AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Thrombocytopenia Medication Treatment

Quick Reference Guide

2026

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LANDSCAPE OF THROMBOCYTOPENIA MEDICATION UTILIZATION IN VALUE-BASED CARE

Thrombocytopenia is a laboratory finding, **not a single disease**.[1,2] **Medication decisions depend on** the cause, bleeding phenotype, platelet trend, age, comorbidities, concurrent antithrombotic therapy, and whether an urgent procedure is planned.[1,2] **In older adults**, a low platelet count may reflect **immune thrombocytopenia** (**ITP**), drug toxicity, infection, liver disease, nutritional deficiency, marrow failure or myelodysplastic syndrome, **thrombotic thrombocytopenic purpura** (**TTP**), **disseminated intravascular coagulation** (**DIC**), or **heparin-induced thrombocytopenia** (**HIT**).[1,2] Applying an ITP pathway **before** excluding these alternatives can **delay life-saving care** or expose patients to ineffective, toxic treatment.[3,4]

AAVBC PERSPECTIVE

*The **American Academy of Value-Based Care** (**AAVBC**) supports a stepwise thrombocytopenia pathway centered on **safe hemostasis rather than normalization of the platelet count**. For confirmed ITP, the goal is to prevent clinically important bleeding using the **lowest effective treatment intensity** while preserving function and quality of life.*[3,4] ***Stable, asymptomatic patients** may be safer under **structured observation** than exposed to corticosteroids, immunosuppression, or high-cost maintenance therapy.*[3]
*When treatment is required, corticosteroids should be **time-limited**.*[3,5] *Repeated or prolonged steroid courses that produce diabetes, osteoporosis, infection, delirium, mood disturbance, sarcopenia, or hospitalization represent **low-value care**.*[3,5] *Patients who relapse, become steroid-dependent, or require recurrent **intravenous immunoglobulin** (**IVIG**) should **transition promptly to a hematology-directed maintenance strategy**.*[3,4]
***Thrombopoietin receptor agonists** (**TPO-RAs**), rituximab, fostamatinib, rilzabrutinib, and selected other therapies should be chosen according to bleeding risk, thrombotic risk, desired durability, route, monitoring burden, cost, and patient preference.*[4,6,7]
***The PCP's highest-value actions occur before and between hematology visits**: verify that thrombocytopenia is real, recognize emergency syndromes, audit medications, protect patients from bleeding-promoting drugs, monitor treatment toxicity, confirm vaccination and infection screening, address affordability, and **close the loop** when platelet counts fall or rescue therapy becomes recurrent.*[1,8]

↔ MAKING CONNECTIONS

For additional context on **immune thrombocytopenia**, please consult the **AAVBC Immune Thrombocytopenia QRG**

Clinical Context in Older Adults

CLINICAL SCENARIO	CLINICAL SIGNIFICANCE[1,3,4,9,10]	KEY PCP CONSIDERATIONS*[1,4,9,11,12]
Unexpected isolated low platelet count	May be **pseudothrombocytopenia** rather than disease	**Repeat CBC**, review smear, and recollect in citrate or heparin tube if platelet clumping is suspected
Platelets at least 30,000/µL without clinically important bleeding	Many adults with newly diagnosed ITP can be observed	**Consider**: age, comorbidities, antithrombotics, procedures, reliability, and trend **before withholding treatment**
Platelets below 20,000 to 30,000/µL or mucosal bleeding	Risk-benefit more often **favors treatment**	Arrange **same-day hematology** or emergency evaluation according to symptoms, trajectory, and context
Thrombocytopenia plus anemia, schistocytes, neurologic/renal findings, fever, or coagulation abnormalities	TTP, DIC, hemolysis, sepsis, or marrow disease may be present	**Urgent hospital evaluation**; do not label as uncomplicated ITP
Platelet fall after heparin exposure with thrombosis risk	**HIT is prothrombotic** despite thrombocytopenia	Calculate **4Ts score**, stop all heparin if intermediate/high probability, and initiate urgent non-heparin management pathway
Older adult with additional cytopenias or abnormal smear	MDS, leukemia, marrow failure, or infiltrative disease becomes **more likely**	**Expedite hematology evaluation** and consider marrow assessment
Recurrent IVIG or steroid rescue	Indicates **unstable disease** or **inadequate maintenance**	Establish a **steroid-sparing second-line plan** rather than continuing episodic rescue
Concurrent aspirin, antiplatelet, or anticoagulant indication	Both bleeding and thrombotic consequences are substantial	**Do not apply a universal platelet cutoff**; coordinate indication-specific holding and resumption with hematology/cardiology

ABBREVIATIONS: PCP = primary care provider; CBC = complete blood count; ITP = immune thrombocytopenia; TTP = thrombotic thrombocytopenic purpura; DIC = disseminated intravascular coagulation; HIT = heparin-induced thrombocytopenia; MDS = myelodysplastic syndrome; IVIG = intravenous immunoglobulin
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Direct Savings and Value Impact Matrix

