ at baseline, median [95% confidence interval (CI)] times to platelet counts $\geq 50 \times 10^9/L$ were 3.1 (2.1–6.1) for ritux(+) patients (n=46/60) vs 2.1 (2.0–2.3) weeks for ritux(-) patients (n=175/197). Likewise, among patients with $< 100 \times 10^9/L$ at baseline, median (95% CI) times to platelet counts $\geq 100 \times 10^9/L$ were 8.1 (3.3–22.4; n=45/67) vs. 4.4 (3.1–6.1; n=178/222) weeks respectively. In all, n=11/70 (16%) ritux(+) and 63/232 (27%) ritux(-) patients responded at 24 weeks' treatment; proportions increased to 44% (11/25) and 59% (63/106), respectively, in those patients with evaluable platelet counts. Proportions of withdrawals from EXTEND [35 (50%) ritux(+) and 132 (57%) ritux(-)] appeared similar. Splenectomised ritux(+) patients appeared to have lower ORRs to eltrombopag versus non-splenectomised ritux(+) patients (32/47, 68% vs. 21/23, 91%). In contrast, splenectomised and non-splenectomised ritux(-) patients appeared to have similar ORRs (62/68, 91% and 146/164, 89% respectively); suggesting that non-response to both splenectomy and rituximab indicated a generally refractory patient group. Nevertheless, the ORR to eltrombopag remained $> 60\%$ in splenectomised ritux(+) patients, and long-term eltrombopag treatment appeared effective in a substantial proportion of these difficult-to-treat patients. Incidence of serious AEs appeared similar between the 2 groups. The analysis authors concluded there were apparent numerical differences in response rates and certain AEs with long-term eltrombopag use between patients who previously received rituximab and those who had not. Some differences were dependent on the time of starting

eltrombopag relative to when rituximab was administered. Efficacy differences appeared to be largely a function of severity of the underlying ITP, including splenectomy and more prior treatments. Importantly, however, eltrombopag was effective and generally well tolerated, regardless of previous rituximab, splenectomy, or both.²⁹

Safety

The pooled safety data analysis by Arai et al, including 10 RCTs (n=,1121) reported eltrombopag and romiplostim showing the same risk as placebo for serious adverse events. (eltrombopag: RR 0.69; 95% CI 0.31-1.56; p=0.36; romiplostim: RR 0.59; 95% CI 0.25-1.36; p=0.22), with the pooled data showing no specific difference for thrombotic events. Comparisons for all agents including avatrombopag, were only possible for all grade adverse events, due to lack of patient numbers, but no differences were observed in the limited data available.¹⁶ No stratification or analysis of adverse events and duration of ITP was published.

Puavilai et al reported that the treatment with the greatest probability for highest serious adverse events was rhTPO + rituximab followed by rituximab, eltrombopag, placebo and romiplostim.¹⁷

Adverse effects with rituximab are mostly infusion related reactions and infections, with an estimated incidence of 2.3 infections/100 patient years.²⁶

Cost impact

Drug costs

The cost prices are shown in **table 1** and are based on current NHS list prices and exclude VAT.^{30,31}

Confidential commercial arrangements are in place for eltrombopag, romiplostim, avatrombopag and fostamatinib, allowing the NHS to access these drugs at a discounted price from the published NHS list price. Positive NICE TAs are contingent on the companies providing these drugs to the NHS according to the commercial arrangement.⁵⁻⁸

The UK patent for eltrombopag expired in September 2025 and generic versions are now available.

Note that significant confidential discounts are available for generic eltrombopag in secondary care, making generic eltrombopag a considerably more affordable treatment option than other TPO-RAs when prescribed and supplied in a secondary care setting.

Rituximab biosimilars are available in secondary care at discounted prices under the NHS Medicines Procurement and Supply Chain (MPSC) framework.³²

All TPO-RAs and fostamatinib are currently listed as excluded high-cost drugs. Rituximab biosimilars are now included in tariff or HRG costs in the 2026/2027 NHS Payment scheme. Eltrombopag and romiplostim are listed as suitable for inclusion in the fixed element of the payment scheme.^{33,34}

Additional activity costs would apply for all secondary care activity associated with the prescribing, monitoring and where applicable administration of medication (i.e. rituximab, romiplostim, other IV treatments).

