

DRUG DETERMINATION POLICY

Title: DDP-18 Erythropoietin-Stimulating Agents (ESAs)

Effective Date: 4/24/24



Physicians Health Plan
PHP Insurance Company
PHP Service Company

Important Information - Please Read Before Using This Policy

The following policy applies to health benefit plans administered by PHP and may not be covered by all PHP plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Benefit determinations for individual requests require consideration of:

1. The terms of the applicable benefit document in effect on the date of service.
2. Any applicable laws and regulations.
3. Any relevant collateral source materials including coverage policies.
4. The specific facts of the particular situation.

Contact PHP Customer Service to discuss plan benefits more specifically.

1.0 Policy:

This policy describes the determination process for coverage of specific drugs that require prior approval.

This policy does not guarantee or approve benefits. Coverage depends on the specific benefit plan. Drug Determination Policies are not recommendations for treatment and should not be used as treatment guidelines.

2.0 Background or Purpose:

Erythropoiesis-stimulating agents are drugs indicated for a number of diagnoses and are associated with significant toxicity. These criteria were developed and implemented to ensure appropriate use for the intended diagnoses and mitigation of toxicity, if possible.

3.0 Clinical Determination Guidelines:

Document the following with chart notes:

- I. Chronic kidney disease (CKD)-induced anemia [must meet all listed below]:
 - A. Diagnosis and severity [must meet both listed below]:
 1. Requiring blood transfusions in dialysis and non-dialysis patients.
 2. Hemoglobin at or below 10gm per dL or hematocrit at or below 30 percent.
 - B. Dosage regimen: intravenous administration preferred for patients on dialysis [must meet both listed below]:
 1. Initial [must meet one listed below]:
 - a. Epogen/Procrit/Retacrit intravenous or subcutaneous (epoetin alfa): 50 to 100 units per kg three times per week.

- b. Mircera intravenous or subcutaneous (methoxy polyethylene glycol-epoetin beta): 0.6mg per kg every two weeks or 1.2mg per kg every four weeks in stabilized patients.

2. Titration [must meet one listed below]:

- a. Maintain hemoglobin below 11g per dL.
- b. Inadequate or lack of response over 12-week escalation: further increase not justified.

C. Approval:

- 1. Initial: six months.
- 2. Re-approval:
 - a. Hemoglobin below 11g per dL or hematocrit below 33 percent.
 - b. Six months.

II. Anemia due to chemotherapy in cancer patients [must meet all listed below]:

A. Diagnosis and severity [must meet both listed below]:

- 1. Patient receiving myelosuppressive chemotherapy to treat non-myeloid malignancies for more than two months.
- 2. Hemoglobin below 10g per dL.

B. Dosage regimen:

- 1. Initial: Epogen/Procrit/Retacrit intravenous or subcutaneous (epoetin alpha IV or SQ): 150 units per kg three times per week or 40,000 units one time per week until completion of chemotherapy.
- 2. Titration: maintain hemoglobin below 11g per dL.

C. Approval:

- 1. Initial: six months.
- 2. Re-approval:
 - a. Hemoglobin below 11g per dL.
 - b. Six months.

III. Zidovudine use in human immunodeficiency virus (HIV) infection-induced anemia [must meet all listed below]:

A. Diagnosis and severity [must meet both listed below]:

- 1. Endogenous erythropoietin levels equal or below 500mu per mL and zidovudine doses at or below 4,200mg per week.
- 2. Hemoglobin at or below 12g per dL.

B. Dosage regimen:

1. Initial: Epogen/Procrit/Retacrit intravenous or subcutaneous (epoetin alpha methoxy polyethylene glycol-epoetin beta IV or SQ) – 100 units per kg.
2. Titration:
 - a. Maintain hemoglobin below 12g per dL.
 - b. Maximum dose: Epogen/Procrit/Retacrit intravenous or subcutaneous (epoetin IV or SQ) 300 units/kg; discontinue if hemoglobin goal not reached in eight weeks.