VALUE LEVER	CLINICAL STRATEGY[1,3,4,9,13]	FINANCIAL MECHANISM AND IMPACT[3,4,9,14]
Diagnostic accuracy — confirmation before treatment	**Exclude**: platelet clumping, secondary causes, and emergency mimics **before ITP therapy**	**Prevents**: unnecessary biologics, infusions, admissions, and delayed disease-specific treatment
Overtreatment reduction — observation when safe	**Monitor stable non-bleeding patients** rather than treating a number	Avoids drug toxicity and pharmacy spend **without increasing meaningful risk in appropriate patients**
Toxicity limitation — steroid-duration control	Use a **short first-line course** and avoid treatment **beyond 6 weeks** including taper	**Reduces**: diabetes, fractures, infection, psychiatric toxicity, and steroid-related hospitalization
Utilization redirection — rescue-to-maintenance conversion	Treat recurrent IVIG or steroid rescue as **pathway failure**	Replaces cyclical emergency/infusion utilization with **planned outpatient control**
Dose stewardship — TPO-RA optimization	**Target a hemostatic count**, not a normal count, and use the lowest effective dose	**Limits**: thrombosis, excessive monitoring, and avoidable drug consumption
Site-of-care optimization — benefit-channel selection	Compare **oral pharmacy-benefit** and **clinic-administered medical-benefit** therapies	**Reduces**: travel, infusion-center use, discarded vial cost, and patient financial toxicity
Harm avoidance — medication reconciliation	**Remove causative drugs** and **bleeding-promoting OTC agents** when clinically appropriate	**Prevents**: recurrent thrombocytopenia, GI bleeding, and avoidable emergency care
Patient-centered value — patient-reported outcomes	**Track**: fatigue, bleeding anxiety, activity, and treatment burden	**Prevents escalation based solely on platelet variability** and aligns therapy with patient benefit

ABBREVIATIONS: ITP = immune thrombocytopenia; IVIG = intravenous immunoglobulin; TPO-RA = thrombopoietin receptor agonist; OTC = over-the-counter; GI = gastrointestinal
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

INDICATIONS AND CONTRAINDICATIONS

Indications

Observation Versus Active Treatment in ITP

Treatment should be driven by **bleeding and overall risk**, **not a universal numeric threshold**.[4,9] In newly diagnosed adult ITP, **observation is generally favored** when platelets are **at least 30,000/µL with no or minor mucocutaneous bleeding**.[3,9] **Corticosteroid treatment** is generally favored **below 30,000/µL**, but the decision should be individualized.[3,9] Older age, a rapid decline, clinically important mucosal bleeding, anticoagulant or antiplatelet need, uncontrolled hypertension, fall/trauma exposure, planned procedure, and limited follow-up **may justify treatment at a higher count**.[4,9]

Patients with major bleeding, suspected intracranial hemorrhage, hemodynamic instability, significant GI bleeding, or rapidly progressive wet purpura **require emergency care regardless of platelet count**.[4] Platelet goals for surgery, neuraxial procedures, dental care, childbirth, or antithrombotic therapy are **procedure-** and **patient-specific** and should be **set with the responsible specialist**.[4,9]

ITP Medication Roles

- **Corticosteroids**: **Prednisone** or **dexamethasone** is **first-line treatment** for newly diagnosed symptomatic or higher-risk ITP. Use a **defined short course**; **avoid** prolonged prednisone **beyond 6 weeks** including taper[4,9]
- **IVIG**: Provides a **rapid but temporary platelet increase** for major bleeding, urgent procedures, or when corticosteroids are unsuitable or insufficient. It is **rescue or bridging therapy**, not efficient chronic maintenance[4]
- **Platelet transfusion**: Reserve primarily for **critical** or **life-threatening bleeding**, usually combined with ITP-directed therapy because immune destruction can **rapidly consume transfused platelets**. Prophylactic thresholds used in hypoproliferative marrow failure should **not be transferred automatically to ITP**[4]
- **TPO-RAs**: **Eltrombopag**, **romiplostim**, and **avatrombopag** are major **second-line options** for persistent/chronic or steroid-dependent ITP. Dose to maintain a **safe count sufficient to reduce bleeding**, not to normalize platelets[4,15]
- **Rituximab**: Offers a **finite-course**, **potentially treatment-free response** but carries infusion, infection, hepatitis B reactivation, and impaired vaccine-response risks[4,15]
- **Fostamatinib**: An oral spleen tyrosine kinase inhibitor for **chronic ITP after insufficient response to prior treatment**; monitor hypertension, diarrhea, hepatotoxicity, and neutropenia[4]

- **Rilzabrutinib**: FDA-approved in 2025 for adults with **persistent or chronic ITP after insufficient response to prior treatment**. It is an oral 400 mg twice-daily option; infection and gastrointestinal tolerability require review[16]
- **Splenectomy**: Can provide durable remission but **should usually be delayed for at least 1 year after diagnosis when feasible** because spontaneous remission can occur and lifelong infection/thrombosis risks persist[4,15]

