ERYTHROPOIESIS-STIMULATING AGENTS
Pharmacy Coverage Policy

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>GPI</th>
<th>Drug Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARANESP</td>
<td>darbepoetin alfa</td>
<td>8240101511****</td>
<td>Erythropoiesis-Stimulating Agents (ESAs)</td>
</tr>
<tr>
<td>EPOGEN</td>
<td>epoetin alfa</td>
<td>8240102000****</td>
<td></td>
</tr>
<tr>
<td>PROCRIT</td>
<td>peginesatide</td>
<td>8240106010****</td>
<td></td>
</tr>
<tr>
<td>MIRCERA</td>
<td>methoxy polyethylene glycol-epoetin beta</td>
<td>824010401020**</td>
<td></td>
</tr>
</tbody>
</table>

CRITERIA FOR COVERAGE/NONCOVERAGE

Erythropoiesis-stimulating agents (ESAs) will be considered for coverage under the pharmacy benefit program when the following criteria are met:

- The patient has adequate iron stores confirmed by ferritin levels greater than 100 mcg/L OR serum transferrin saturation greater than 20%

AND

- Other causes of anemia have been ruled out: iron deficiency, folate deficiency, B12 deficiency, hemolysis, gastrointestinal bleeding, active or occult bleeding, or underlying hematologic disease (such as sickle cell anemia, thalassemia, and porphyria)

AND

- For ARANESP and EPOGEN: The patient has tried and had an inadequate response or intolerance to Procrit (epoetin alfa)

AND

EPOGEN/PROCRIT

- The patient does not have the following contraindications to therapy:
  - Uncontrolled hypertension
  - Pure red cell aplasia (PRCA) that begins after ESA treatment

AND

Chronic kidney disease (CKD)

- The patient has anemia due to CKD with or without dialysis AND
- The medication is prescribed by a nephrologist or hematologist

Non-myeloid malignancy

- The patient has a non-myeloid malignancy AND
- The patient has anemia due to concomitant myelosuppressive chemotherapy AND
- Two (2) additional months of chemotherapy is anticipated AND
- The medication is prescribed by an oncologist or hematologist

Perioperative use for elective, noncardiac, nonvascular surgery

- The patient is undergoing elective, noncardiac nonvascular surgery AND
ERYTHROPOIESIS-STIMULATING AGENTS
Pharmacy Coverage Policy

- The patient has anemia and is at high risk for perioperative blood loss AND
- The medication is being used to reduce the need for allogeneic red blood transfusion AND
- The medication is prescribed by a surgeon

Zidovudine-treated HIV (human immunodeficiency virus) infection
- The patient has anemia due to HIV treatment with zidovudine AND
- The patient’s endogenous serum erythropoietin levels is 500 mUnits/mL or less AND
- The zidovudine dose is 4,200 mg/week or less AND
- The medication is prescribed by an infectious disease specialist

Hepatitis C therapy with ribavirin and interferon/peginterferon
- The patient has anemia due to treatment of hepatitis C infection with ribavirin and interferon/peginterferon AND
- The medication is prescribed by a hepatologist, infectious disease specialist, or gastroenterologist

Myelodysplastic syndrome (MDS)
- The patient has anemia due to myelodysplastic syndrome (MDS) AND
- The patient’s endogenous serum erythropoietin level is 500 mUnits/mL or less AND
- The medication is prescribed by an oncologist or hematologist
AND
- The patient’s pretreatment hemoglobin (Hb) level is 10 g/dL or less OR, for patient’s at high risk for perioperative blood loss, between 10 to 13 g/dL

ARANESP
- The patient does not have the following contraindications to therapy:
  - Uncontrolled hypertension
  - Pure red cell aplasia (PRCA) that begins after ESA treatment
AND

Chronic kidney disease
- The patient has anemia due to CKD with or without dialysis AND
- The medication is prescribed by a nephrologist or hematologist

Non-myeloid malignancy
- The patient has a non-myeloid malignancy AND
- The patient has anemia due to concomitant myelosuppressive chemotherapy AND
- Two (2) additional months of chemotherapy is anticipated AND
- The medication is prescribed by an oncologist or hematologist

Myelodysplastic syndrome (MDS)
- The patient has anemia due to myelodysplastic syndrome (MDS) AND
- The patient’s endogenous serum erythropoietin level 500 mUnits/mL or less AND
- The medication is prescribed by an oncologist or hematologist
AND
- The patient’s pretreatment Hb level is less than 10 g/dL