Adult management of ITP is currently commissioned and funded by ICBs. Specialist children's haematology services are commissioned and funded by NHS England, but have been listed as suitable for greater ICS leadership in the road map for the transition of specialised services.[35] IVIg is a high cost excluded drug which is currently funded, and its use is monitored, by NHS England. IVIg has been subject to significant supply shortages in the past.³⁶

Supply arrangements should be agreed locally using the most cost-effective route e.g. via outsourced outpatient dispensing services where available.

The use of homecare arrangements for the supply of eltrombopag is not supported by EoE commissioning pharmacists.

Patients with newly diagnosed or persistent ITP who fail to respond to generic eltrombopag should be managed conservatively with first line treatments until eligible for treatment with other TPO-RA in line with NICE TAs.

ICBs should monitor the uptake of treatment and patient clinical progression e.g. via Bluteq or equivalent.

Table 1: Comparative costs for ITP medications^{30,31}

Drug & Dose	Pack size	Cost per pack	Cost/28days	Cost per year
Thrombopoietin Receptor Agonists*				
Eltrombopag – generic 25 -75mg ONCE daily	28 tablets	£621.78 - £1,963.50	£621.78 - £19,63.50	£8,083.14 - £25,525.50
Eltrombopag (Revolade) -originator 25 -75mg ONCE daily	28 tablets	£770 - £2,310	£770 - £2,310	£10,010 - £30,030
Romiplostim 1mcg/kg ONCE weekly sub cut	1x250mcg micrograms powder and solvent for solution for injection (Reconstitution Pack)	£482	£1,928	£25,064
	1x125mcg vial Powder for solution for injection	£241	£964	£12,532
Avatrombopag 20 - 40mg ONCE daily	30 tablets	£1,920	£1,792 - £3,584	£23,296 - £46,592
Spleen tyrosine kinase inhibitor				
Fostamatinib 100 - 150mg TWICE daily	60 tablets	£3,090 - £4,635	£2,884 - £4,326	£37,492 - £56,238

Rituximab				
Dose regime	Number of vials per course	Cost per vial (NHS indicative price)**	Indicative cost for one course of treatment	Annual cost if course repeated every 6 months
Rituximab (biosimilar) 375mg/m ² i.v. weekly for 4 weeks for 70kg individual, 1.7m tall, body surface area 1.67m ² = 626mg	7x100mg x 4 doses = 28 x 100mg vials	100mg vial (Rixathon): £157.17	£4,400	£8,800
Rituximab (biosimilar) 2 fixed 1g i.v. doses two weeks apart	2x500mg vials x 2 doses = 4 x 500mg vials	500mg vial (Rixathon): £785.84	£3,143	£6,286
Rituximab price based approximately on current contract prices in secondary care, Rituximab is due to go into tariff from April 2026.				
Acute Treatments for symptomatic patients ²⁸				
IVIG		£2,800-£4,550, based on possible cost of 40-65 grams and 70Kg adult	Not applicable	
IV methylprednisolone		Check local pricing	Not applicable	

* Eltrombopag (Revolade brand), romiplostim, avatrombopag and fostamatinib are available to the NHS at confidential discounted prices under Commercial Access arrangements.

Generic eltrombopag shows the NHS indicative price according to DM+D.

Note that significant confidential discounts for generic eltrombopag are available in secondary care.

** Biosimilar rituximab products are available in secondary care at discounted prices under NHS Medicines Procurement and Supply Chain (MPSC) frameworks.

Table 2: HRG costs for pathway related treatment spells

Relevant activity costs ^{33,34}				
HRG codes - Splenectomy				
SA08G - Other Haematological or Splenic Disorders - CC Score 6+				
Elective/day case: £963				
Non-elective spell: £5,822				
Trim points: 5 days (EL), 24 days (NE)				
Per-diem: £383/day				
SA08H - Other Haematological or Splenic Disorders - CC Score 3–5				
Elective/day case: £605				
Non-elective spell: £2,658				
Trim points: 5 days (EL), 10 days (NE)				
Per-diem: £383/day				
SA08J - Other Haematological or Splenic Disorders - CC Score 0–2				
Elective/day case: £427				
Non-elective spell: £998				
Trim points: 5 days (EL), 5 days (NE)				
Per-diem: £383/day				