Cause-Specific Treatment Outside ITP

- **HIT**: **Stop all heparin**, including flushes, and use a non-heparin anticoagulant when clinical probability supports treatment. **Platelet transfusion is generally avoided** unless active major bleeding or a high-risk procedure requires it[17,18]
- **TTP**: Requires emergency plasma exchange, corticosteroids, caplacizumab, and specialist-directed immunosuppression. **Do not await routine outpatient workup** when suspected[1]
- **DIC/sepsis**: Treat the underlying cause and provide component support according to bleeding, procedure, and laboratory status[1]
- **DAPT**: Use aspirin plus a P2Y12 inhibitor **for a defined period after PCI or ACS**. Potent agents such as ticagrelor or prasugrel are generally **reserved for higher-risk ACS/PCI settings**, not indefinite stable angina treatment[8,12]
- **Drug-induced immune thrombocytopenia**: **Stop the suspected agent**. Recovery often begins after drug clearance; **document the culprit** prominently and avoid rechallenge[1]
- **Nutritional, hepatic, infectious, or marrow-related thrombocytopenia**: Treat the cause; ITP medications are not interchangeable with cause-directed care[1]

Special Considerations in Older Adults

CONSIDERATION	KEY POINTS*[4,9,19–21]
Diagnosis and mimics	**ITP incidence peaks after age 80** and is a diagnosis of exclusion; rule out myelodysplasia, drug-induced, and secondary causes; **low threshold for hematology referral** and marrow evaluation
Baseline risk profile	Higher rates of bleeding, thrombosis, and infection at any count; **weigh treatment toxicity against disease risk** rather than chasing a normal count
Corticosteroids	First-line, but **toxicity** (hyperglycemia, hypertension, infection, psychiatric effects, bone loss, falls) **is greater** → use **shortest effective course**; monitor glucose, BP, and mood
IVIG	Rapid, temporary rise for bleeding or urgent procedures, but **higher risk of renal failure**, **volume overload**, and **thrombosis**; attend to hydration and cardiac/renal status

CONSIDERATION	KEY POINTS*[4,9,19–21]
TPO-RAs (preferred second-line)	Effective and well-tolerated (eltrombopag, romiplostim, avatrombopag); no major age-related safety difference; **thrombosis is the main concern** → dose to a safe, not normal, count
Rituximab	Fewer durable remissions; **meaningful infection risk** → **screen for hepatitis B**, monitor IgG, **avoid in immunocompromised patients**
Splenectomy	**Less effective and higher risk** (thrombosis, late infection, operative complications); usually deferred; if pursued, vaccinate and counsel on antibiotics
Comorbidities and polypharmacy	**Reconcile**: antiplatelet/anticoagulant needs and platelet-lowering or bleeding-promoting drugs; account for **falls**, **cognition**, **renal function**, and **cardiovascular risk**
Goals of care	**Individualize to bleeding risk and function**, not a numeric threshold; incorporate frailty, preference, and shared decision-making

ABBREVIATIONS: ITP = immune thrombocytopenia; IVIG = intravenous immunoglobulin; TPO-RA = thrombopoietin receptor agonist; BP = blood pressure; IgG = immunoglobulin G
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Contraindications and Major Precautions

CATEGORY	CONTRAINDICATION/ PRECAUTION*[1,4,9,12,22]	APPLIES TO*	PCP RESPONSE[1,9,22–24]
Active severe infection	**Sepsis**, uncontrolled systemic **infection**, or untreated **invasive fungal disease**	Corticosteroids, rituximab, other immunosuppression	**Control infection** and involve hematology; use **emergency hemostatic therapy** if bleeding demands treatment
Uncontrolled metabolic disease	Severe diabetes, hypertension, psychosis, peptic ulcer, osteoporosis, or delirium risk	Corticosteroids	Prefer **shortest possible exposure**, proactive mitigation, or an alternative when feasible
Thrombotic risk	Prior VTE/arterial thrombosis, active cancer, antiphospholipid syndrome, immobility, or excessive platelet rise	TPO-RAs	**Do not chase normal counts**; review individualized risk and monitor for thrombosis
Hepatic disease	Baseline or treatment-emergent liver injury	Eltrombopag, fostamatinib, selected other agents	**Check labeling and LFTs**; adjust, interrupt, or select an alternative

CATEGORY	CONTRAINDICATION/ PRECAUTION*[1,4,9,12,22]	APPLIES TO*	PCP RESPONSE[1,9,22–24]
Hepatitis B	Current or prior HBV infection **without reactivation plan**	Rituximab	**Obtain HBsAg and anti-HBc**; coordinate antiviral prophylaxis/ monitoring **before treatment**
Live vaccines	Significant immunosuppression or B-cell depletion	High-dose corticosteroids, rituximab	**Avoid live vaccines** during the restricted period; complete indicated vaccines **beforehand** when feasible
Pregnancy/ reproductive considerations	Pregnancy, planned pregnancy, or lactation	Agent-specific	Coordinate **maternal-fetal medicine** and hematology; do not assume chronic ITP regimens are interchangeable
HIT	Suspected or confirmed HIT	UFH, LMWH, heparin flushes	Stop all heparin and initiate urgent HIT pathway
Platelet dysfunction/ bleeding promotion	Aspirin, NSAIDs, P2Y12 inhibitors, anticoagulants, alcohol, and selected supplements	Patients with thrombocytopenia	**Reassess indication and bleeding risk**; avoid blanket discontinuation when thrombosis risk is high

