Mass General Brigham
Health Plan

Erythropoiesis Stimulating Agents (ESA)
Aranesp (darbepoetin)
Epogen (epoetin alfa recombinant)
Mircera (methoxy polyethylene glycol epoetin beta)
Procrit (epoetin alfa recombinant)
Retacrit (epoetin alfa recombinant)
Effective 01/01/2023

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

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.

Preferred	Non-preferred
Aranesp	Epogen
Retacrit	Mircera
Procrit	

Coverage Guidelines
Authorization may be granted for members new to the plan who are currently receiving treatment with an ESA, excluding when the product is obtained as samples or via manufacturer's patient assistance program
OR
Authorization may be granted for members with who meet all the following drug-specific criteria and documentation has been provided

1. Anemia Due to Chronic Kidney Disease (CKD)
    a. The member has a diagnosis of anemia due to CKD
    b. Pretreatment hemoglobin < 10 g/dL
    c. **For Epogen and Mircera**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
2. Anemia in Members with Malignancy
    a. The member has a diagnosis of anemia in members with malignancy
    b. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit and Retacrit

3. Anemia in Myelodysplastic Syndrome (MDS)
    a. The member has a diagnosis of anemia in MDS
    b. Pretreatment hemoglobin < 10 g/dL whose pretreatment serum erythropoietin (EPO) level < 500 mU/mL.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
4. Reduction of Allogeneic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery
    a. Member is using medication for reduction of allogenic red blood cell transfusion in members scheduled to have an elective, noncardiac, nonvascular surgery
    b. Pretreatment hemoglobin ≤ 13 g/dL.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
5. Anemia in Congestive Heart Failure (CHF)
    a. The member has a diagnosis of anemia in congestive heart failure
    b. Pretreatment hemoglobin < 9 g/dL.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
6. Anemia in Rheumatoid Arthritis (RA)
    a. The member has a diagnosis of anemia in RA
    b. Pretreatment hemoglobin < 10 g/dL.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
7. Anemia Due to Hepatitis C Treatment
    a. The member has a diagnosis of anemia due to Hepatitis C treatment
    b. Pretreatment hemoglobin < 10 g/dL who are receiving ribavirin in combination with either interferon alfa or peginterferon alfa.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
8. Anemia Due to Zidovudine in HIV-infected Patients
    a. The member has a diagnosis of anemia due to zidovudine in HIV-infected patients
    b. Pretreatment hemoglobin < 10 g/dL whose pretreatment serum EPO level is < 500 mU/mL.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
9. Anemia in Members Whose Religious Beliefs Forbid Blood Transfusions
    a. The member has a diagnosis of anemia in members whose religious beliefs forbid blood transfusions
    b. Pretreatment hemoglobin < 10 g/dL.
    c. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit
10. Anemia in Primary Myelofibrosis (MF), Post-polycythemia Vera MF, or Post-Essential Thrombocythemia MF
    a. The member has a diagnosis of anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis in members who meet ALL of the following criteria:
        i. Pretreatment hemoglobin < 10 g/dL
        ii. Pretreatment serum EPO level < 500 mU/mL
    b. **For Epogen**, the member has intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Continuation of Therapy

For all indications, all members must show a response with a rise in hemoglobin of ≥ 1 g/dL after at least 12 weeks of ESA treatment and the current hemoglobin is < 12 g/dL.

Limitations

1. Initial approvals and reauthorizations for all diagnoses will be granted for 12- week intervals
    a. Reduction of Allogeneic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery: 30 days
    b. Reauthorizations will not be provided for Reduction of Allogeneic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery

References

1. Aranesp (darbepoetin alfa) [prescribing information]. Thousand Oaks, CA: Amgen Inc; February 2019
2. Epogen (epoetin alfa) [prescribing information]. Thousand Oaks, CA: Amgen; July 2018.
3. Mircera (methoxy polyethylene glycol-epoetin beta) [prescribing information]. South San Francisco, CA: Hoffmann-La Roche Inc; June 2018
4. Procrit (epoetin alfa) [prescribing information]. Horsham, PA: Janssen Products LP; July 2018
5. Retacrit (epoetin alfa-epbx) [prescribing information]. Lake Forest, IL: Hospira, Inc; June 2020

Review History

11/18/2020- Updated: combined all ESA products to one document, moved Aranesp and Retacrit to preferred status per rebate strategy; P+T review; separated out MH vs. Comm/Exch criteria.
11/16/2022 – Reviewed and Updated for Nov P&T; moved Procrit as a preferred agent. Effective 01/01/2023.