Table 3: HRG costs for possible complications

HRG	Description	2026/27 Spell Cost (£)	Trim Point (days)	PerDiem (£/day)
GI Bleed HRGs				
FD03A	GI bleed, multiple interventions, CC 5+	9,631	42	328
FD03B	GI bleed, multiple interventions, CC 0–4	4,971	17	328
FD03C	GI bleed, single intervention, CC 8+	7,323	33	328
FD03D	GI bleed, single intervention, CC 5–7	4,369	16	328
FD03E	GI bleed, single intervention, CC 0–4	3,203	11	328
FD03F	GI bleed, no intervention, CC 9+	4,986	25	328
FD03G	GI bleed, no intervention, CC 5–8	2,815	11	328
FD03H	GI bleed, no intervention, CC 0–4	1,024	5	328
Stroke HRGs				
AA35A	Stroke CC score 16 +	11,027	95	304
AA35B	Stroke CC 13-15	5,319	55	304
AA35C	Stroke CC 10-12	3,839	38	304
AA35D	Stroke CC 7-9	2,564	25	304
AA35E	Stroke CC 4-6	1,720	16	304
AA35F	Stroke CC 0-3	905	9	304

Costings used by NICE cite annual cost of rescue therapy as £6,500.²⁶

There is limited cost effectiveness data in relation to newly diagnosed patients. A study by Allen et al has evaluated the cost effectiveness of eltrombopag compared with romiplostim in the treatment of chronic immune thrombocytopenia in patients refractory to other treatments. Eltrombopag dominated romiplostim (i.e., eltrombopag was as effective but less costly than romiplostim) in both splenectomised and non-splenectomised patients, assuming a class effect for the two treatments.³⁷

The overall patient numbers who require treatment with eltrombopag for early but persistent is unclear but likely to be relatively low.

A study utilising NHS Digital derived data for the period 2010-2014, has estimated an average annual primary ITP incidence rate of 6.1 per 100,000 population. An estimated 2.5/100,000 (based on UKITP Registry data) was estimated to require 1st line treatment whereas 2.4/100,000 would have 1st and 2nd line treatments within 6 months from diagnosis.³⁸ A previous nationwide population study in the UK, published in 2009 reported an incidence of 3.9 cases in 100,000 person-years based on the information in the General Practice Records database (GPRD).³⁹

If you extrapolate these figures for the East of England patient population of approximately 6.58 million, then approximately 60-80 patients across the East of England may remain persistent and be eligible for early treatment with generic eltrombopag under this policy.

Patient criteria and outcomes

Treatment goals

- Prevent/avoid complications due to severe bleeding, haemorrhage i.e. anaemia, stroke, GI bleeds.
- Reduce need for repeated IVIg, blood or platelet transfusions and associated treatments.
- Reduce/Avoid need for major surgery for management of chronic ITP i.e. splenectomy.

Patient criteria

Starting criteria for TPO-RAs

- Initiation by Consultant Haematologist only
- Platelets $<20-30 \times 10^9/L$
- Patient has failed to respond adequately or has relapsed following 1st line treatment with corticosteroids and/or IVIG.

Review and Stopping criteria for TPO-RAs

- Platelets $>50 \times 10^9/L$
- No active bleeding

The lowest dose of eltrombopag to achieve and maintain a platelet count $\geq 50 \times 10^9/L$ should be used. Dose adjustments are based upon the platelet count response in accordance with the appropriate summary of product characteristics.¹

Normalisation of the platelet count is not necessary and increasing TPO-RAs dosage to achieve a normal platelet count is not appropriate.

During therapy with TPO-RAs, full blood counts (FBCs), including platelet count is usually assessed weekly until a stable platelet count ($\geq 50,000/\mu L$ for at least 4 weeks) has been achieved. FBCs including platelet counts should be obtained monthly thereafter.