ABBREVIATIONS: PCP = primary care provider; VTE = venous thromboembolism; TPO-RA = thrombopoietin receptor agonist; LFT = liver function test; HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; anti-HBc = hepatitis B core antibody; ITP = immune thrombocytopenia; HIT = heparin-induced thrombocytopenia; UFH = unfractionated heparin; LMWH = low-molecular-weight heparin; NSAID = nonsteroidal anti-inflammatory drug; P2Y12 = P2Y12 platelet receptor

***Consult current FDA labeling for agent-specific dosing, renal thresholds, contraindications, reversal, and peri-procedural interruption**

CLINICAL PEARL: ESSENTIAL PCP PRE-TREATMENT CHECKS

Before initiating ITP-directed medication:

- **Verify the result**: Repeat CBC, review peripheral smear, and exclude EDTA-related platelet clumping[1,4]
- **Identify emergencies**: Assess active bleeding, neurologic symptoms, fever, renal injury, hemolysis, coagulation abnormalities, thrombosis, pregnancy, and **recent heparin exposure**[1,4]
- **Define whether thrombocytopenia is isolated**: Review hemoglobin, leukocytes, reticulocytes, smear morphology, liver/spleen findings, and constitutional symptoms[4,9]
- **Search for secondary causes**: Reconcile new drugs and supplements; assess HIV, HCV, HBV when relevant, nutritional deficiency, thyroid disease, autoimmune disease, liver disease, alcohol, infection, and malignancy according to context[4,9]
- **Establish treatment safety**: CBC, CMP/LFTs, creatinine, pregnancy testing when relevant, hepatitis B screening before rituximab, vaccination status, BP, glucose/A1c, bone health, and thrombotic risk[9,23]
- **Document the target**: Specify bleeding goal, platelet range sufficient for hemostasis, intended duration, monitoring schedule, and criteria to taper, switch, or stop[9,25]

Common Drug-Drug and Food Interaction Management

COMBINATION	MAIN RISK*[12,26,27]	PCP STRATEGY*[12,26,28]
Eltrombopag + calcium, iron, magnesium, aluminum, zinc, dairy, or antacids	Chelation and loss of absorption	Give eltrombopag **at least 2 hours before** or **4 hours after** polyvalent cations; use teach-back
Eltrombopag + OATP1B1/ BCRP substrates such as rosuvastatin	Increased substrate exposure and **myopathy risk**	Use label-directed **dose adjustment** and monitor toxicity
Fostamatinib + strong CYP3A4 inhibitor	Increased active-metabolite exposure and **toxicity**	Monitor closely and **consider alternative** or adjustment according to labeling
Fostamatinib + strong CYP3A4 inducer	Reduced exposure and **treatment failure**	**Avoid when possible**
Corticosteroid + NSAID	GI ulceration and bleeding	**Avoid NSAIDs**; consider **gastroprotection** when risk remains elevated

COMBINATION	MAIN RISK*[12,26,27]	PCP STRATEGY*[12,26,28]
Rituximab + live vaccine	Vaccine-associated infection or **ineffective immunization**	Complete vaccines **before B-cell depletion** when feasible; **avoid live vaccines** during immunosuppression
Thrombocytopenia therapy + antiplatelet/ anticoagulant	Competing bleeding and thrombosis risks	Coordinate **indication-specific thresholds** and resumption plan; do not use a universal cutoff

ABBREVIATIONS: PCP = primary care provider; OATP1B1 = organic anion transporting polypeptide 1B1; BCRP = breast cancer resistance protein; CYP3A4 = cytochrome P450 3A4; NSAID = nonsteroidal anti-inflammatory drug; GI = gastrointestinal
***Consult current FDA labeling for agent-specific dosing, renal thresholds, contraindications, reversal, and peri-procedural interruption**

ITP MEDICATION SELECTION, DURATION, AND DE-ESCALATION

First-Line Therapy and Steroid Stewardship

CLINICAL NEED	PREFERRED APPROACH[3,4,9,15,29]	DURATION PRINCIPLE*[3,4,9,15,29]
Newly diagnosed ITP requiring treatment, noncritical bleeding	Short prednisone or dexamethasone course	Avoid prednisone courses **longer than 6 weeks** including taper
Need for faster rise	Add IVIG or use appropriate rapid first-line strategy	Reassess within days; **IVIG benefit is transient**
Critical bleeding	IVIG + corticosteroid + platelet transfusion and **local/ emergency hemostatic care**	**Hospital-based rescue** while definitive response develops
Steroid response followed by relapse/dependence	Move to second-line shared decision-making	**Do not recycle prolonged steroids** as chronic maintenance

ABBREVIATIONS: ITP = immune thrombocytopenia; IVIG = intravenous immunoglobulin
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

Steroid toxicity prevention should begin with the first prescription, especially in older adults.[5,9] Monitor glucose, BP, mood, sleep, delirium, infection, proximal weakness, fluid retention, GI risk, and bone health.[9,30] The value metric is not merely "response to steroids," but **response achieved without converting ITP into treatment-induced multimorbidity**.[9,30]

