PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Erythropoiesis-Stimulating Agents Preferred Specialty Management Policy for High Performance and National Preferred Formularies

- Aranesp® (darbepoetin alfa intravenous or subcutaneous injection – Amgen)
- Epogen® (epoetin alfa intravenous or subcutaneous injection – Amgen)
- Mircera® (methoxy polyethylene glycol-epoetin beta intravenous or subcutaneous injection – Vifor)
- Procrit® (epoetin alfa intravenous or subcutaneous injection – Janssen)
- Retacrit® (epoetin alfa-epbx intravenous or subcutaneous injection – Pfizer)

REVIEW DATE: 02/07/2024

OVERVIEW

The erythropoiesis-stimulating agents (ESAs) are indicated for **anemia** in certain patient populations.[1-5] More specifically, all ESAs are indicated for the treatment of anemia due to chronic kidney disease. Additionally, epoetin alfa (Epogen, Procrit, Retacrit) and Aranesp are indicated for the treatment of anemia due to myelosuppressive chemotherapy in patients with cancer. Epoetin alfa is also indicated for the treatment of anemia due to zidovudine in human immunodeficiency virus-infected patients and the reduction of allogeneic red blood cell transfusions in elective, noncardiac, nonvascular surgery. All ESAs stimulate erythropoiesis by the same mechanism as endogenous erythropoietin. Retacrit is the biosimilar to Epogen/Procrit.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of Preferred Products. For all products (Preferred and Non-Preferred), the patient is required to meet the respective standard *Erythropoiesis-Stimulating Agents Prior Authorization Policy* criteria. This program also directs the patient to try at least one Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). For patients with chronic kidney disease who are on dialysis, Prior Authorization and Step Management are not required for pharmacy benefit coverage. Approval duration for patients with chronic kidney disease who are on dialysis is for 3 years. For all Other Conditions, approval durations are as noted in the respective standard *Erythropoiesis-Stimulating Agents Prior Authorization Policy*. If the patient meets the respective standard *Erythropoiesis-Stimulating Agents Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for the Preferred Product(s) will be authorized.

Automation: None.

Preferred Products: Procrit, Retacrit
Non-Preferred Products: Aranesp, Epogen, Mircera

RECOMMENDED EXCEPTION CRITERIA

REFERENCES

1. Procrit® intravenous or subcutaneous injection [prescribing information]. Horsham, PA: Janssen; May 2020.
2. Epogen® intravenous or subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; July 2018.
3. Retacrit™ intravenous or subcutaneous injection [prescribing information]. New York, NY and Lake Forest, IL: Pfizer and Hospira; April 2023.
4. Mircera® intravenous or subcutaneous injection [prescribing information]. Basking Ridge, NJ: Vifor Pharma; August 2019.
5. Aranesp® intravenous or subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; January 2019.