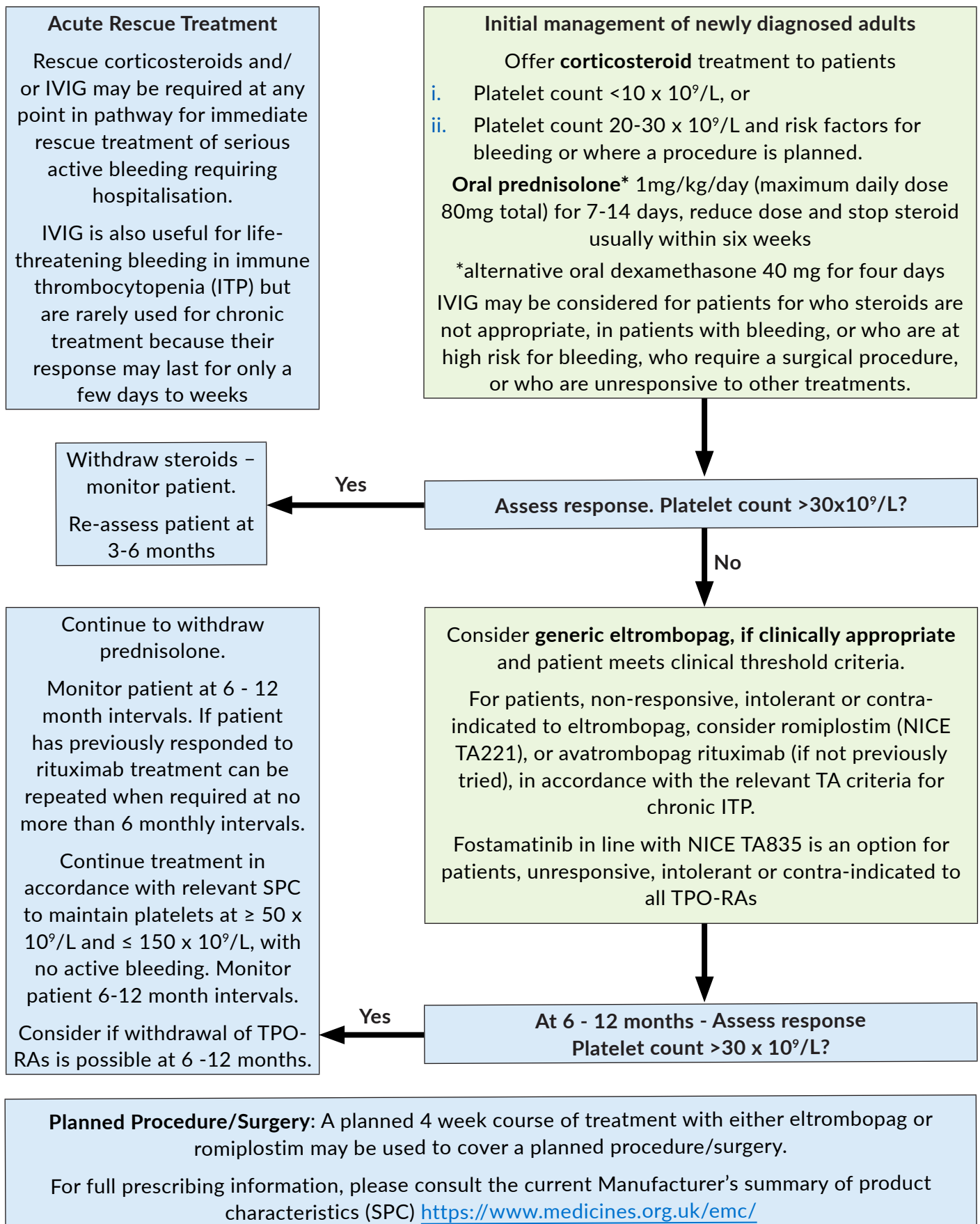
A platelet count of $20-30 \times 10^9/L$ ($20-30 \times 10^3/\text{microlitre}$) is generally chosen as a threshold for treatment due to the increased risk of bleeding once platelet count reaches this level.^{40,41} Patients treated above $30 \times 10^9/L$ ($30 \times 10^3/\text{microlitre}$), based purely on platelet count only with no obvious bleeding symptoms, may have increased morbidity from therapy rather than from the underlying bleeding symptoms associated with ITP.⁴²

Equality assessment

No issues were identified in relation to disability, race, sex, gender or gender reassignment.

This policy is only in relation to the treatment of adult patients >18 years. At the time of writing the management of children with ITP was the responsibility of NHSE.