Second-Line Selection

OPTION	BEST FIT CONSIDERATIONS*[4,7,9,15,31]	MAIN LIMITATIONS AND MONITORING*[4,6,32]
Eltrombopag	**Oral therapy**, preference to avoid injections, potential treatment-free taper in responders	**Food/mineral restrictions**, LFT monitoring, thrombotic risk, adherence complexity
Avatrombopag	**Oral therapy** without eltrombopag's polyvalent-cation fasting restrictions	**Cost/access**, thrombosis, CBC-guided dosing
Romiplostim	**Weekly subcutaneous therapy**, useful when adherence to daily oral therapy is difficult	**Clinic/medical-benefit burden**, dose titration, vial waste, thrombosis
Rituximab	**Preference for finite course** and possibility of treatment-free response	**Infection**, **HBV reactivation**, infusion reaction, impaired vaccine response, less durable response in many patients
Fostamatinib	**Oral** mechanism that **reduces immune-mediated destruction** after prior therapy	**Hypertension**, diarrhea, LFT abnormalities, neutropenia, interactions
Rilzabrutinib	**Oral twice-daily therapy** after insufficient response to prior treatment	**Infection and GI adverse effects**, **twice-daily adherence**, new-drug cost/access
Splenectomy	Patient prioritizes highest chance of **durable treatment-free response**	**Operative risk**, **lifelong infection/thrombosis risk**, vaccinations, delayed timing

ABBREVIATIONS: LFT = liver function test; CBC = complete blood count; HBV = hepatitis B virus; GI = gastrointestinal
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

No universal sequence can be accurately applied to every patient. **Shared decision-making should cover** the desire for durable remission versus chronic maintenance, daily oral versus weekly injection/infusion, dietary restrictions, pregnancy plans, thrombotic and infection risks, monitoring, travel, insurance benefit, and out-of-pocket cost.[3,15]

Target, Stopping Rules, and De-Escalation

- **Target**: Use the lowest dose needed to maintain a platelet count sufficient to reduce bleeding, **commonly at least 50,000/µL**. Do not target a normal count routinely[4,25]
- **Nonresponse**: Apply **agent-specific response windows and stopping rules**. Reassess diagnosis, adherence, absorption, interactions, and mechanism **before continuing an expensive ineffective therapy**[15]

- **Steroids**: Taper according to regimen and exposure; prolonged therapy may require **gradual taper** to **prevent adrenal insufficiency**[5,9]
- **TPO-RAs**: After a sustained stable response, hematology may **gradually reduce dose** with closer CBC monitoring. Abrupt unsupervised discontinuation can produce recurrent thrombocytopenia[33,34]
- **Rescue therapy**: Two or more unplanned rescue episodes should trigger **maintenance-plan review** rather than automatic repetition[3,15]
- **Treatment-free remission**: Selected stable patients may attempt **supervised taper after sustained response**, with a written relapse and rescue plan[34,35]

Confirming Control

Control means **absence of clinically important bleeding** with a **stable hemostatic platelet count**, minimal or no rescue therapy, acceptable medication toxicity, and **preserved daily function**.[4,25] **A normal platelet count is not required**. Track bleeding manifestations, platelet trend, rescue use, steroid exposure, fatigue, treatment burden, and patient confidence **rather than a single CBC value**.[4,25]

TREATMENT FAILURE AND SAFETY MONITORING

Managing Apparent Treatment Failure

SCENARIO	ACTION*[4,6,9,15]
No response to first-line steroid	**Confirm diagnosis and adherence**; move to **hematology-directed second-line therapy** rather than prolonging steroids
Eltrombopag failure	Audit **calcium/dairy/supplement timing**, adherence, liver function, and interactions **before declaring biologic failure**
TPO-RA nonresponse or loss of response	**Reassess diagnosis and marrow disease**; consider switching within class or to a different mechanism
Repeated IVIG requirement	**Treat as unstable disease** and establish maintenance rather than continuing high-cost rescue cycles
New anemia, leukopenia, macrocytosis, abnormal smear, splenomegaly, or constitutional symptoms	**Reopen the diagnosis**; evaluate MDS, marrow failure, malignancy, hemolysis, liver disease, and sequestration
Platelet rise above target or new thrombosis	**Reduce/hold TPO-RA** according to labeling and urgently evaluate thrombosis

SCENARIO	ACTION*[4,6,9,15]
Bleeding despite an apparently adequate count	**Review**: Platelet dysfunction, anticoagulants/antiplatelets, renal/liver disease, local lesion, and alternate hemostatic defects
Persistent fatigue despite platelet response	**Evaluate**: Anemia, sleep, depression, thyroid disease, medication toxicity, deconditioning, and other causes; **do not escalate solely for fatigue**

ABBREVIATIONS: TPO-RA = thrombopoietin receptor agonist; IVIG = intravenous immunoglobulin; MDS = myelodysplastic syndrome
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On-Treatment Monitoring Schedule