C. Approval.

1. Initial: four months.
2. Re-approval:
 - a. Hemoglobin at or below 12g per dL.
 - b. Four months.

IV. Surgery [must meet all listed below]:

A. Indication: to reduce allogenic red blood cell transfusions [must meet both listed below]:

1. Elective non-cardiac, non-vascular surgery.
2. Hemoglobin above 10g per dL and less than or equal to 13g per dL.

B. Dosage regimen: Epogen/Procrit/Retacrit intravenous or subcutaneous (epoetin alpha IV or SQ) [must meet one listed below]:

1. 300 units/kg daily for 15 doses; given ten days pre-op, day of surgery, and four days post-op.
2. 600 units/kg one time per week for four doses; given three, two, and one week pre-op and day of surgery.

V. Non-preferred (Epogen, Procrit and Retacrit): contraindicated, failed or had significant adverse effects to Aranesp and Mircera,

VI. Appropriate medication use [must meet all listed below]:

- A. Diagnosis: meets standard diagnostic criteria that designates signs, symptoms and test results to support specific diagnosis.
- B. FDA approval status [must meet one listed below]:
 1. FDA approved: product, indication, and/or dosage regimen.
 2. Non-FDA approved: compendium support (Lexicomp™) for use of a drug for a non-FDA approved indication or dosage regimen.
- C. Place in therapy: sequence of therapy supported by national or international accepted guidelines and/or studies (e.g., oncologic, infectious conditions).

VII. Exclusions:

- A. Cancer patients receiving hormonal treatment, therapeutic biologics, or radiation (unless on concurrent myelosuppressive chemotherapy).
- B. Cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure.
- C. Surgery patients who are willing to donate autologous blood.
- D. Surgery patients undergoing cardiac or vascular surgery.
- E. As a substitute for red blood cell transfusion in patients requiring immediate correction of anemia.

4.0 Coding:

COVERED CODES - MEDICAL BENEFIT				
HCPCS Code	Brand Name	Generic Name	Billing (1 Unit)	Prior Approval
J0887	Mircera (for ESRD on dialysis)	methoxy polyethylene glycol-epoetin beta	1 mcg	Y
J0888	Mircera (for non-ESRD use)	methoxy polyethylene glycol-epoetin beta	1 mcg	Y

COVERED PRODUCTS - PHARMACY BENEFIT		
Brand Name	Generic Name	Prior Approval
Aranesp	darbepoetin alfa	Y
Epogen	epoetin alfa	Y
Procrit	epoetin alfa	Y
Retacrit	epoetin alpha-epbx	Y

EXCLUDED CODES AND PRODUCTS			
HCPCS Code	Brand Name	Generic Name	Benefit Plan Reference/Reason
J0885	Epogen/Procrit	epoetin alpha	Covered on the pharmacy benefit with prior approval
Q5105	Retacrit (ESRD on dialysis use)	epoetin alpha-epbx	Covered on the pharmacy benefit with prior approval
Q5106	Retacrit (non-ESRD use)	epoetin alpha-epbx	Covered on the pharmacy benefit with prior approval

5.0 References, Citations & Resources:

1. National Government Services. Erythropoietin Stimulating Agents (ESA) – Supplemental Instructions (DRUG-AC-07-06-02)12/01/07.
2. FDA Alert 11/8/07: Information for Healthcare Professionals: Erythropoiesis Stimulating Agents (ESA).

3. Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Lexi-Comp, Inc.; Epoetin Alpha, Aranesp and Mircera accessed March 2021.
4. Management of cancer-associated anemia with erythropoiesis-stimulating agents: ASCO/ASH clinical practice guideline update. Blood Adv 2019; 3 (8): 1197–1210. doi: <https://doi.org/10.1182/bloodadvances.2018030387>
5. Kidney Disease: Improving Global Outcomes Anemia Work Group. KDIGO clinical practice guideline for anemia in chronic kidney disease. Kidney Int Suppl. 2012;2:S1–S335.

6.0 Appendices:

See page 5.

7.0 Revision History:

Original Effective Date: 08/13/2008

Next Review Date: 05/01/2025

Revision Date	Reason for Revision
4/19	Moving to new format; presented and approved at P&T Committee.
3/20	Annual review; replaced abbreviations, added drug Retacrit
2/21	Annual review; reformatting, replaced abbreviations, added appropriate use section; approved at 4/28/21 P&T
2/22	Annual review, added compendium reference in appropriate use section
2/23	Annual review, formatting changes for consistency, updated non preferred section to be reflective of current PDL, added guideline citation, added exclusion of curative chemotherapy
2/24	Annual review; updated coding, added guideline reference citation, removed Patient Safety and Monitoring appendix