Management of immune thrombocytopenic purpura (ITP) in adult patients:



Comments sought from: East of England clinicians via PAC members

Author: Victoria Gibson on behalf of PAC

Document history

PAC approval date	14th September 2026
Version	Version 1
Consultation process	East of England clinicians via PAC members
QA process	Katie Smith, Director of Clinical Quality, PrescQIPP. 13th July 2026

References

1. Provan D, Arnold MD, Bussel JB, et al. Updated international consensus report on the investigation and management of primary immune thrombocytopenia. *Blood Advances* 2019; 3(22): 3780-3817. <https://doi.org/10.1182/bloodadvances.2019000812>
2. Scully M. Immune Thrombocytopenia. *BMJ Best Practice*. Last reviewed Jan 2023. <https://bestpractice.bmj.com/topics/en-gb/138>
3. NICE Clinical Knowledge summary. Platelets – abnormal counts and cancer: What are the causes of thrombocytopenia? Last revised December 2025. <https://cks.nice.org.uk/topics/platelets-abnormal-counts-cancer/background-information/causes-of-thrombocytopenia/>
4. Arnold DM. Bleeding complications in immune thrombocytopenia. *Hematology Am Soc Hematol Educ Program* 2015; 2015(1): 237–242. <https://doi.org/10.1182/asheducation-2015.1.237>
5. NICE. Eltrombopag for treating chronic immune (idiopathic) thrombocytopenic purpura. Technology appraisal guidance [TA293]. Published: 24 July 2013. Last updated: 26 October 2018. <https://www.nice.org.uk/guidance/ta293>
6. NICE. Romiplostim for the treatment of chronic immune (idiopathic) thrombocytopenic purpura. Technology appraisal guidance [TA221]. Published: 27 April 2011. Last updated: 26 October 2018. <https://www.nice.org.uk/guidance/ta221>
7. NICE. Avatrombopag in combination for treating chronic immune thrombocytopenia. Technology appraisal guidance [TA853]. Published: 15 December 2022. <https://www.nice.org.uk/guidance/ta853>
8. NICE. Fostamatinib for treating refractory chronic immune thrombocytopenia. Technology appraisal guidance [TA835]. Published: 19 October 2022. <https://www.nice.org.uk/guidance/ta835>
9. Pavord S, Thachil J, Hunt BJ et al. Practical guidance for the management of adults with immune thrombocytopenia during the COVID-19 pandemic. *British Journal of Haematology* 2020; 189(6):1038-1043. <https://doi.org/10.1111/bjh.16775>
10. NHS England Rapid Policy Statement. Interim clinical commissioning policy: Thrombopoietin receptor agonist as first line therapy for new or relapsed immune thrombocytopenia in adults and children over the age of 1 year during the COVID-19 pandemic [C1258]. April 2021, version 3. (No longer available – revoked June 2022.) Copy on File.
11. NHS England Specialised Commissioning and Health and Justice. Letter: NHS England Rapid clinical commissioning policy statements implemented during the COVID-19 Pandemic. 20th June 2022. Copy on File.

