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 07/01/2025

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 within the past 90 days who are currently receiving treatment with the requested medication, 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 diagnosis-specific criteria have been met:

Anemia Due to Chronic Kidney Disease (CKD)
1. Documented diagnosis of anemia due to CKD
2. Documentation of pretreatment hemoglobin < 10 g/dL
3. **For Epogen and Mircera**: Documentation the member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia in Members with Malignancy

1. Documented diagnosis of anemia in malignancy
2. **For Epogen:** Documentation the member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit and Retacrit

Anemia in Myelodysplastic Syndrome (MDS)

1. Documented diagnosis of anemia in MDS
2. Documentation of pretreatment hemoglobin < 10 g/dL whose pretreatment serum erythropoietin (EPO) level < 500 mU/mL.
3. **For Epogen:** Documentation member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Reduction of Allogeneic Red Blood Cell Transfusion in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery

1. Documentation member is using requested medication for reduction of allogenic red blood cell transfusion in members scheduled to have an elective, noncardiac, nonvascular surgery
2. Documentation of pretreatment hemoglobin ≤ 13 g/dL.
3. **For Epogen:** Documentation member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia in Congestive Heart Failure (CHF)

1. Documentation member has a diagnosis of anemia in congestive heart failure
2. Documentation of pretreatment hemoglobin < 9 g/dL.
3. **For Epogen**: Documentation member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia in Rheumatoid Arthritis (RA)

1. Documentation member has a diagnosis of anemia in RA
2. Documentation of pretreatment hemoglobin < 10 g/dL.
3. **For Epogen**: Documentation member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia Due to Hepatitis C Treatment

1. Documentation member has a diagnosis of anemia due to Hepatitis C treatment
2. Documentation of pretreatment hemoglobin < 10 g/dL who are receiving ribavirin in combination with either interferon alfa or peginterferon alfa.
3. **For Epogen**: Documentation member has had intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia Due to Zidovudine in HIV-infected Patients

1. Documentation member has a diagnosis of anemia due to zidovudine in HIV-infected patients
2. Documentation of pretreatment hemoglobin < 10 g/dL whose pretreatment serum EPO level is < 500 mU/mL.
3. **For Epogen:** Documentation the member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia in Member Whose Religious Beliefs Forbid Blood Transfusions

1. Documentation of diagnosis of anemia in member whose religious beliefs forbid blood transfusions

2. Documentation of pretreatment hemoglobin < 10 g/dL.
3. **For Epogen**: Documentation the member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Anemia in Primary Myelofibrosis (MF), Post-polycythemia Vera MF, or Post-Essential Thrombocythemia MF

1. Documentation the member has a diagnosis of anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
2. Documentation of ALL of the following criteria:
    a. Pretreatment hemoglobin < 10 g/dL
    b. Pretreatment serum EPO level < 500 mU/mL
3. **For Epogen:** Documentation the member has had an intolerance, inadequate response or contraindication to Aranesp, Procrit, and Retacrit

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. Member meets BOTH of the following:
    a. Member's hemoglobin has increased by ≥ 1 g/dL after at least 12 weeks of ESA treatment
    b. Member's current hemoglobin is < 12 g/dL.

Limitations

1. Requests for reduction of allogeneic red blood cell transfusion in patients undergoing elective, noncardiac, nonvascular surgery will be approved for 30 days. Reauthorizations for this indication will not be granted.
2. For all other diagnoses, initial approvals and reauthorizations will be granted for 12-week intervals
3. Mircera is only approvable for the treatment of anemia due to chronic kidney disease.

References

1. Aranesp (darbepoetin alfa) [prescribing information]. Thousand Oaks, CA: Amgen Inc; December 2024.
2. Epogen (epoetin alfa) [prescribing information]. Thousand Oaks, CA: Amgen; December 2024.
3. Mircera (methoxy polyethylene glycol-epoetin beta) [prescribing information]. Gallen, Switzerland: Vifor (International) Inc; June 2024.
4. Procrit (epoetin alfa) [prescribing information]. Thousand Oaks, CA: Amgen; April 2024.
5. Retacrit (epoetin alfa-epbx) [prescribing information]. Lake Forest, IL: Hospira, Inc; June 2024.

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.
06/11/2025 – Reviewed and updated for June P&T. Administrative update- clarified documentation requirements and updated Limitations section to indicate that Mircera is only approvable for the diagnosis of anemia in chronic kidney disease. Clarified approval lengths for diagnoses. Effective 07/01/2025.