

Clinical Pharmacy Program Guidelines for Erythropoietic Agents

Program	Prior Authorization
Medication	Aranesp (darbepoetin alfa), Epogen (epoetin alfa), Procrit (epoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), Retacrit (epoetin alfa)
Markets in Scope	Arizona, California, Florida- CHIP, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Ohio, Pennsylvania, Rhode Island
Issue Date	9/2009
Pharmacy and Therapeutics Approval Date	4/2019
Effective Date	7/2019

1. Background:

Epogen, Procrit, and Retacrit (epoetin alfa biosimilar) are indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis; treatment of anemia in zidovudine-treated HIV-infected patients; treatment of anemia in cancer patients on concomitant myelosuppressive chemotherapy and upon initiation, there is a minimum of two additional months of planned chemotherapy; and in reduction of the need for allogeneic blood transfusion in noncardiac, nonvascular, elective surgery patients.

Aranesp is indicated for the treatment of anemia associated with chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis; and for the treatment of anemia in cancer patients on concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy.

Mircera is indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis.

For the purposes of this policy, a conversion factor of 3 should be used to estimate hematocrit when only the hemoglobin is measured, e.g., hemoglobin 10g/dL is approximately equal to a hematocrit of 30%, a hemoglobin of 11g/dL is approximately equal to a hematocrit of 33%, and a hemoglobin of 12g/dL is approximately equal to a hematocrit of 36%.

2. Coverage Criteria:

A. **Anemia Due to Chronic Kidney Disease (CKD)**

1. **Authorization**

a. **Aranesp, Epogen, Procrit, or Retacrit** will be approved based on **all** of the following:

(1) Diagnosis of chronic kidney disease (CKD)

-AND-

(2) Hematocrit is less than 30% at initiation of therapy

-AND-

(3) **One** of the following:

(a) Patient is on dialysis

-OR-

(b) **All** of the following:

i. Patient is NOT on dialysis

-AND-

ii. The rate of hematocrit decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

-AND-

iii. Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

-AND-

(4) If the request is for Epogen or Procrit, **both** of the following:

(a) Patient has a history of failure, contraindication or intolerance to Retacrit

(b) Physician attestation that in their clinical opinion the clinical

response would be expected to be superior with Epogen or Procrit than experienced with Retacrit

Authorization will be issued for 12 months.

b. **Mircera** will be approved based on all of the following:

(1) Diagnosis of chronic kidney disease (CKD)

-AND-

(2) Hematocrit less than 30% at initiation of therapy

-AND-

(3) **One** of the following:

(a) Patient is on dialysis

-OR-

(b) **All** of the following:

i. Patient is NOT on dialysis

-AND-

ii. The rate of hematocrit decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

-AND-

iii. Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

-AND-

(4) **One** of the following:

(a) History of failure, contraindication, or intolerance to both of the following:

- Aranesp
- Retacrit

-OR-

(b) For continuation of prior therapy

Authorization will be issued for 12 months.

B. Anemia Associated with Zidovudine Treatment in HIV-Infected Patients

1. Authorization

a. **Epogen, Procrit, or Retacrit** will be approved based on **all** of the following:

(1) Patient is receiving zidovudine administered at $\leq 4200\text{mg/week}$

-AND-

(2) Endogenous serum erythropoietin level ≤ 500 mUnits/mL

-AND-

(3) Hematocrit is less than 30% at initiation of therapy

-AND-

(4) If the request is for Epogen or Procrit, **both** of the following:

(a) Patient has a history of failure, contraindication or intolerance to Retacrit

(b) Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Epogen or Procrit than experienced with Retacrit

Authorization will be issued for 12 months.

C. Anemia Due to Cancer Chemotherapy

1. Authorization

a. **Aranesp, Epogen, Procrit, or Retacrit** will be approved based on **all** of the following:

(1) Hematocrit less than 30% at initiation of therapy

-AND-

- (2) There is a minimum of two additional months of planned chemotherapy

-AND-

- (3) If the request is for Epogen or Procrit, **both** of the following:

- (a) Patient has a history of failure, contraindication or intolerance to Retacrit
(b) Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Epogen or Procrit than experienced with Retacrit

Authorization will be issued for 12 months.

D. Preoperative Use for Reduction of Allogeneic Blood Transfusions in Surgery Patients

- 1. Epogen, Procrit, or Retacrit** will be approved based on **all** of the following:

- (a) Perioperative hematocrit is greater than 30% and less than or equal to 39%

-AND-

- (b) Patient is at high risk for blood loss during surgery

-AND-

- (c) Patient is unable or unwilling to donate autologous blood

-AND-

- (d) Surgery procedure is elective, non-cardiac, and non-vascular

-AND-

- (e) If the request is for Epogen or Procrit, **both** of the following:

- (a) Patient has a history of failure, contraindication or intolerance to Retacrit
(b) Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Epogen or Procrit than experienced with Retacrit

Authorization will be issued for 1 month.

E. Anemia Associated with Myelodysplastic Disease

1. Initial Authorization

- a. **Aranesp, Epogen, Procrit, or Retacrit** will be approved based on **all** of the following:

(1) Diagnosis of myelodysplastic disease (MDS)

-AND-

(2) **One** of the following:

- Serum erythropoietin level less than or equal to 500 mUnits/mL
- Hematocrit is less than or equal to 30% at the initiation of therapy

-AND-

(3) If the request is for Epogen or Procrit, **both** of the following:

- (a) Patient has a history of failure, contraindication or intolerance to Retacrit
- (b) Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Epogen or Procrit than experienced with Retacrit

Authorization will be issued for 12 months.

