

# Erythropoiesis-Stimulating Agents (for Indiana Only)

**Policy Number:** CSIND0028.05  
**Effective Date:** January 1, 2024

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Related Policy
<ul style="list-style-type: none"> <li><a href="#">Oncology Medication Clinical Coverage (for Indiana Only)</a></li> </ul>

## Application

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

## Coverage Rationale

This policy addresses the following erythropoiesis-stimulating agents (ESAs):

- Aranesp® (darbepoetin alfa)
- Epogen® (epoetin alfa)
- Procrit® (epoetin alfa)
- Retacrit™ (epoetin alfa)
- Mircera® (methoxy polyethylene glycol-epoetin beta [MPG-epoetin beta])

**Epoetin alfa, darbepoetin alfa, and methoxy polyethylene glycol-epoetin beta are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria.** For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline:

- **Aranesp®:** CP: Specialty Rx Non-Oncology, Darbepoetin alfa (Aranesp)
- **Epogen® or Procrit®:** CP: Specialty Rx Non-Oncology, Epoetin alfa (Epogen, Procrit)
- **Retacrit®:** CP: Specialty Rx Non-Oncology, Epoetin alfa-epbx (Retacrit)
- **Mircera®:** CP: Specialty Rx Non-Oncology, Methoxy polyethylene glycol-epoetin beta (Mircera)

Click [here](#) to view the InterQual® criteria.

## Applicable Codes

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

HCPCS Code	Description
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use)

HCPCS Code	Description
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)
Q5105	Injection, epoetin alfa-epbx, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units
Q5106	Injection, epoetin alfa-epbx, biosimilar, (Retacrit) (for non-ESRD use), 1000 units

## Policy History/Revision Information

Date	Summary of Changes
01/01/2024	<ul style="list-style-type: none"> <li>Routine review; no content changes</li> <li>Archived previous policy version CSIND0028.04</li> </ul>

## Instructions for Use

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

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