MASSACHUSETTS

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Pharmacy Medical Policy
Erythropoietin, Recombinant Human

Table of Contents

Policy Number: 262

BCBSA Reference Number: N/A

Related Policies

- Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy #621A.

Prior Authorization Information

Policy	☒ Prior Authorization ☐ Step Therapy ☒ Quantity Limit ☐ Administrative	Reviewing Department	**Pharmacy Operations:** Tel: 1-800-366-7778 Fax: 1-800-583-6289
		Policy Effective Date	**1/2024**
Pharmacy (Rx) or Medical (MED) benefit coverage	☒ Rx ☐ MED	**To request for coverage:** Providers may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below. **Blue Cross Blue Shield of Massachusetts** **Pharmacy Operations Department** 25 Technology Place Hingham, MA 02043 Tel: 1-800-366-7778 Fax: 1-800-583-6289 **Individual Consideration for the atypical patient:** Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration	
Policy applies to Commercial Members: • Managed Care (HMO and POS), • PPO and Indemnity • MEDEX with Rx plan • Managed Major Medical with Custom BCBSMA Formulary • Comprehensive Managed Major Medical with Custom BCBSMA Formulary • Managed Blue for Seniors with Custom BCBSMA Formulary **Policy does NOT apply to**: • Medicare Advantage			

Summary

This is a comprehensive policy covering prior authorization and quantity limit requirements for Erythropoiesis-Stimulating Agent (ESA) used for the treatment of anemias.

Formulary status/requirements for Erythropoiesis-Stimulating Agents is as follows

Drug	Formulary Status (BCBSMA Commercial Plan)	Requirement	Special Considerations
Preferred			
Retacrit ™ (epoetin alfa-epbx)	Covered, PA, QCD	PA required. See below for criteria.	*SPBO - Covered under Pharmacy benefit only (see other information section) – Does not apply to emergency room, inpatient, ambulatory surgery center or home infusion Current Hemoglobin levels are required prior to dispensing.
Non-preferred			
Aranesp ® (darbepoetin alfa)	NFNC*, PA*, QCD*	PA required. See below for criteria. Requires treatment failure with Retacrit	
Epogen ® (erythropoietin)	NFNC*, PA*, QCD*		
Jesduvroq ™ (daprodustat)	NFNC, PA, QCD		
Procrit ® (erythropoietin)	NFNC*, PA*, QCD*		

QCD - Quality Care Dosing (quantity limits policy #621B); SPBO – Specialty Pharmacy benefit only coverage; PA – Prior Authorization required; ST – Step Therapy; NFNC – Non-formulary / Non-covered

Policy

Length of Approval	1 - 6 months
Formulary Status	All requests must meet the Prior Authorizations requirement. For non-covered medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria

For medications dispensed under the retail pharmacy benefit, current hemoglobin levels will be required upon request by the specialty pharmacy prior to each dispense.

NOTE: Hemoglobin (Hb) levels must be actual lab values from within the previous seven days and not target levels.

Retacrit, Epogen, and Procrit

Retacrit may be considered **MEDICALLY NECESSARY** for treatment of the following indications when ALL of the corresponding criteria are met (***Note: Epogen, and Procrit*** *may be covered only AFTER treatment failure of Retacrit when the corresponding criteria are met*):

1. **Anemia of chronic renal failure[6] – defined as GFR ≤ 60 mL/min/1.73m^2 for at least 3 months or patients on dialysis[16]**
   a. Initiation: Approve x 6 months if Hb ≤ 11.0 g/dL
   b. Continuation: Approve x 6 months if Hb ≤ 12.0 g/dL

2. **Anemia due to AZT treatment in AIDS**
   a. Initiation: Approve x 6 months if Hb ≤ 10.0 g/dL or endogenous erythropoietin levels ≤ 500mUnits/mL
   b. Continuation: Approve x 6 months if Hb ≤ 12.0g/dL

3. **Anemia due to Ribavirin therapy in the treatment of Hepatitis C**[9,10,11, 25]
   a. Initiation: Approve x 6 months if Hb ≤ 10.0 g/dL
   b. Continuation: Approve x 6 months is Hb ≤ 12.0g/dL

