

Drug Policy:

Erythropoiesis Stimulating Agents

POLICY NUMBER UM ONC_1138	SUBJECT Erythropoiesis Stimulating Agents (ESAs) and Biosimilars – Epogen, Procrit, Aranesp, Mircera and Retacrit		DEPT/PROGRAM UM Dept	PAGE 1 OF 4
DATES COMMITTEE REVIEWED 07/22/11, 09/12/12, 06/13/13, 07/10/13, 07/24/14, 06/22/16, 07/26/16, 08/24/16, 09/12/16, 03/04/17, 05/10/17, 09/13/17, 08/08/18, 07/10/19, 12/11/19, 03/11/20, 08/12/20, 01/13/21, 02/10/21, 07/14/21, 11/15/21	APPROVAL DATE November 15, 2021	EFFECTIVE DATE November 29, 2021	COMMITTEE APPROVAL DATES 07/22/11, 09/12/12, 06/13/13, 07/10/13, 07/24/14, 06/22/16, 07/26/16, 08/24/16, 09/12/16, 03/04/17, 05/10/17, 09/13/17, 08/08/18, 07/10/19, 12/11/19, 03/11/20, 08/12/20, 01/13/21, 02/10/21, 07/14/21, 11/15/21	
PRIMARY BUSINESS OWNER: UM		COMMITTEE/BOARD APPROVAL Utilization Management Committee		
URAC STANDARDS HUM 1	NCQA STANDARDS UM 2		ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS		APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

To define and describe the accepted indications for Erythropoiesis Stimulating Agents (ESAs) and biosimilar-Epogen and Procrit (epoetin alfa), Aranesp (darbepoetin alfa), Mircera (epoetin beta), and Retacrit (epoetin alfa-epbx) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:

1. When health plan Medicaid coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the [Preferred Drug Guidelines](#) OR
2. When health plan Exchange coverage provisions-including any applicable PDLs (Preferred Drug Lists)-conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the [Preferred Drug Guidelines](#) OR
3. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the [Preferred Drug Guidelines shall follow NCH L1 Pathways](#) when applicable, otherwise shall follow NCH drug policies AND
4. Continuation requests of previously approved, non-preferred medication are not subject to this provision.
5. When applicable, generic alternatives are preferred over brand-name drugs AND
6. Retacrit (epoetin alfa-epbx) and Procrit/Epogen (epoetin alfa) are the **PREFERRED** medications whenever Aranesp (darbepoetin alfa) is requested AND
7. Non-preferred ESA will be approved only if there is a contraindication/intolerance to the **PREFERRED** medication.

B. Chemotherapy induced anemia (CIA)

1. ESA is being used in members at risk of requiring red blood cell transfusions within 30 days of anemia with solid tumors or non-myeloid malignancies receiving myelosuppressive chemotherapy [without curative intent](#) and such chemotherapy is ongoing or has been completed ≤ 8 weeks prior to initiation or continuation of ESA, and the member meets the following criteria:
 - a. For initial/continuation requests the baseline Hgb is < 8 g/dL or HCT is < 24 (as recommended by NCH L1 pathway) or Hgb < 10 g/dL or HCT < 30 (as required by NCH policy) prior to the initiation of ESA therapy (levels are obtained within the last 4 weeks) AND
 - b. Prior to initiating ESA therapy, concomitant iron deficiency has been ruled out and serum ferritin is ≥ 30 ng/mL AND/OR transferrin saturation is $\geq 20\%$. For continuation requests, above levels should be available at least 12 months prior to the continuation request.

C. Anemia of Chronic Kidney Disease (CKD)

1. The member has chronic kidney disease defined as GFR < 60 ml/min over a period of at least three months AND concomitant iron deficiency has been ruled out with a serum ferritin ≥ 30 ng/mL AND/OR transferrin saturation $\geq 20\%$ with levels obtained within the last 12 months) AND
2. ESA can be initiated when Hgb < 10 g/dL or HCT < 30 .