MEASURE	TIMING AND PURPOSE*[4,9,36]
CBC and platelet trend	**Frequently during initiation/titration**, then extend when stable; repeat urgently with bleeding, infection, or new medication
Bleeding assessment	**Every contact**; include wet purpura, epistaxis, gingival bleeding, hematuria, melena, heavy menstrual bleeding, headache, neurologic symptoms, and trauma
Steroid toxicity	**During and after exposure**; BP, glucose, mood, sleep, infection, muscle weakness, falls, GI and bone risk
TPO-RA safety	**CBC-guided dosing**; **thrombosis symptoms**; LFTs for eltrombopag; consider smear/marrow evaluation if new abnormalities suggest reticulin or another process
Fostamatinib	**BP every 2 weeks** until stable then monthly, plus CBC and LFT monitoring according to labeling
Rilzabrutinib	CBC response, infection symptoms, GI tolerability, and adherence **according to current labeling**
Rituximab	Infusion reactions, infections, HBV reactivation plan, immunoglobulins when indicated, and vaccine timing
Medication/OTC review	**Every visit**; heparin exposure, antibiotics, quinine, NSAIDs, aspirin, antiplatelets, anticoagulants, alcohol, and supplements
Patient-reported outcomes	Fatigue, bleeding anxiety, activity restriction, travel/infusion burden, and ITP-PAQ or another structured measure when available

MEASURE	TIMING AND PURPOSE*[4,9,36]

ABBREVIATIONS: CBC = complete blood count; BP = blood pressure; GI = gastrointestinal; TPO-RA = thrombopoietin receptor agonist; LFT = liver function test; HBV = hepatitis B virus; OTC = over-the-counter; NSAIDs = nonsteroidal anti-inflammatory drugs; ITP-PAQ = Immune Thrombocytopenia Patient Assessment Questionnaire
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

CLOSED-LOOP THROMBOCYTOPENIA PATHWAY FOR PCPS

- **Verify**: Repeat the count, inspect the smear, and **exclude pseudothrombocytopenia**[1,4]
- **Triage**: Identify major bleeding, TTP/DIC, HIT, sepsis, pregnancy emergencies, acute leukemia, and additional cytopenias requiring urgent care[1,37]
- **Find the cause**: Audit medications, infections, liver disease, alcohol, nutrition, autoimmunity, splenomegaly, and marrow clues[1,4]
- **Protect**: Remove **avoidable platelet-impairing drugs**, provide bleeding precautions, and coordinate essential antithrombotic therapy rather than stopping it reflexively[1,3]
- **Treat or observe**: Base the decision on bleeding, trend, age, comorbidities, procedures, follow-up, and cause, **not the platelet number alone**[3,9]
- **Limit rescue toxicity**: Put an **end date on steroids** and flag repeated IVIG/steroid rescue for hematology maintenance review[4,9]
- **Monitor value**: Track bleeding, platelet stability, rescue use, steroid days, adverse events, quality of life, adherence, and total medical/pharmacy burden[4,9]
- **Close transitions**: After hospitalization or medication change, confirm the active diagnosis, culprit-drug list, doses, lab schedule, vaccination/infection plan, and thresholds for urgent contact[4,9]

PCP and Specialist Responsibilities

CARE FUNCTION	PRIMARY CARE*[1,3,4,9]	HEMATOLOGY/PHARMACY*[9,15,36,38]
Initial evaluation	**Confirm count**, assess bleeding, review smear and medications, **screen common secondary causes**	**Confirm ITP** or **alternate hematologic diagnosis**; direct marrow and specialized testing
Emergency recognition	**Route** suspected TTP, DIC, HIT, acute leukemia, or major bleeding urgently	Direct **plasma exchange**, caplacizumab, **non-heparin anticoagulation**, rescue combinations, and inpatient care

CARE FUNCTION	PRIMARY CARE*[1,3,4,9]	HEMATOLOGY/PHARMACY*[9,15,36,38]
ITP treatment	Support **short-course steroid monitoring** and execute shared plan	**Select and titrate** second-line agents, taper therapy, and assess splenectomy
Comorbidity safety	**Manage**: diabetes, BP, osteoporosis, infection, falls, cognition, and interacting medications	Balance thrombosis/bleeding and treatment-specific hematologic toxicity
Access and adherence	**Reconcile**: benefits, transport, diet restrictions, copays, and refill gaps	**Navigate**: specialty pharmacy, prior authorization, medical-benefit infusion/ injection, and switching

ABBREVIATIONS: BP = blood pressure; ITP = immune thrombocytopenia; TTP = thrombotic thrombocytopenic purpura; DIC = disseminated intravascular coagulation; HIT = heparin-induced thrombocytopenia
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COST-SMART PRESCRIBING

The central cost comparison is not inexpensive steroids versus costly second-line agents. It is short-term rescue versus the total burden of repeated rescue, steroid complications, infusion-center utilization, bleeding admissions, and loss of function.[39,40] **Advanced therapies can be high value** when they replace recurrent IVIG, emergency treatment, or chronic corticosteroids; they are **low value when used without diagnostic certainty**, **response assessment**, or a **stopping rule**.[4,9,15,41]