4. Myelodysplastic syndromes[1] confirmed by bone marrow biopsy and/or aspirate[23]
   a. Initiation: Approve x 6 months if Hb ≤ 12.0 g/dL
   b. Continuation: Approve x 6 months if Hb ≤ 12.0 g/dL

5. **Anemia due to the effects of concurrently administered chemotherapy in patients with non-myeloid malignancies**[2,4,18,19]
   a. Initiation: Approve x 6 months if Hb ≤ 10.0 g/dL OR Hb > 10.0 g/dL but ≤12 g/dL and the physician anticipates a Hb decrease OR the patient has comorbidities that require higher Hb levels
   b. Continuation: Approve x 6 months if Hb ≤ 12.0 g/dL

6. **Anemia following allogeneic bone marrow transplant**[1,4]
   a. Initiation: Approve x 6 months if Hb ≤ 10.0 g/dL
   b. Continuation: Approve x 6 months is Hb ≤ 12.0g/dL

7. **Anemic surgical patients who meet ALL the following:**
   a. The surgery is elective, non-cardiac, and non-vascular; **AND**
   b. Hemoglobin levels are between 10 and 13 g/d; **AND**
   c. Not willing to donate blood.

   Approve x 1 month of therapy

Aranesp

Aranesp ® may be covered after treatment failure of **Retacrit** ™ for the below indications only and when the corresponding criteria are met:

1. **Anemia associated with chronic renal failure**[7,15] **defined as GFR ≤ 60 mL/min/1.73m^2 for at least 3 months or patients on dialysis**
   a. Initiation: Approve x 6 months if Hb ≤ 11.0 g/dL
   b. Continuation: Approve x 6 months if Hb ≤ 12.0 g/dL

2. **Anemia due to the effects of concurrently administered chemotherapy in patients with non-myeloid malignancies**[8,18,19]
   a. Initiation: Approve x 6 months if Hb ≤ 10.0 g/dL OR Hb > 10.0 g/dL but ≤12 g/dL and the physician anticipates a Hb decrease OR the patient has comorbidities that require higher Hb levels
   b. Continuation: Approve x 6 months if Hb ≤ 12.0 g/dL

Jesduvroq

Jesduvroq ™ may be covered after treatment failure of **Retacrit** ™ for the below indications only and when the corresponding criteria are met:

1. **Anemia associated with chronic renal failure**[7,15] **defined as GFR ≤ 60 mL/min/1.73m^2 for at least 3 months and the patient is on dialysis:**
   a. Initiation: Approve x 6 months if Hb ≤ 11.0 g/dL
   b. Continuation: Approve x 6 months if Hb ≤ 11.0 g/dL

Non-Covered Indications

We do NOT cover Epoetin alpha or Darbepoetin alpha to treat other anemias, including the following, because there is inadequate published evidence to show that health outcomes (such as decreased need for transfusions) are improved:

1. Anemia due to hemolysis, nutritional deficiencies, GI bleeds, and other GI problems[2]
2. Iron deficiency anemia: It is known that patients with iron deficiency do not respond as well to epoetin alpha or darbepoetin alpha, therefore these drugs are not covered for patients whose transferrin saturation is less than 20%[2]
3. Anemia due to cancer in patients not receiving cancer chemotherapy

Other Information

Blue Cross Blue Shield of Massachusetts (BCBSMA*) members (other than Medex®; Blue MedicareRx, Medicare Advantage plans that include prescription drug coverage) will be required to fill their prescriptions for the above medications at one of the providers in our retail specialty pharmacy network, as listed below:

Retail Specialty Pharmacy Contact Information:
AcariaHealth. Phone:1-866-892-1202 Fax: 1-866-892-3223 Website: www.acariahealth.com
Accredo Health Group Phone: 1-877-988-0058 Fax: 1-866-489-1907 Website: www.accredo.com
AllCare Plus Pharmacy Phone: 1-855-880-1091 Fax: 1-844-265-0265 Website: www.allcarepluspharmacy.com
Caremark, Inc. Phone: 1-866-846-3096 Fax: 1-800-323-2445 Website: www.caremark.com
Onco360, the Oncology Pharmacy Phone: 1-877-662-6633 Fax: 1-877-662-6355 Website: www.onco360.com
AllianceRx Walgreens Prime Phone: 1-800-649-2872 Fax: 1-866-935-0719 Website: https://alliancerxwp.com