12. UKITP Forum. Joint Position statement on the use of generic eltrombopag. October 2025. <https://ukitpforum.org/wp-content/uploads/2025/09/Position-statement-Generic-TPO-RA-from-ITP-Forum-and-the-ITPSA.pdf>
13. Wang L, Gao Z, Chen XP, et al. Efficacy and safety of thrombopoietin receptor agonists in patients with primary immune thrombocytopenia: A systematic review and meta-analysis. *Scientific Reports* 2016; 6:39003. <https://doi.org/10.1038/srep39003>
14. Liu Y, Zhang N, Jiang T, et al. Efficacy and safety and analysis of thrombopoietin receptor agonists for the treatment of immune thrombocytopenia in adults: analysis of a systematic review and network meta-analysis of randomized controlled trials and results of real-world safety data. *Frontiers in Medicine* 2025; 12:1531824. <https://doi.org/10.3389/fmed.2025.1531824>
15. Luo L, Jin S, Song Z, et al. Bridging the gaps between randomized controlled trials and real-world use of thrombopoietin receptor agonists for adult primary immune thrombocytopenia: a systematic review and meta-analysis. *Frontiers in Medicine* 2025; 12:1667457. <https://doi.org/10.3389/fmed.2025.1667457>
16. Arai Y, Matsui H, Jo T, et al. Comparison of treatments for persistent/chronic immune thrombocytopenia: a systematic review and network meta-analysis. *Platelets* 2019; 30(8): 946-956. <https://doi.org/10.1080/09537104.2018.1543864>
17. Puavilai T, Thadanipon K, Rattanasiri S, et al. Treatment efficacy for adult persistent immune thrombocytopenia: a systematic review and network meta-analysis. *British Journal of Haematology* 2020; 188(3): 450-459. <https://doi.org/10.1111/bjh.16161>
18. González-López TJ, Fernández-Fuertes F, Hernández-Rivas JA, et al. Efficacy and safety of eltrombopag in persistent and newly diagnosed ITP in clinical practice. *International Journal of Hematology* 2017;106(4): 508-516. <https://doi.org/10.1007/s12185-017-2275-4>
19. Gómez-Almaguer D, Herrera-Rojas MA, Jaime-Pérez JC, et al. Eltrombopag and high-dose dexamethasone as frontline treatment of newly diagnosed immune thrombocytopenia in adults. *Blood* 2014;123(25): 3906-8. <https://doi.org/10.1182/blood-2014-01-549360>
20. Rast J, Schramm T, Mehic D, et al. Management of Adult Patients with Newly Diagnosed or Relapsed Primary Immune Thrombocytopenia in Eastern Austria. *Hamostaseologie* 2024 Nov. Online ahead of print. <https://doi.org/10.1055/a-2404-0306>
21. Cuker A, Buckley B, Mousseau MC, et al. Early initiation of second-line therapy in primary immune thrombocytopenia: insights from real-world evidence. *Annals of Hematology* 2023; 102(8): 2051-2058. <https://doi.org/10.1007/s00277-023-05289-0>
22. Kuter DJ, Newland A, Chong BH, et al. Romiplostim in adult patients with newly diagnosed or persistent immune thrombocytopenia (ITP) for up to 1 year and in those with chronic ITP for more than 1 year: a subgroup analysis of integrated data from completed romiplostim studies. *British Journal of Haematology* 2019; 185(3): 503-513. <https://doi.org/10.1111/bjh.15803>
23. Mihaylo, G, Skopec B, Sninska Z, et al. PLATON: use of romiplostim to treat chronic primary immune thrombocytopenia. *Memo - magazine of European medical oncology* 2020; 13: 227-234. <https://doi.org/10.1007/s12254-020-00580-6>
24. Skopec B, Sninska Z, Tzvetkov, N et al. Effectiveness and safety of romiplostim among patients with newly diagnosed, persistent and chronic ITP in routine clinical practice in central and Eastern Europe: an analysis of the PLATON study. *Hematology* 2021; 26(1): 497-502. <https://doi.org/10.1080/16078454.2021.1948209>
25. Snell Taylor SJ, Nielson CM, Breskin A, et al. Effectiveness and Safety of Romiplostim Among Patients with Newly Diagnosed, Persistent and Chronic Immune Thrombocytopenia in European Clinical Practice. *Advances in Therapeutics* 2021; 38(5): 2673-2688. <https://doi.org/10.1007/s12325-021-01727-5>