STRATEGY	DIRECT COST PATTERN[36,39,41]	VALUE-BASED USE[1,4,9,15,41]
Observation	Minimal drug cost	Preferred for **appropriate stable nonbleeding patients** with reliable follow-up
Short steroid course	Low acquisition cost	**Useful first-line bridge**; **cumulative toxicity** makes prolonged/repeated exposure **expensive**
IVIG	High medical-benefit infusion cost	**Reserve for**: rapid rescue, major bleeding, or urgent procedure **rather than chronic maintenance**
Oral TPO-RA	High specialty-pharmacy cost	**May reduce rescue and clinic use**; compare dietary burden, adherence, copay, and response

STRATEGY	DIRECT COST PATTERN[36,39,41]	VALUE-BASED USE[1,4,9,15,41]
Romiplostim	Medical-benefit injection and monitoring cost	Valuable when **weekly supervised dosing fits the patient**; account for visits and vial waste
Rituximab	Finite infusion-course cost	**Potential treatment-free interval** must be balanced against **infection and vaccine consequences**
Fostamatinib/ rilzabrutinib	High oral specialty-drug cost	Use **after prior-treatment failure** with defined response and stopping criteria

ABBREVIATIONS: IVIG = intravenous immunoglobulin; TPO-RA = thrombopoietin receptor agonist
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

Cost-smart actions:

- Confirm the diagnosis **before** specialty-drug authorization[4,9]
- **Cap steroid duration** and track cumulative exposure across prescribers[9,39]
- Use recurrent rescue therapy as a **trigger for maintenance redesign**[9,15]
- Compare **pharmacy-benefit oral therapy** with **medical-benefit injection/infusion cost**, travel, and missed work[36,41]
- Prevent avoidable eltrombopag failure through **dietary and supplement teach-back**[15]
- Apply **response-based stopping rules** rather than continuing ineffective high-cost therapy[9,15]
- Use **manufacturer assistance** only when legally available; verify Medicare Part D, Extra Help, foundation, and payment-plan options without promising copay-card eligibility[36,41]
- Track **total cost** across pharmacy, infusion, monitoring, bleeding, thrombosis, infection, fractures, diabetes, ED use, and hospitalization[39,41]

BRAND (EST. COST)*[42–45]	GENERIC (EST. COST)*[42–45]	EST. SAVINGS + COST-SMART TIP[4,9,42–44,46]
Brand Rayos (delayed-release prednisone) (~$450–600/month)	Generic **prednisone** (**~$9–15/month**); all other brands discontinued	**~$435–585/month** Generic prednisone is the correct first-line choice — guideline-consistent and negligible cost; limit to **<6 weeks** and avoid prolonged courses especially in older adults due to infection, fracture, and metabolic risk; high-dose **dexamethasone 40 mg × 4 days** is an equivalent first-line alternative at similarly low cost

BRAND (EST. COST)*[42–45]	GENERIC (EST. COST)*[42–45]	EST. SAVINGS + COST-SMART TIP[4,9,42–44,46]
Brand Gamunex-C (~$11,000–22,000/ treatment course for 70 kg patient at 1 g/kg/day × 2 days) or brand Privigen(~$13,600/ course same dosing)	No generic IVIg exists in the US; multiple branded IVIg products priced comparably; formulary selection may yield modest cost differences	**Variable by brand and site of care** IVIg is reserved for **life-threatening bleeding, urgent pre-surgical prep, or when steroids are contraindicated** — not a long-term strategy; route site-of-care to an **outpatient infusion center** rather than inpatient hospital when clinically safe- inpatient episodes average significantly higher total costs than outpatient administration
Brand Promacta (eltrombopag 50mg/day, ~$13,852/month)	Generic **eltrombopag** (**~$6,600-10,300/ month**; FDA approved September 2024)	**~$3,500–7,200/month** Generic eltrombopag is FDA-approved and now available; confirm specialty pharmacy benefit allows generic substitution
Brand Nplate (romiplostim SC weekly injection, ~$15,000/month at typical 2-3 mcg/kg maintenance dose for 70 kg patient	No biosimilar exists; oral TPO-RA alternatives are **generic eltrombopag** (**~$6,600–10,300/ month**) or brand Promacta (**~$13,852/ month**)	**Romiplostim generally costlier than either eltrombopag option once real-world dosing and vial waste are included** Both Nplate and eltrombopag are FDA-approved for chronic ITP; Nplate (weekly SC injection, clinic-administered) may be preferred in **high thrombosis-risk elderly patients**; generic eltrombopag (oral, daily) is the lower-cost alternative when oral route is feasible; **TPO-RA selection and monitoring requires hematology management**
Brand Danocrine (danazol) — discontinued	Generic **danazol** (**~$100-150/month**)	**N/A — brand discontinued** Generic danazol is a low-cost steroid-sparing alternative; primarily relevant in older adults and VBC frailty contexts; long-term use requires **hepatotoxicity monitoring**

ABBREVIATIONS: IVIg = intravenous immunoglobulin; SC = subcutaneous; TPO-RA = thrombopoietin receptor agonist; ITP = immune thrombocytopenia; VBC = value-based care
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