OMONTYS
- The patient does not have uncontrolled hypertension
AND

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ERYTHROPOIESIS-STIMULATING AGENTS
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Chronic kidney disease (CKD)
- The patient is 18 years of age or older AND
- The patient has anemia due to CKD and is on dialysis AND
- The medication is prescribed by a nephrologist or hematologist AND
- The patient’s pre-treatment Hb level is less than 10 g/dL

MIRCERA
- The patient does not have the following contraindications to therapy:
  - Uncontrolled hypertension
  - Pure red cell aplasia (PRCA) that begins after ESA treatment

AND
Chronic kidney disease (CKD)
- The patient is 18 years of age or older AND
- The patient has anemia due to CKD with or without dialysis AND
- The medication is prescribed by a nephrologist or hematologist AND
- The patient’s pre-treatment Hb level is less than 10 g/dL

Duration of Approval
Initial Approval
Initial approval shall be approved for 4 months for the indications and products specified in the table below.

<table>
<thead>
<tr>
<th>Indication</th>
<th>Epogen/Procrit</th>
<th>Aranesp</th>
<th>Omontys</th>
<th>Mircera</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic kidney disease (CKD)</td>
<td>4 months</td>
<td>4 months</td>
<td>4 months (on dialysis only)</td>
<td>4 months</td>
</tr>
<tr>
<td>Non-myeloid malignancy</td>
<td>4 months</td>
<td>4 months</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Perioperative use</td>
<td>1 month</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Zidovudine-treated HIV infection</td>
<td>4 months</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Hepatitis C therapy with ribavirin and interferon/peginterferon</td>
<td>4 months</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Myelodysplastic syndrome</td>
<td>4 months</td>
<td>4 months</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Renewal Criteria
Continued use shall be reviewed at least every 4 months for all indications except for anemia due to CKD will be reviewed at least every 12 months to confirm the criteria in the table below.

<table>
<thead>
<tr>
<th>Renewal Criteria</th>
<th>Epogen/Procrit</th>
<th>Aranesp</th>
<th>Mircera</th>
<th>Omontys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraindications for each ESA product</td>
<td>Patient does not have uncontrolled hypertension AND</td>
<td>Patient does not have uncontrolled hypertension AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient has not developed antibody-mediated PRCA AND</td>
<td>Patient has not developed antibody-mediated PRCA AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient has adequate iron stores (ferritin &gt;100 mcg/L OR serum transferrin saturation &gt;20%)</td>
<td>Patient has adequate iron stores (defined as ferritin &gt;100 mcg/L OR serum transferrin saturation &gt;20%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Chronic kidney disease (CKD)
- **Dialysis patients:** Hb <11 g/dL OR if Hb >11 g/dL, physician will decrease or interrupt dose
- **Non-dialysis patients:** Hb <10 g/dL OR if Hb >10, physician will decrease or interrupt dose
- **For dialysis patients only:** Hb <11 g/dL OR if Hb >11 g/dL, physician will decrease or interrupt dose

### Non-myeloid malignancy
- Concurrent myelosuppressive chemotherapy AND
- Hb is ≤12 g/dL AND
- Increase in Hb ≥1 g/dL or a reduced need for RBC transfusion after 8 weeks
- Product is not approved for this indication.
- Product is not approved for this indication.

### Perioperative use
- No renewal criteria are available.
- Product is not approved for this indication.
- Product is not approved for this indication.
- Product is not approved for this indication.

### Zidovudine-treated HIV infection
- Hb ≤12 g/dL AND
- Zidovudine dose remains ≤ 4,200 mg/week AND
- Increase in Hb or a reduced need for RBC transfusion after 8 weeks OR documented dose escalation up to a max. of 300 units/kg/dose
- Product is not approved for this indication.
- Product is not approved for this indication.
- Product is not approved for this indication.

### Hepatitis C therapy with ribavirin and interferon/peg-interferon
- Hb ≤12 g/dL AND
- Concurrent therapy with ribavirin and interferon/ pegylated interferon
- Product is not approved for this indication.
- Product is not approved for this indication.
- Product is not approved for this indication.

### Myelodysplastic syndrome
- Hb ≤12 g/dL AND
- ≥1.5 g/dL rise in Hb or a reduced need for a RBC transfusion after 8 weeks OR
- Patient will have a concomitant trial of G-CSF AND a measurable response defined as ≥ 1.5 g/dL rise in Hb or a reduced need for a RBC transfusion after 8 weeks of concomitant therapy
- Product is not approved for this indication.
- Product is not approved for this indication.
- Product is not approved for this indication.

ESAs are considered experimental/investigational for conditions not listed in this coverage policy section.