26. NICE. Immune (idiopathic) thrombocytopenic purpura: rituximab. Evidence summary [ESUOM35]. Published: 21 October 2014. <https://www.nice.org.uk/advice/esuom35/chapter/Key-points-from-the-evidence>
27. Chugh S, Darvish-Kazem S, Lim W, et al. Rituximab plus standard of care for treatment of primary immune thrombocytopenia: a systematic review and meta-analysis. *Lancet Haematology* 2015; 2(2): e75-81. [https://doi.org/10.1016/S2352-3026\(15\)00003-4](https://doi.org/10.1016/S2352-3026(15)00003-4)
28. Patel, VL Mahévas M, Lee SY, et al. Outcomes 5 years after response to rituximab therapy in children and adults with immune thrombocytopenia. *Blood* 2012; 119(25): 5989-95. <https://doi.org/10.1182/blood-2011-11-393975>
29. Meyer O, Wong RSM, Khelif A, et al. Treatment of immune thrombocytopenia with eltrombopag in patients who had and who had not received prior rituximab: post-hoc analysis of the EXTEND study. *British Journal of Haematology* 2022; 196(2): 448-452. <https://doi.org/10.1111/bjh.17800>
30. NHS BSA. Drug Tariff. June 2026. <https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff>
31. NHS dm & d browser. Last updated 28th May 2026. <https://dmd-browser.nhsbsa.nhs.uk/>
32. NHS Specialist Pharmacy Service. Medicines Procurement and Supply Chain (MPSC) frameworks. Last updated 19th February 2026. <https://sps.nhs.uk/articles/medicines-procurement-and-supply-chain-mpsc-frameworks/>
33. NHS England. 2026/27 national tariff workbook (Annex A). Last updated April 2026. <https://www.england.nhs.uk/wp-content/uploads/2026/03/26-27-NHSPS-Annex-A-Prices-workbook.xlsx>
34. NHS England. 2026/27 NHS Payment Scheme. <https://www.england.nhs.uk/long-read/2026-27-nhs-payment-scheme/>
35. NHS England. Roadmap for integrating specialised services within Integrated Care Systems. May 2022. <https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf>
36. NHS England Immunoglobulin Expert Working Group. Commissioning Criteria Policy for the use of therapeutic immunoglobulin (Ig) England, 2021. NHS England. <https://igd.mdsas.com/wp-content/uploads/Commissioning-Criteria-Policy-for-the-use-of-Ig-Version-Finala.pdf>
37. Allen R, Bryden P, Grotzinger KM, et al. Cost-Effectiveness of Eltrombopag versus Romiplostim for the Treatment of Chronic Immune Thrombocytopenia in England and Wales. *Value in Health* 2016; 19(5): 614-22. <https://doi.org/10.1016/j.jval.2016.03.1856>
38. Doobaree IU, Conway K, Miah H, et al. UK adult ITP registry. Incidence of adult primary immune thrombocytopenia in England-An update. *European Journal of Haematology*. 2022; 109(3): 238-249. <https://doi.org/10.1111/ejh.13803>
39. Schoonen WM, Kucera G, Coalson J, et al. Epidemiology of immune thrombocytopenic purpura in the General Practice Research Database. *British Journal of Haematology* 2009; 145(2): 235-44. <https://doi.org/10.1111/j.1365-2141.2009.07615.x>
40. Neunert C, Lim W, Crowther M, et al. American Society of Hematology. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. *Blood* 2011;117(16): 4190-207. <https://doi.org/10.1182/blood-2010-08-302984>
41. Neunert C, Terrell DR, Arnold MD, et al. American Society of Hematology 2019 guidelines for immune thrombocytopenia. *Blood Advances* 2019; 3(23): 3829–3866. <https://doi.org/10.1182/bloodadvances.2019000966>
42. Portielje JE, Westendorp RG, Kluin-Nelemans HC, et al. Morbidity and mortality in adults with idiopathic thrombocytopenic purpura. *Blood*. 2001; 97(9): 2 549-54. <https://doi.org/10.1182/blood.V97.9.2549>

Summary assessment - Ethical and commissioning principles

Treatment assessed	Generic eltrombopag for adult persistent ITP
East of England Priorities Advisory Committee recommendation	Generic eltrombopag is recommended as a second line treatment option in adult patients with newly diagnosed and persistent ITP, who meet the following additional commissioning criteria: • Initiation by Consultant Haematologist only • Platelets $<20-30 \times 10^9/L$ • Patient has failed to respond adequately or has relapsed following 1st line treatment with corticosteroids and/or IVIG Current international standards classifies the stages of ITP into acute or newly diagnosed (<3 months), persistent (0-12 months) and chronic ITP (>12 months). Patients will be monitored and reviewed at least 6-12 months and if clinically appropriate, withdrawal of eltrombopag treatment will be considered. Supply arrangements should be agreed locally using the most cost-effective route e.g. via outsourced outpatient dispensing services where available. The use of homecare arrangements for the supply of eltrombopag is not supported by EoE commissioning pharmacists. Patients with newly diagnosed or persistent ITP who fail to respond to generic eltrombopag should be managed conservatively with first line treatments until eligible for treatment with other TPO-RA in line with NICE TAs. ICBs should monitor the uptake of treatment and patient clinical progression e.g. via Bluteq or equivalent.

