PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Erythropoiesis-Stimulating Agents Preferred Specialty Management Policy

- Aranesp® (darbepoetin alfa injection – Amgen)
- Epogen® (epoetin alfa injection – Amgen)
- Mircera® (methoxy polyethylene glycol epoetin beta injection – Vifor)
- Procrit® (epoetin alfa injection – Janssen Products)
- Retacrit™ (epoetin alfa-epbx injection – Hospira/Pfizer)

REVIEW DATE: 09/23/2020

OVERVIEW

Aranesp, Epogen, Procrit, Mircera and Retacrit are erythropoiesis-stimulating agents (ESAs).[1-5] All ESAs stimulate erythropoiesis by the same mechanism as endogenous erythropoietin. Retacrit is biosimilar to Epogen/Procrit. All ESAs are indicated for the treatment of anemia due to chronic kidney disease in patients on dialysis and patients not on dialysis. Epoetin alfa (Epogen, Procrit, Retacrit) and Aranesp are indicated for the treatment of anemia due to myelosuppressive chemotherapy in patients with cancer. Epoetin alfa is also indicated for the treatment of anemia due to zidovudine in human immunodeficiency virus-infected patients and the reduction of allogeneic red blood cell transfusions in elective, noncardiac, nonvascular surgery.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of Preferred Products. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Erythropoiesis-Stimulating Agents Prior Authorization Policy* criteria. The program also directs the patient to try at least one Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). For patients with chronic kidney disease who are on dialysis, prior authorization and step management are not required for medical benefit coverage. If the patient meets the corresponding standard *Erythropoiesis-Stimulating Agents Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for the Preferred Products will be authorized. Approval duration for patients with chronic kidney disease who are on dialysis is for 3 years. For Other Conditions, approval durations are as noted in the respective standard *Erythropoiesis-Stimulating Agents Prior Authorization Policy*.

Automation: None.

Preferred Products: Procrit, Retacrit
Non-Preferred Products: Aranesp, Epogen, Mircera

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product(s)	Exception Criteria
Aranesp	**1.** **Anemia in Patients with Chronic Kidney Disease who are on Dialysis.** Approve. **2.** **Other Conditions.** Patient must meet the following criteria (A and B): **A)** Patient meets the standard *Erythropoiesis-Stimulating Agents – Aranesp Prior Authorization Policy* criteria; AND **B)** Patient has tried one of Procrit or Retacrit. **3.** If the patient has met criterion 2A (the standard *Erythropoiesis-Stimulating Agents – Aranesp Prior Authorization Policy* criteria), but criterion 2B is not met and the requested agent is not approved: approve the Preferred Products.
Epogen	**1.** **Anemia in Patients with Chronic Kidney Disease who are on Dialysis.** Approve. **2.** **Other Conditions.** Patient must meet the following criteria (A and B): **A)** Patient meets the standard *Erythropoiesis-Stimulating Agents – Epoetin Alfa Prior Authorization Policy* criteria; AND **B)** Patient meets both of the following (i and ii): **i.** Patient has tried one of Procrit or Retacrit; AND **ii.** Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **3.** If the patient has met criterion 2A (the standard *Erythropoiesis-Stimulating Agents – Epoetin Alfa Prior Authorization Policy* criteria), but criterion 2B is not met and the requested agent is not approved: approve the Preferred Products.
Mircera	**1.** **Anemia in Patients with Chronic Kidney Disease who are on Dialysis.** Approve. **2.** **Other Conditions.** Patient must meet the following criteria (A and B): **A)** Patient meets the standard *Erythropoiesis-Stimulating Agents – Mircera Prior Authorization Policy* criteria; AND **B)** Patient has tried one of Procrit or Retacrit. **3.** If the patient has met criterion 2A (the standard *Erythropoiesis-Stimulating Agents – Mircera Prior Authorization Policy* criteria), but criterion 2B is not met and the requested agent is not approved: approve the Preferred Products.

REFERENCES

1. Procrit® injection for intravenous or subcutaneous use [prescribing information]. Horsham, PA: Janssen Products; July 2018.
2. Epogen® injection for intravenous or subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen, Inc; July 2018.
3. Aranesp® injection for intravenous or subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen, Inc.; January 2019.
4. Mircera® injection for intravenous or subcutaneous use [prescribing information]. Switzerland; June 2018.
5. Retacrit™ injection for intravenous or subcutaneous use [prescribing information]. Lake Forest, IL and New York, NY; Hospira and Pfizer; June 2020.