Policy Title: Erythropoiesis stimulating agents: Retacrit (epoetin alfa), Epogen (epoetin alfa), Procrit(epoetin alfa), Aranesp (darbepoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta) NON-ONCOLOGY POLICY

| Effective Date: | 01/01/2020 |
| Review Date: | 12/18/19, 1/29/20, 8/3/2020, 4/15/2021 |
| Revision Date: | 9/18/19, 1/29/20, 8/3/2020 |

Purpose: To support safe, effective and appropriate use of Erythropoiesis stimulating agents.

Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

Policy Statement:
Erythropoiesis stimulating agents are covered under the Medical Benefit when used within the following guidelines for non-oncology indications. Use outside of these guidelines may result in non-payment unless approved under an exception process. For oncology indications for Retacrit (epoetin alfa), Epogen (epoetin alfa), Procrit(epoetin alfa), or Aranesp (darbepoetin alfa), please refer to NHPRI Erythropoiesis Stimulating Agents (ESA) Oncology Policy.

Procedure:
Coverage of Erythropoiesis stimulating agents will be reviewed prospectively via the prior authorization process based on criteria below.

Initial Criteria:
Retacrit (epoetin alfa), Epogen (epoetin alfa), Procrit(epoetin alfa):
- Patient must have one of the following indications:
  - Anemia due to chronic kidney disease (CKD), including patients on dialysis and not on dialysis with pretreatment hemoglobin < 10 g/dL; OR
  - Anemia due to zidovudine in patients with HIV-infection with pretreatment hemoglobin < 10 g/dL; OR
  - Reduction of Allogeneic Red Blood Cell Transfusion in Patients Undergoing Elective, Non-cardiac, Nonvascular Surgery and patients are scheduled to have an elective, non-cardiac, nonvascular surgery when the pretreatment hemoglobin is > 10 to ≤ 13 g/dL; OR
  - Anemia in congestive heart failure (CHF) with pretreatment hemoglobin < 9 g/dL; OR
  - Anemia in rheumatoid arthritis (RA) with pretreatment hemoglobin < 10 g/dL; OR
- Anemia due to hepatitis C treatment in patients with pretreatment hemoglobin < 10 g/dL who are receiving ribavirin in combination with either interferon alfa or peginterferon alfa; OR
- Anemia in patients whose religious beliefs forbid blood transfusions with pretreatment hemoglobin < 10 g/dL; OR

- For patients requesting Epogen (epoetin alfa) or Procrit (epoetin alfa) they must have a documented intolerable adverse event to Retacrit (epoetin alfa), and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information; OR
- For patients that are currently on treatment with Epogen (epoetin alfa) or Procrit (epoetin alfa) they can remain on treatment OR MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

**Aranesp (darbepoetin alfa):**

- Patient must have one of the following indications:
  - Anemia in patients with CKD with pretreatment hemoglobin < 10 g/dL; OR
  - Anemia in patients whose religious beliefs forbid blood transfusions with pretreatment hemoglobin < 10 g/dL; AND

- For patients requesting Aranesp (darbepoetin alfa) they must have a documented intolerable adverse event to Retacrit (epoetin alfa), and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information; OR
- For patients that are currently on treatment with Aranesp (darbepoetin alfa) they can remain on treatment OR MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

**Mircera (methoxy polyethylene glycol-eopoetin beta):**

- Patient must have anemia in patients with CKD with pretreatment hemoglobin < 10 g/dL; AND
- For patients requesting Mircera (methoxy polyethylene glycol-eopoetin beta) they must have a documented intolerable adverse event to Retacrit (epoetin alfa), and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information; OR
- For patients that are currently on treatment with Mircera (methoxy polyethylene glycol-eopoetin beta) they can remain on treatment OR MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

**Renewal Coverage (Retacrit (epoetin alfa), Epogen (epoetin alfa), Procrit(epoetin alfa), Aranesp (darbepoetin alfa)Mircera (methoxy polyethylene glycol-eopoetin beta):**

**For all indications below:** all members (including new members) requesting authorization for continuation of therapy after at least 12 weeks of ESA treatment must show a response with a rise in
hemoglobin of $\geq 1 \text{ g/dL}$. Members who completed less than 12 weeks of ESA treatment and have not yet responded with a rise in hemoglobin of $\geq 1 \text{ g/dL}$ may be granted authorization of up to 12 weeks to allow sufficient time to demonstrate a response.