2. Reauthorization

- a. **Aranesp, Epogen, Procrit, or Retacrit** will be approved based on the following:

(1) Hematocrit remains less than 36%

Authorization will be issued for 12 months.

F. Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy

1. Initial Authorization

- a. **Epogen, Procrit, or Retacrit** will be approved based on **all** of the following:

(1) Diagnosis of hepatitis C virus (HCV) infection

-AND-

(2) Patient is receiving ribavirin and interferon therapy

-AND-

(3) Hematocrit is less than or equal to 30% at initiation of therapy

-AND-

(4) If the request is for Epogen or Procrit, **both** of the following:

(a) Patient has a history of failure, contraindication or intolerance to Retacrit

(b) Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Epogen or Procrit than experienced with Retacrit

Authorization will be issued for 3 months.

2. Reauthorization

a. **Epogen, Procrit, or Retacrit** will be approved based on the following:

(1) Hematocrit remains less than 36%

Authorization will be issued for 12 months or if patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy.

G. Erythropoietin Stimulating Agents –Off-Label Uses

1. Off-label requests for **Aranesp, Epogen, Mircera, Procrit, or Retacrit** will be evaluated on a case-by-case basis by a clinical pharmacist.

-AND-

2. Requests for coverage in patients with Hgb greater than 10 g/dL or Hct greater than 30% will not be approved.

3. References:

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Program	Prior Authorization
Change Control	
Date	Change
9/2009	Criteria taken from previously approved AmeriChoice Erythroid Stimulant policy and Unison Erythropoiesis Stimulating Proteins policy. Policy was reformatted.
12/2010	Updated guidelines as follows: <ul style="list-style-type: none"> • Added criteria for anemia related to Hepatitis C treatment. • Added criteria for anemia in patients with MDS. • Added criteria for anemia associated with HIV infection (patients not receiving Zidovudine). • Removed re-authorization criteria for preoperative use in surgery patients for reduction of allogeneic blood transfusion. • Add requirement that initial Hgb/Hct be within 30 days of the epoetin request. • Clarified that an iron study is required for initial therapy (across indications).
9/2011	Updated guidelines as follows: <ul style="list-style-type: none"> • Added new target hemoglobin levels for patients with chronic renal failure on dialysis per FDA guidance • Added new target hemoglobin levels for patients with chronic renal failure not on dialysis per FDA guidance. • Updated policy reference list

9/2012	<p>Updated indications and references sections. Added an endnotes section to support guideline.</p> <p>Reformatted guideline.</p>
9/2013	<ul style="list-style-type: none"> • Updated formatting to current UHC standard • Updated to remove specific TSAT and ferritin levels for all indications (FDA and off -label) due to consultant comment that ferritin levels are not a good marker for iron stores and that there should be no difference in ferritin levels between dialysis and non dialysis populations. • Changed verbiage of “average hemoglobin/hematocrit (hgb/hct)” to “most recent or average hgb/hct” in all reauthorization criteria for the following indications: CKD, HIV, MDS, HCV. • Changed criteria for CKD reauthorization to ask for verification of anemia with hgb/ hct cutoffs over a 3 month period to be ≤ 11 g/dL or $\leq 33\%$, respectively, indiscriminate of dialysis status. • Removed criteria requiring verification of anemia with Hgb/Hct values for initial authorization in MDS because compendia do not support specific values of hgb/hct for treatment (it supports only a serum epo initiation threshold). • Added Omontys to ESA off-labels use criteria • Changed the reauthorization hgb/hct cutoffs for the HCV indication to mirror the Medicare and UHCP values of ≤ 12 g/dL/$\leq 36\%$, respectively.
12/2014	<ul style="list-style-type: none"> • Updated criteria for anemia due to chronic kidney disease (CKD) to include additional requirements for patients not on dialysis per the prescribing information. <ul style="list-style-type: none"> • For patients not on dialysis, criteria will additionally require both of the following for approval: <ul style="list-style-type: none"> o The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and o Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal • Updated criteria for anemia due to HIV to additionally require a serum erythropoietin level of ≤ 500 mU/mL per the prescribing information and the inclusion criteria from clinical trials supporting the use of epoetin alfa in HIV. • Removed criteria for Omontys as this product is no longer available
6/2015	<ul style="list-style-type: none"> • Combined all Epogen initial therapy sections with respective sections for Aranesp and/or Procrit. Epogen initial therapy should align with Aranesp and/or Procrit. • Mircera added as a formulary note stating it is non-preferred on

	<p>the criteria header</p> <ul style="list-style-type: none"> • Mircera criteria added for Anemia Due to Chronic Kidney Disease (CKD). Aligns with Aranesp, Epogen, Procrit criteria except for an additional requirement that requires the use of Aranesp and Epogen/Procrit first • Mircera added to “Erythropoietin Stimulating Agents - Off-Label Uses” criteria section
11/2016	Annual review, updated policy template
3/2017	Changed authorization durations to 12 months for most indications. Updated policy template.
8/2018	Revised criteria to align with Erythropoietic Agents policy on the medical benefit. Updated references.
4/2019	Revised step therapy criteria due to change in preferred products for 7/1/19.