NON-PHARMACOLOGICAL AND PATIENT-CENTERED CARE

INTERVENTION	RECOMMENDATION*[1,22,25,47,48]
Medication and supplement safety	**Avoid unnecessary aspirin/NSAIDs** and high-dose platelet-impairing supplements; coordinate essential antithrombotics
Alcohol	**Reduce or avoid** because alcohol can **suppress marrow production**, **worsen liver disease**, and **increase bleeding**
Injury prevention	**Match activity to**: platelet count, bleeding history, fall risk, and treatment; **avoid contact/high-fall-risk activity** when counts are severely low
Oral/home safety	**Soft toothbrush**, electric razor, constipation prevention, safe footwear, clear walking paths, and medical alert information
Nutrition	**Correct confirmed B12**, **folate**, or **other deficiency**; do not imply that food or supplements treat immune platelet destruction; avoid tonic water (contains quinine)
Vaccination	**Update indicated vaccines before** rituximab, splenectomy, or major immunosuppression when feasible; **avoid live vaccines when contraindicated**
Psychosocial care	Address fatigue, depression, bleeding anxiety, work/travel burden, and caregiver stress; **offer patient-support resources**

ABBREVIATIONS: NSAIDs = nonsteroidal anti-inflammatory drugs

Patient-Centered Conversation Framework

- **Explain the target**: "We need a platelet count that **prevents bleeding**, not necessarily a normal count."[4,9]
- **Use teach-back**: Ask the patient to identify urgent bleeding signs, prohibited OTC drugs, medication timing, lab schedule, and who to call after a count drop[1,48]
- **Separate rescue and maintenance**: Explain that IVIG or steroids **may raise platelets quickly** but are **not automatically safe long-term solutions**[9,15]
- **Discuss lifestyle burden**: Compare oral, injection, infusion, dietary, monitoring, and travel demands rather than discussing response rate alone[36,49]
- **Make the culprit-drug list durable**: Document suspected **drug-induced thrombocytopenia** in the allergy/adverse-reaction field and discharge materials[1,38]

- **Define emergencies**: Severe headache, neurologic change, head trauma, hematemesis, melena, heavy uncontrolled bleeding, dyspnea, chest pain, or thrombosis symptoms require **urgent evaluation**[4,9]

QUALITY ALIGNMENT

Key HEDIS/MIPs Measures

No thrombocytopenia-specific HEDIS or MIPS measures are active in MY2026.

TEN KEY TAKEAWAYS FOR THROMBOCYTOPENIA PHARMACOTHERAPY

1 Thrombocytopenia is a finding, not a diagnosis

Confirm the result and exclude TTP, DIC, HIT, marrow disease, infection, liver disease, and drug causes before applying an ITP pathway.[1,9]

2 Treat bleeding risk, not a number alone

Symptoms, trend, age, comorbidities, antithrombotics, procedures, and follow-up modify every threshold.[9,25]

3 Observation is active high-value care

Stable non-bleeding adults with platelets at least 30,000/µL often avoid more harm through monitoring than medication.[4,9]

4 Steroids need an end date

Avoid courses longer than 6 weeks including taper and do not recycle chronic steroids instead of establishing maintenance.[9,15]

5 IVIG is rescue, not routine maintenance

Repeated use signals an unstable pathway and should trigger a second-line plan.[9,15]

6 Target hemostasis, not normal platelets

TPO-RAs should use the lowest dose that maintains a safe count, commonly at least 50,000/µL.[9,15]

7 Second-line therapy must fit the patient

Route, durability, thrombosis, infection, diet, monitoring, pregnancy, benefit channel, and cost all matter.[36,41]

8 Audit drugs at every platelet drop.

Heparin, antibiotics, quinine, NSAIDs, antiplatelets, anticoagulants, alcohol, and supplements can cause or amplify harm.[1,38]

9 Older adults need toxicity surveillance

Frailty, falls, cognition, diabetes, osteoporosis, CKD, liver disease, thrombosis, and polypharmacy should guide intensity.[9,39]

10 Closed-loop care prevents crises

Every rescue episode, hospitalization, drug switch, or taper should end with a lab schedule, thresholds for action, and an accountable follow-up owner.[15,36]

AAVBC SUMMARY AND CONCLUSION

Value-based thrombocytopenia medication management begins with diagnostic stewardship. PCPs should verify the platelet count, review the smear, recognize emergency syndromes, identify medications and secondary causes, and determine whether observation or treatment offers a safer net outcome. **In confirmed ITP**, the objective is a **stable hemostatic count** with no clinically important bleeding, minimal rescue therapy, acceptable toxicity, and preserved function, **not normalization of the CBC**.

When medication is required, **short-course** corticosteroids and IVIG can provide initial or rapid control, but **recurrent rescue** and **prolonged steroid exposure should trigger timely hematology-directed maintenance**. TPO-RAs, rituximab, fostamatinib, rilzabrutinib, and splenectomy offer **different balances** of durability, toxicity, monitoring, lifestyle burden, and cost. Their value depends on correct diagnosis, patient selection, response-based stopping rules, and a target that avoids both bleeding and excessive thrombosis risk.

The PCP role extends well beyond referral. Closed-loop care requires medication reconciliation, metabolic and bone protection, infection and vaccination planning, bleeding and thrombosis education, affordability navigation, quality-of-life assessment, and **explicit follow-up after every transition**. The highest-value regimen is the **least burdensome strategy that reliably prevents meaningful bleeding** and allows the older adult to live safely and independently.

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