

HEALTHCARE OPERATIONS

UTILIZATION PROTOCOLS 2007

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**PROCEDURE: Epoetin alfa (Procrit®) and Darbepoetin alfa (Aranesp®) PHM043
Erythropoiesis Stimulating Agents (ESAs)**

CPT:

Approval through Pharmacy Services

Last Reviewed: 8/4/07

PLEASE NOTE: *Aranesp dosed every other week is the preferred product on all lines of business (Commercial, Senior Dimensions, and SierraRx). Procrit or Epogen require failure of Aranesp.*

Coverage Criteria:

1. The diagnosis requiring ESA must be specified on request.
 - If the submitted diagnosis is one of the “unaccepted diagnoses”, the request will NOT be approved.

Accepted Diagnoses for ESA Therapy	Unaccepted Diagnoses for ESA Therapy
Anemia associated with CRF (chronic renal failure)	Any anemia due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
Anemia associated with chronic disease	The anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML), or erythroid cancers
Anemia associated with CHF (congestive heart failure)	The anemia of cancer not related to cancer treatment
Anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma and lymphocytic leukemia.*	Any anemia associated only with radiotherapy
	Prophylactic use to prevent chemotherapy-induced anemia
	Prophylactic use to reduce tumor hypoxia
	Patients with erythropoietin-type resistance due to neutralizing antibodies
	Anemia due to cancer treatment if patients have uncontrolled hypertension
*Only reasonable and necessary when Hemoglobin level immediately prior to initiation or maintenance of ESA treatment is <10g/dL (or the hematocrit is <30%)	

This guideline is to be used in the decision-making process and does not represent standards of care of an individual patient. The use of this guideline should not substitute for the professional judgment of a provider which takes into account the unique problems and circumstances of the individual patient. They are proprietary documents and may not be copied or distributed without express permission.

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2. Patient must have documented, recent lab results showing:
 - Hemoglobin and Hematocrit values (within the last 1 month):
 - Hgb \leq 11 gm/dL **or** a Hct \leq 33% (CHF: Hgb \leq 11.5 gm/dL)
 - On ESA (continuation of coverage): Hgb $<$ 12 gm/dL or Hct \leq 36%
 - Chemotherapy-induced anemia (initial and continuation of treatment): Hgb $<$ 10 gm/dL or Hct $<$ 30%
 - Iron Studies values (within the last 3 months):
 - Serum Ferritin \geq 100mcg/L
 - Transferrin Saturation (TSat%) \geq 20%
3. Dialysis Status needs to be documented for Medicare members. ESA is considered a Part B benefit, **not** a Part D benefit if the patient is on dialysis.
 - If the patient is currently **on dialysis** (hemo or peritoneal):
 - a. **SierraRx, SierraRx Basic, SierraRx Plus** – ESA will not be approved. Please refer patient to their Part B carrier.
 - b. **Sierra Spectrum, Sierra Nevada Spectrum, Village Health, Senior Dimensions** – if patient meets the coverage criteria, medication will be billed through their Part B benefit (20% coinsurance) and will not apply to TrOOP.
 - c. **Commercial Member** – covered under the SIO benefit. Prior authorization through UM.

➤ ACTION: If criteria for use are met, approve for up to 3 months**.

**In chemotherapy-induced anemia, ESA treatment may be approved for the duration of each course of chemotherapy plus 8 weeks following the final dose of myelosuppressive chemotherapy.

4. Continuation of coverage will require submission of an updated hemoglobin and hemotacrit as well as updated iron studies. Patient must meet criteria for their specified diagnosis for approval. If patient's H/H exceed criteria (in non-chemo-induced anemias), a dose reduction must occur or continued coverage will not be provided.

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Coverage Information and Conversion Charts

1. **Senior Dimensions and Commercial members:** *Aranesp[®] dosed every other week* is the preferred agent for these plans. Epogen[®] is non-formulary.
2. **All other lines of coverage:** Aranesp[®] and Procrit[®] have equal status on the formulary. Epogen[®] is non-formulary.
3. In anemia in neoplastic disease, due to chemotherapy (non-myeloid malignancy), the starting dose for ESA treatment is the FDA label-starting dose, no more than 150U/kg/three times weekly for epoetin (Procrit[®]) and 2.25mcg/kg/weekly for darbepoetin alpha (Aranesp[®]). Equivalent doses may be given over other approved time periods.

Cumulative 2-week Procrit [®] /Epogen [®] (epoetin alpha) dose (units)	Q2W Aranesp[®] (darbepoetin alpha) dose (mcg)
5,000 – 10,999 units	25 mcg/2wk
11,000 – 17,999 units	40 mcg/2wk
18,000 – 33,999 units	60 mcg/2wk
34,000 – 89,999 units	100 mcg/2wk
90,000 units and above	200 mcg/2wk

4. Inadequate response (Hemoglobin remains <10 after 12 weeks of therapy) to a dose given every 2 weeks.
 - a. Patient qualifies for weekly dosing regimen (see conversion chart for Aranesp[®] once weekly dosing)

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Aranesp[®] once weekly dosing Conversion Chart

Epoetin alfa (Units/wk)	Aranesp [®] (mcg/wk)
<2,500 units	6.25 mcg/wk
2,500 – 4,999 units	12.5 mcg/wk
5,000 – 10,999 units	25 mcg/wk
11,000 – 17,999 units	40 mcg/wk
18,000 – 33,999 units	60 mcg/wk
34,000 – 89,999 units	100 mcg/wk
90,000 units and above	200 mcg/wk