Treatment assessed	Generic eltrombopag for adult persistent ITP
Clinical effectiveness	Current international consensus guidance recommends corticosteroids as the standard initial treatment for adults with IVIG reserved for patients with significant bleeding or at risk of bleeding. Subsequent recommended treatments include TPO-RAs, rituximab (RTX) or fostamatinib, although no specific order of treatment is suggested. There is less robust evidence for mycophenolate and other immunosuppressive treatments.¹ The National Institute for Health and Care Excellence (NICE) have published technology appraisals (TAs) which recommend the use of the TPO-RAs avatrombopag (TA853), eltrombopag (TA293), romiplostim (TA221) and the spleen tyrosine kinase (SYK) inhibitor, fostamatinib (TA835) as treatment options for patients with primary chronic ITP. There is an increasing, albeit small, amount of evidence regarding the use of TPO-RAs in patients with early newly diagnosed but persistent ITP. Comparative studies between agents for ITP are lacking. Several systematic reviews and meta-analyses have attempted to confirm the comparative status of the TPO-RAs One review by Wang et al identified 13 randomised controlled trials involving 1,126 ITP patients with persistent or chronic ITP. Ten of the included studies reported the incidence of any or severe bleeding events. The pooled results demonstrated that TPO-RAs significantly reduced the incidence of any or severe bleeding events (RR: 0.80, 95% CI: 0.67–0.95, $p = 0.013$; RR: 0.52, 95% CI: 0.27–0.99, $p = 0.048$; respectively) and in eight studies indicated that there was a significant reduction in the proportion of patients needing rescue medications in the TPO-RA groups compared with the control groups (RR: 0.50, 95% CI: 0.42–0.59, $p = 2.0 \times 10^{-15}$). Subgroup analysis based on TPO-RA regimens indicated that romiplostim did not substantially decrease the incidence of any or severe bleeding events (RR: 0.93, 95% CI: 0.72–1.21; RR: 0.64, 95% CI: 0.31–1.35; respectively). However, there were substantial reductions in the incidence of any or severe bleeding events in eltrombopag treated patients compared with control patients (RR: 0.68, 95% CI: 0.51–0.90; RR: 0.27, 95% CI: 0.07–1.00; respectively).¹³ Conversely, the systematic review and meta-analysis by Liu et al reported that in terms of efficacy romiplostim is superior and avatrombopag had a better safety profile¹⁴ and therefore it is difficult to draw a definitive conclusion and until further data becomes available. No TPO-RA can be considered to be clinically superior to another. A joint position statement on the use of generic eltrombopag has recommended that generic eltrombopag should be considered first when a TPO-RA is clinically needed and confirms that effectiveness of TPO-RA treatments is broadly similar.¹²
Cost effectiveness	There is no cost effectiveness data in relation to the use of ITPs for newly diagnosed and persistent ITP in adults.
Equity	No issues were identified in relation to disability, race, sex, gender or gender reassignment. This policy is only in relation to the treatment of adult patients >18 years. Specialist consultation is required for the management of ITP and sufficient capacity will be required to manage patients appropriately.

Treatment assessed	Generic eltrombopag for adult persistent ITP
Needs of the community	Generic eltrombopag is a cost effective treatment option for the management of ITP with proven efficacy and safety when monitored appropriately. A study utilising NHS Digital derived data for the period 2010-2014, has estimated an average annual primary ITP incidence rate of 6.1 per 100,000 population. An estimated 2.5/100,000 would require 1st line treatment whereas 2.4/100,000 would have 1st and 2nd line treatments within 6 months from diagnosis. If you extrapolate these figures for the East of England patient population of approximately 6.58 million, then approximately 60-80 patients across the East of England may remain persistent and be eligible for early treatment with generic eltrombopag under this policy.
Need for healthcare (incorporates patient choice and exceptional need)	Adoption of eltrombopag at an earlier point in the treatment pathway, would allow clinicians to provide an alternative treatment option which may obviate or reduce the need for IVIG or blood transfusions in ITP patients whilst they wait to become eligible for treatment under the various NICE TAs at approximately 6-12 months after initial disease presentation.
Policy drivers	Withdrawn NHS England COVID Policy 2021. Availability of generic eltrombopag
Disinvestment	The need for IVIG or other rescue costs or other TPO-RAs may be reduced, delayed or obviated altogether. Delay or obviate need for splenectomy.