Clinical Trials for Cancer Mandate

As required by law, we provide coverage for services and supplies received as part of a qualified clinical trial (for treatment of cancer) when the member is enrolled in that trial. This coverage is provided for services and supplies that are consistent with the study protocol and with the standard of care for someone with the patients' diagnosis, and that would be covered if the patient did not participate in the trials. This coverage

may also be provided for investigational drugs and devices that have been approved for use as part of the trial. Coverage for services and supplies that are received as part of a qualified clinical trial is provided to the same extent as it would have been provided if the patient did not participate in the trial.

However, no coverage is provided for:

- Investigational drugs and devices that have not been approved for use in the trial.
- Investigational drugs and devices that are paid for by the manufacturer, distributor or provider of the drug or device, whether or not the drug or device has been approved for use in the trial.
- Non-covered services under the member's contract.
- Costs associated with managing the research for the trial.
- Items, services or costs that are reimbursed or otherwise furnished by the sponsor of the trial.
- Costs of services that are inconsistent with widely accepted and established national and regional standards of care.
- Costs of clinical trials that are not "qualified trials."

Provider Documentation Requirements

Documentation from the provider to support a reason preventing trial of formulary alternative(s) must include the name and strength of alternatives tried and failed (if alternatives were tried, including dates if available) and specifics regarding the treatment failure. Documentation to support clinical basis preventing switch to formulary alternative should also provide specifics around clinical reason.

Individual Consideration (For Atypical Patients)

Our medical policies are written for most people with a given condition. Each policy is based on peer reviewed clinical evidence. We also take into consideration the needs of atypical patient populations and diagnoses.

If the coverage criteria outlined is unlikely to be clinically effective for the prescribed purpose, the health care provider may request an exception to cover the requested medication based on an individual's unique clinical circumstances. This is also referred to as "individual consideration" or an "exception request."

Some reasons why you may need us to make an exception include: therapeutic contraindications; history of adverse effects; expected to be ineffective or likely to cause harm (physical, mental, or adverse reaction).

To facilitate a thorough and prompt review of an exception request, we encourage the provider to include additional supporting clinical documentation with their request. This may include:

- Clinical notes or supporting clinical statements;
- The name and strength of formulary alternatives tried and failed (if alternatives were tried) and specifics regarding the treatment failure, if applicable;
- Clinical literature from reputable peer reviewed journals;
- References from nationally recognized and approved drug compendia such as American Hospital Formulary Service® Drug Information (AHFS-DI), Lexi-Drug, Clinical Pharmacology, Micromedex or Drugdex®; and
- References from consensus documents and/or nationally sanctioned guidelines.

Providers may call, fax or mail relevant clinical information, including clinical references for individual patient consideration, to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Phone: 1-800-366-7778
Fax: 1-800-583-6289

We may also use prescription claims records to establish prior use of formulary alternatives or to show if step therapy criteria has been met. We will require the provider to share

additional information when prescription claims data is either not available or the medication fill history fails to establish use of preferred formulary medications or that step therapy criteria has been met.

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

HCPCS Codes

HCPCS codes:	Code Description
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use) [Arenesp]
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis) [Arenesp]
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units [Epogen, Procrit]
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis) [Epogen, Procrit]
Q5105	Injection, epoetin alfa, biosimilar, (retacrit) (for esrd on dialysis), 100 units
Q5106	Injection, epoetin alfa, biosimilar, (retacrit) (for non-esrd use), 1000 units

The following ICD Diagnosis Codes are considered medically necessary when submitted with the HCPCS codes above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD-10-CM diagnosis codes:	Code Description
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.22	Refractory anemia with excess of blasts 2
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes
D61.1	Drug-induced aplastic anemia
D61.2	Aplastic anemia due to other external agents
D61.3	Idiopathic aplastic anemia
D61.89	Other specified aplastic anemias and other bone marrow failure syndromes
D61.9	Aplastic anemia, unspecified
D63.0	Anemia in neoplastic disease
D63.1	Anemia in chronic kidney disease