Appendix A- Standardized Comments:

<p>More info- all lines -only include comments that apply</p>	<p><u>Drug Dose Duration</u> for <u>Diagnosis</u> coverage requires more information for approval. Please provide by [5 business day] or the request will be closed and considered denied.</p> <ol style="list-style-type: none"> 1) state if the patient is or is not on dialysis (for Medicare patient's only) 2) provide a recent (with in the last month) hemoglobin & hematocrit level 3) state if the submitted hemoglobin & hematocrit was taken while the patient was on Epo therapy (if yes, please provide dose and schedule) 4) provide recent (with in the last 3 months) iron studies showing an adequate Ferritin and Transferrin
<p>Add line #5 for</p>	<ol style="list-style-type: none"> 5) Aranesp is the preferred product dosed every 2 weeks. Please

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Commercial and Senior Dimensions members	consider using this product and dosing, or provide rationale with supporting documents as to why this would not be appropriate for the patient.
Approval	<u>Drug Dose Duration</u> for <u>Diagnosis</u> coverage is approved x 6 months. For coverage past 6 months, will require updated Hemoglobin and Hematocrit showing response to therapy. Will also require iron studies showing patient has adequate iron stores for epo therapy. Pt not on dialysis at time of approval.
Denial – Part B	[Drug] [Dose] [Schedule] [Duration] for [Diagnosis] coverage is not approved. Patient is currently on dialysis. Please contact the members Medicare Part B carrier for coverage.
Part D (Senior Dimensions)	[Drug] [Dose] [Schedule] [Duration] coverage is not approved. Formulary alternatives include [drug(s)]. Please submit request for formulary alternative.
Denial w/coverage	[Drug] [Dose] [Schedule] [Duration] for [Diagnosis] coverage is not approved. Chart notes documenting most recent lab results indicate patients H/H is beyond the target goal. Dosage adjustment is required. Members plan will cover this medication at a lower dose.

Coverage Information – Aranesp®

Medicare:

Senior Dimensions, VillageHealth, Sierra Spectrum, Sierra Nevada Spectrum –

covered under the Medicare Part D if patient is NOT receiving dialysis; applicable specialty drug co-insurance will apply. Claims will adjudicate through the pharmacy online billing system and WILL apply to TrOOP. If patient is receiving dialysis, will be covered under Medicare Part B with applicable 20%coinsurance.

SierraRx, SierraRx Basic, SierraRx Plus – Covered under Medicare Part D only if patient is NOT receiving dialysis; applicable specialty drug co-insurance will apply. Claims will adjudicate through the pharmacy online billing system and WILL apply to TrOOP. If patient is receiving dialysis, refer to patient’s Part B carrier

Sierra Optima Plans – If this is being billed for a member who is receiving dialysis, this is a Part B benefit. Applicable 20% coinsurance will apply. If member is NOT receiving dialysis, refer member to Part D carrier, or refer to coverage lines above.

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All other lines of Business – Covered by the Self Injectable/Orphan drug component of the Prescription benefit at either Expanded or Limited level, please see individual plan documents for copayment information

General Information

Erythropoietin (epoetin alfa) is a glycoprotein produced by the kidney that stimulates red blood cell production. Darbepoetin alfa (Aranesp[®]) is an analogue of erythropoietin that has a longer plasma half-life and can be given less often.

FDA-approved indications

1. For the treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis
2. For the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy.

Recommendation for dosage adjustment/reduction

1. Dose should be reduced by 25-50% if Hgb > 12gm/dL or Hct > 36% while patient is currently on epoetin alfa. Titrate dose to Hgb 10-12gm/dL.
2. Approve dose reduction x 3 months and request recent H/H and iron studies to continue coverage.

Contraindications

1. Hypersensitivity to darbepoetin alfa, albumin, or polysorbate 80 (formulation component)
2. Prior hypersensitivity to epoetin alfa formulations
3. Uncontrolled hypertension
4. Acute Blood loss
5. Active GI bleed

Dosing Recommendations

1. Chronic renal failure – studies are being conducted to support a fixed dose regimen of Aranesp[®] for the treatment of CRF. **These fixed doses are 25 mcg QW, 60 mcg QOW, 75 mcg Q3W, or 100 mcg Q4W.**

(The FDA-approved recommended starting dose of Aranesp[®] for the correction of anemia due to CRF 0.45mcg/kg, administered as a single IV or SC injection once weekly. Some patients have been treated successfully with a SC dose (0.75mcg/kg) every other week. For patients receiving epoetin alfa one to three times weekly the dose of darbepoetin alfa is based on the weekly epoetin alfa dose at the time of substitution. The calculated dose should be adjusted to the next strength up or down to achieve a 1.0 or greater gram/deciliter but less

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than 3.0gm/dl rise in hemoglobin. Dosage should be adjusted to maintain a target hemoglobin not to exceed 12 g/dL.)

2. Chemotherapy induced anemia – studies are being conducted to support a fixed dose regimen of Aranesp[®] for the treatment of chemotherapy induced anemia. **These fixed doses are 100 mcg QW, 200 mcg QOW, or 300 mcg Q3W.**

(The FDA-approved recommended starting dose for Aranesp[®] for the correction of anemia due to chemotherapy is 2.25mcg/kg administered as a weekly subcutaneous injection. Dosage should be adjusted based on hemoglobin levels and response to therapy.)

Special Notes

Fixed-dose regimen is preferred for all members; however, FDA approved doses may also be approved in some instances. Medical Director Review and approval required for non-fixed dose regimens.

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