D. Myelodysplastic Syndrome (MDS)

1. The member has lower risk MDS (IPSS Low and INT-1) AND ESA is being used for the following:
 - a. For member with symptomatic anemia with serum erythropoietin level < 500 mU/mL AND
 - b. ESA can be initiated/continued when Hgb < 10 g/dL or HCT < 30 (levels are obtained within the last 4 weeks) AND
 - c. ESA is being used with serum ferritin ≥ 30 ng/mL AND/OR transferrin saturation $\geq 20\%$ (levels are obtained within the last 12 months) OR if iron stains in the bone marrow show adequate iron AND
 - d. ESA is being used as a single agent in members with $< 10\%$ blasts in the bone marrow OR

- e. ESA is being used in combination with filgrastim in members with < 10% blasts in the bone marrow and the Hgb is unresponsive to a trial of ESA.

III. EXCLUSION CRITERIA

- A. For MDS: lack of response after 12 weeks trial (response defined as 1 g/dL hemoglobin increase or decrease of transfusion requirements).
- B. Mircerca (epoetin beta) is not indicated in CIA and MDS.
- C. The member is on chemotherapy with curative intent.
- D. Patient completed myelosuppressive chemotherapy more than 8 weeks prior to initiation of ESA therapy for CIA.
- E. ESA is not used for myeloid malignancies (i.e. acute and chronic myeloid leukemia, myelofibrosis, polycythemia vera, or essential thrombocytopenia) or intermediate risk and high risk MDS **OR** MDS with a bone marrow blast count of $\geq 10\%$.
- F. The member has any of the following causes of anemia:
 - 1. Deficiencies in B12, folate, or iron
 - 2. Hemolysis, occult blood loss, hypothyroidism, or nutritional deficiency.
- G. ESA is being used for the acute correction of anemia or as a substitute for RBC transfusions.
- H. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT

- A. Requests for ESAs shall be reviewed for appropriateness as per FDA approved product labeling, NKF KDOQI anemia in CKD guidelines, ASCO and NCCN clinical practice guidelines, or CMS approved compendia.

V. APPROVAL AUTHORITY

- A. Review – Utilization Management Department
- B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

- A. None

VII. REFERENCES

- A. Aranesp Product Information. Amgen, Inc. Thousand Oaks, CA. 2019.
- B. Epogen Product Information. Amgen, Inc. Thousand Oaks, CA. 2018.
- C. Procrit Product Information. Janssen Products, LPHorsham, PA 2020.
- D. Mircerca Product Information. Vifor (International) Inc.2019.
- E. Retacrit Product Information. Pfizer Laboratories Div Pfizer Inc. New York, NY 2020
- F. Clinical Pharmacology Elsevier Gold Standard 2021.
- G. Micromedex® Healthcare Series: Thompson Micromedex, Greenwood Village, CO 2021.

- H. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2021.
- I. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD. 2021.
- J. Bohlius J, Bohlke K, Castelli R, Djulbegovic B, Lustberg MB, Martino M, Mountzios G, Peswani N, Porter L, Tanaka TN, Trifirò G, Yang H, Lazo-Langner A. Management of Cancer-Associated Anemia With Erythropoiesis-Stimulating Agents: ASCO/ASH Clinical Practice Guideline Update. *J Clin Oncol*. 2019 May 20;37(15):1336-1351. doi: 10.1200/JCO.18.02142. Epub 2019 Apr 10. PMID: 30969847.
- K. Tobian AA, Heddle NM, Wiegmann TL, Carson JL. Red blood cell transfusion: 2016 clinical practice guidelines from AABB. *Transfusion*. 2016 Oct;56(10):2627-2630. doi: 10.1111/trf.13735. PMID: 27739152.
- L. Kliger AS, et al. KDOQI US commentary on the 2012 KDIGO Clinical Practice Guideline for Anemia in CKD. *Am J Kidney Dis*. 2013 Nov;62(5):849-59.