D63.8	Anemia in other chronic diseases classified elsewhere
D64.4	Congenital dyserythropoietic anemia
D64.81	Anemia due to antineoplastic chemotherapy
D64.89	Other specified anemias
D64.9	Anemia, unspecified
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.30	Chronic kidney disease, stage 3 unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
N18.9	Chronic kidney disease, unspecified

Effective 7/1/08:
One of the following modifier codes must accompany the drug HCPCS code on the CMS 1500 form in order for the claim to adjudicate.
ED - Hematocrit level has exceeded 39% (or hemoglobin level has exceeded 13.0 g/dL) for 3 or more consecutive billing cycles immediately prior to and including the current cycle.
EE – Hematocrit level has not exceeded 39% (or hemoglobin level has not exceeded 13.0 g/dL) for 3 or more consecutive billing cycle immediately prior to and including the current cycle.
**PLEASE NOTE: These coding modifiers do not apply to the Federal Employee Program (FEP), the BlueCard® Program (BCBSBMA members), or to plans in which Medicare is the primary insurer (e.g. Medicare Advantage, Medex®, or Managed Blue for Seniors™).

For end stage renal disease (ESRD) patients only:

- The initial claim **must** contain the fo**l**lowing information:
    - patient's diagnosis
    - most recent creatinine prior to starting on erythropoietin
    - most recent hematocrit prior to starting on erythropoietin
    - most recent transferrin saturation
    - dosage in units/kilograms
    - patients weight in kilograms
    - number of units of erythropoietin administered
    - Subsequent claims **must** contain:
    - patient's diagnosis
    - hematocrit
    - number of units administered
- We do not separately reimburse the administration of the drug () when done in conjunction with an office visit.

Policy History

Date	Action
1/2024	Updated to add Jesduvroq ™ to the policy under medical only.
11/2023	Reformatted Policy.
10/2023	Reformatted Policy and updated IC to align with 118E MGL § 51A.
7/2023	Reformatted Policy.
8/2022	Updated to remove peginesatide from the policy.
12/2021	BCBSA National medical policy review. No changes to policy statements. New references added.
12/2020	BCBSA National medical policy review. No changes to policy statements. New references added.
10/2020	Clarified coding information and Removed deleted code
7/2019	Updated to add Procrit to non-covered and to update criteria for Retacrit preferred.
11/2018	BCBSA National medical policy review. No changes to policy statements. New references added.

11/2018	Updated to co-prefer Retacrit & Procrit.
7/2018	Updated to include new to market Retacrit.
10/2017	Updated to change Walgreens Specialty Name.
7/2017	Updated to add AllCare to Pharmacy Specialty list.
6/2017	Updated address for Pharmacy Operations.
5/2017	Updated to clarify Epoetin alpha criteria.
1/2016	Updated to add NC designation to Epogen & Aranesp.
8/2015	Updated to add Pharmacy Benefit only Program designation.
7/2015	Updated to add Walgreens Specialty.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
2/2014	Updated Onco360 name and removed Curascript in Specialty Pharmacy section.
1/2014	Updated ExpressPAth Language and removed Blue Value.
1/2013	Updated 1/2013 to include coverage criteria for new FDA approved medication Omontys®.
4/2012	Updated with specialty pharmacy contact information.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
10/2011	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
1/2011	Updated to define diagnosis criteria, authorization timeframes and hemoglobin level requirements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
4/2010	Updated to include updated Specialty Retail Pharmacy contact and 4/1/2010 transition information.
11/2009	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2009	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
10/2009	Updated to remove Medicare Part D criteria and update UM requirements.
8/7/2009	Updated to add Q code for epoetin alpha on dialysis as requested, formatting updated.
11/2008	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2008	Updated to clarify claim submission requirements and update of ICD-9 code.
10/2008	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
7/2008	Updated to include applicable ICD-9 diagnosis codes, addition of specialty pharmacy vendor OTN Specialty Services and to include modifier codes for physician billing submission.
9/2007	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
6/2007	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
6/2007	Updated to include retail pharmacy specialty network information, addition of criteria for target hemoglobin ≤ 12 g/dL and removal of “anemia due to cancer” as a covered diagnosis based upon.
10/1989	New policy, issued 10/1989, describing covered and non-covered indications.

Forms

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

https://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf

OR

Print and fax, Massachusetts Standard Form for Medication Prior Authorization Requests #434

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