Epogen, Procrit (epoetin alfa)  
Retacrit (epoetin alfa-epbx)  
Aranesp (darbepoetin alfa)  
Mircera (methoxy polyethylene glycol-epoetin beta)  
Effective 06/01/2021

<table>
<thead>
<tr>
<th>Plan</th>
<th>MassHealth</th>
<th>Commercial/Exchange</th>
<th>Program Type</th>
<th>Prior Authorization</th>
<th>Quantity Limit</th>
<th>Step Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit</td>
<td>Pharmacy Benefit</td>
<td>Medical Benefit (NLX)</td>
<td>☒ Prior Authorization</td>
<td>☒ Quantity Limit</td>
<td>☐ Step Therapy</td>
<td></td>
</tr>
</tbody>
</table>

| Specialty Limitations | This medication has been designated specialty and must be filled at a contracted specialty pharmacy when filled through the pharmacy benefit. |

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Specialty Medications</th>
<th>Phone: 866-814-5506</th>
<th>Fax: 866-249-6155</th>
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</thead>
<tbody>
<tr>
<td>Non-Specialty Medications</td>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
<td>Fax: 866-255-7569</td>
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<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
<td></td>
</tr>
<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
<td></td>
</tr>
</tbody>
</table>

| Medical Specialty Medications (NLX) | All Plans | Phone: 844-345-2803 | Fax: 844-851-0882 |

| Exceptions | Mircera is only available on the Medical Benefit (MB). |

Overview
Aranesp, Epogen, Mircera, Procrit and Retacrit are erythropoiesis Stimulating Agents (ESA) which promote the growth and differentiation of stem cells into colonies of specific blood cells.

<table>
<thead>
<tr>
<th>No PA</th>
<th>PA required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mircera® (methoxy polyethylene glycol/epoetin beta)</td>
<td>Aranesp® (darbepoetin alfa)</td>
</tr>
<tr>
<td></td>
<td>Epogen® (epoetin alfa)</td>
</tr>
<tr>
<td></td>
<td>Procrit® (epoetin alfa)</td>
</tr>
<tr>
<td></td>
<td>Retacrit® (epoetin alfa-epbx)</td>
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</table>

Approved Diagnosis:
- Anemia of chronic renal failure
- Anemia in post renal-transplant patients
- Anemia in cancer chemotherapy-treated patients
- Anemia due to myelosuppressive medication regimen for HIV
- Anemia due to myelosuppressive medication regimen Hepatitis C
- Decrease need for blood transfusions in surgery patients
- Anemia due to idiopathic sideroblastic anemia/myelodysplastic syndrome
Coverage Guidelines
Authorization may be granted when ALL the following criteria are met, and documentation is provided:

Anemia due to Chronic Renal Failure (CRF)
Prescriber provides documentation of ALL of the following:
1. Appropriate diagnosis
2. Hemoglobin (Hb) < 10 g/dL (dated within the last 60 days) †
3. ONE of the following:
   a. Glomerular filtration rate (GFR) ≤ 30 mL/min§
   b. Glomerular filtration rate (GFR) 30-60 mL/min noting that other causes of anemia have been ruled out (iron, vitamin B12, folate deficiency and hemolysis) §
4. Member is NOT receiving hemodialysis‡.

Anemia post-renal transplant
Prescriber provides documentation of ALL of the following:
1. Appropriate diagnosis
2. Hb < 10 g/dL (dated within the last 60 days) †
3. Member is NOT receiving hemodialysis†

Anemia due to chemotherapy treatment for cancer
Prescriber provides documentation of ALL of the following:
1. Appropriate diagnosis
2. Hb < 10 g/dL (dated within the last 60 days) †

Anemia due to a myelosuppressive medication regimen for HIV
Prescriber provides documentation of ALL of the following:
1. Appropriate diagnosis
2. ONE of the following:
   a. Paid claim or physician documented medication regimen includes zidovudine or zidovudine-containing products
   b. All other causes of anemia have been ruled out (iron, vitamin B12, folate deficiency, and hemolysis)
3. Hb < 10 g/dL (dated within the last 60 days) †

Anemia due to myelosuppressive medication regimen for Hepatitis C
Prescriber provides documentation of ALL of the following:
1. Appropriate diagnosis
2. Hb < 10 g/dL (dated within the last 60 days) †
3. ONE of the following:
   a. Paid claim or physician documentation that member is currently being treated with a hepatitis C regimen containing an interferon product (with or without ribavirin)
   b. ALL of the following†
      i. Paid claim or physician documentation that member is currently being treated with a hepatitis C regimen containing ribavirin
      ii. Member’s hepatitis C regimen does NOT contain interferon
      iii. Prescriber documents ribavirin dose reduction to 600 mg per day has been attempted§
Decrease need for blood transfusions in surgery patients:
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis (including members who refuse blood donation due to religious beliefs)
2. Hb ≤13 g/dL (dated within the last 30 days)
3. Surgery planned within the next 3 months (Anticipated date of surgery)

**Anemia due to idiopathic sideroblastic anemia/myelodysplastic syndrome (MDS)**
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis
2. Hb < 10 g/dL (dated within the last 60 days)

§ For all GFR calculations, please use the calculator provided by the National Kidney Foundation: (https://www.kidney.org/professionals/KDOQI/gfr_calculator)
‡ If member is receiving hemodialysis, prescriber must contact dialysis clinic for proper billing procedure as medication is provided by the clinic.
†If member is a child and is noted to be symptomatic with a Hb level ≤11 g/dL, request can be approved if all other criterion is met.

**Continuation of Therapy**
Reauthorization requires physician attestation of continuation of therapy and prescriber provides documentation of **ONE** of the following:
1. Hb level ≤12 g/dL (dated within the last 60 days)
2. Hb level >12 g/dL (dated within the last 60 days) and the request addresses if the erythropoietin dose is to be held or reduced to remain with the appropriate target.

**Limitations**
1. Initial authorizations will be approved based on indication:
   a. Anemia of chronic renal failure: 12 months
   b. Anemia post-renal transplant: 6 months
   c. Anemia due to chemotherapy for cancer: 3 months
   d. Anemia in HIV: 6 months
   e. Anemia in Hepatitis C: 3 months
   f. Anemia due to surgery: 2 months
   g. Anemia due to idiopathic sideroblastic anemia/MDS: 6 months
2. Reauthorizations will be approved based on indication:
   a. Anemia due to CRF: 12 months
   b. Anemia due to chemotherapy treatment for cancer and myelosuppressive medication for HIV: 3 months
      i. Prescriber provides documentation of **ALL** of the following:
         1. Hb level ≤12 g/dL (dated within the last 60 days*)
         2. Paid claims or physician documents member continues to receive the causative agent
      c. Anemia due to myelosuppressive medication regimen for Hepatitis C: 3 months
         i. Paid claims or physician documents member continues to receive the causative agent
   d. All other diagnosis: 6 months
References
**Review History**

10/15/2020 – Reviewed Nov P&T Mtg; Transitioned from SGM to custom criteria; updated references; Effective 1/1/21 Updated to be in compliance with the MassHealth partial unified formulary requirements

03/17/2021 – Reviewed and Updated; approvable indications were updated with notes. Allowed higher Hgb threshold for children with symptomatic anemia per MH UPPL. Effective 06/01/2021.

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