MEDICATION POLICY

Generic Name: Epoetin Alfa

Therapeutic Class or Brand Name: Erythropoietins

Applicable Drugs (if Therapeutic Class)**:**

Preferred: Procrit®

Non-Preferred: Epogen®

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 12/1/17

GPI Code: 8240102000

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

I. Documented diagnosis of one of the following conditions A through D AND must meet criteria listed under applicable diagnosis:

A. Anemia due to Chronic Kidney Disease in patients on dialysis and patients not on dialysis, and criterion 1 is met:

1. Minimum age requirement: 1 month old.

B. Anemia due to Zidovudine in HIV-infected patients and criterion 1 is met:

1. Minimum age requirement: 8 months old.

C. Anemia due to the effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy, and criterion 1 is met:

1. Minimum age requirement: 5 years old.

D. Reduction of allogeneic RBC transfusions in patients undergoing elective, nonvascular, noncardiac surgery and criterion 1 is met (approve one time only):

1. Minimum age requirement: 18 years old.

II. Prescribing authority limited to hematologist, oncologist, nephrologist, gastroenterologist, and infectious disease specialist or based upon a consult with one of these specialists.

III. Documentation showing that the patient does not have any GI bleeding.

IV. Documentation that current hemoglobin is less than 10 g/dL.

V. Non-preferred products require a documented failure, intolerance, or contraindication to the preferred product(s).

Exclusion Criteria:

- Patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy.
- Patients with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure.
- Patients with cancer receiving myelosuppressive chemotherapy when the anemia can be managed by transfusion.
- Patients scheduled for surgery who are willing to donate autologous blood.
- Patients undergoing cardiac or vascular surgery.
- As a substitute for RBC transfusions in patients who require immediate correction of anemia.
- Patients with uncontrolled hypertension.
- Patients with Pure Red Cell Aplasia (PRCA) that begins after treatment with erythropoietin protein drugs.

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- The quantity is limited to a maximum of a 30 day supply per fill.

Approval Length:

- **Authorization:** 6 months (unless otherwise stated under Prior Authorization Criteria section).
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing no GI bleeding and hemoglobin less than 11 g/dL.

Appendix:

N/A

References:

1. http://www.fda.gov/Drugs/DrugSafety/ucm259639.htm.

2. Medi-Span.
3. http://www.procrit.com/sites/all/themes/procrit/resources/ProcritBooklet.pdf.
4. http://pi.amgen.com/united_states/epogen/epogen_pi_hcp_english.pdf.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
12/1/2017	1. **Added** "Patients with cancer receiving myelosuppressive chemotherapy when the anemia can be managed by transfusion" **under Exclusion Criteria**.
9/22/2016	1. **Changed** "III. No GI bleeding" **to** "III. Documentation showing that the patient does not have any GI bleeding" **under Prior Authorization Criteria**. 2. **Changed** "IV. Hemoglobin less than 10 g/dL" **to** "IV. Documentation that current hemoglobin is less than 10 g/dL" **under Prior Authorization Criteria**. 3. **Changed** "V. Non-preferred Epogen® requires a documented failure, intolerance, or contraindication to the preferred product Procrit®" **to** "V. Non-preferred products require a documented failure, intolerance, or contraindication to the preferred product(s)" **under Prior Authorization Criteria**. 4. **Removed** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Erythropoetins.pdf" **from References** (link no longer valid).
3/4/2015	1. **Changed Applicable Drugs from** "Procrit® and Epogen®" **to** "Preferred: Procrit®; Non-Preferred: Epogen®". 2. **Deleted duplicate GPI** "8240102000". 3. **Added** "Non-preferred Epogen® requires a documented failure, intolerance, or contraindication to the preferred product Procrit®" **under Prior Authorization Criteria**. 4. **Changed** "N/A" **to** "The quantity is limited to a maximum of a 30 day supply per fill" **under Quantity/Days Supply Restrictions**. 5. **Updated** "http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/pdf/Erythropoetins.pdf" **to** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Erythropoetins.pdf" **under References**.
11/11/2013	1. **Adapted policy to new format**. 2. **Added GPI Codes**. 3. **Changed Re-Authorization from** "No GI bleeding and Hemoglobin less than 11 g/dL" **to** "An updated letter of medical necessity or progress notes showing no GI bleeding and hemoglobin less than 11 g/dL". 4. **Updated references** to include Medi-Span.