- Anemia due to CKD and the current hemoglobin is $\leq 12 \text{ g/dL}$;
- Anemia due to zidovudine in patients with HIV-infection with current hemoglobin $\leq 12 \text{ g/dL}$;
- Anemia in CHF or RA and current hemoglobin is $\leq 12 \text{ g/dL}$;
- Anemia due to Hepatitis C treatment and patient meets all of the following criteria:
  - The member is receiving ribavirin in combination with either interferon alfa or peginterferon alfa
  - The current hemoglobin is $\leq 12 \text{ g/dL}$
- Anemia in patients whose religious beliefs forbid blood transfusions and current hemoglobin is $\leq 12 \text{ g/dL}$

### Dosage and Administration:
**Retacrit (epoetin alfa), Epogen (epoetin alfa), Procrit(epoetin alfa)**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
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</thead>
</table>
| Anemia due to CKD           | Adults: 50-100 units/kg intravenously or subcutaneously three times weekly  
Pediatric patients: 50 units/kg intravenously or subcutaneously three times weekly |
| Anemia due to HIV on zidovudine | 100 units/kg three times weekly  
May titrate up to 300 units/kg |
| Perioperative use           | 300 units/kg/day subcutaneously for 10 days before surgery, on the day of surgery, and for 4 days after surgery (15 days total)  
600 units/kg/dose subcutaneously on days 21, 14, and 7 before surgery plus 1 dose on the day of surgery (4 total doses) |
| All other indications       | Dosing varies; generally up to 150 units/kg intravenously or subcutaneously three times weekly |

### Dosage and Administration:
**Aranesp (darbepoetin alfa)**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
</tr>
</thead>
</table>
| Anemia due to CKD-Not on dialysis | Adults  
Initiate at 0.45 mcg/kg intravenously or subcutaneously every 28 days  
Pediatric patients  
Initiate at 0.45 mcg/kg intravenously or subcutaneously every 7 days or 0.75 mcg/kg every 14 days |
| Most common weekly dose     | Up to 200 mcg |
Most common every 2 week
dose

- Up to 300 mcg

Most common every 3 week
dose

- Up to 500 mcg

**Mircera (methoxy polyethylene glycol-epoetin beta):**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia due to CKD-Not on dialysis</td>
<td>- Starting dose: 0.6 mcg/kg IV or SC once every 2 weeks</td>
</tr>
<tr>
<td></td>
<td>- Maintenance dose: Once monthly dosing at twice the every-two-week dose once Hb has been stabilized. Most commonly 120 to 360 mcg every 4 weeks</td>
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</tbody>
</table>

**Billable Units:**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Billable unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epogen/Procrit (non-ESRD use)</td>
<td>1000 IU = 1 billable unit</td>
</tr>
<tr>
<td>Retacrit (non-ESRD use)</td>
<td>1000 IU = 1 billable unit</td>
</tr>
<tr>
<td>Aranesp (non-ESRD use)</td>
<td>1mcg = 1 billable unit</td>
</tr>
<tr>
<td>Mircera (non-ESRD use)</td>
<td>1mcg = 1 billable unit</td>
</tr>
</tbody>
</table>

**Coverage durations:** 12 weeks

*** Requests will also be reviewed to National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) if applicable. ***

**Investigational use:** All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

**Applicable Codes:**

Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.

The following HCPCS/CPT codes are:
<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5106</td>
<td>Injection, epoetin alfa, biosimilar, (retacrit) (for non-esrd use), 1000 units</td>
</tr>
<tr>
<td>J0885</td>
<td>Injection, epoetin alfa, (for non-esrd use), 1000 units</td>
</tr>
<tr>
<td>J0881</td>
<td>Injection, darbepoetin alfa, 1 mcg (non-esrd use)</td>
</tr>
<tr>
<td>J0888</td>
<td>Injection, epoetin alfa, 1mcg (non-esrd use)</td>
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Note: The following HCPCS codes Q5105, Q4081 & J0882 & J0887 are **NOT covered under this policy**, but are covered under the dialysis bundle.

References: