

Reference number(s)
5626-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	<input type="checkbox"/>
Standard Control – Choice (SCCF)	<input type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input type="checkbox"/>
Advanced Control Specialty – Choice (ACSCF)	<input type="checkbox"/>
Managed Medicaid Template (MMT)	<input type="checkbox"/>
Marketplace (MF)	<input type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA)	<input type="checkbox"/>
Aetna Health Exchange (AHE)	<input type="checkbox"/>
Aetna Individual Lives (IVL)	<input type="checkbox"/>
Value (VF)	<input type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSF)	<input type="checkbox"/>
Value Formulary Chart (VFC)	<input type="checkbox"/>
Medical Benefit	<input checked="" type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Medical Benefit: Managed Medicaid (MMMB)	<input type="checkbox"/>
Medicare Part B	<input type="checkbox"/>
Medicare Part B: Advanced Biosimilars First	<input type="checkbox"/>

Exceptions Criteria

Anemia

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Medical Benefit.

Plan Design Summary

This program applies to the anemia products specified in this document. Coverage for the targeted products is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Anemia Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	<ul style="list-style-type: none"> Aranesp (darbepoetin alfa) Procrit (epoetin alfa)

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	Product(s)
Target	<ul style="list-style-type: none"> • Epogen (epoetin alfa) • Mircera (methoxy polyethylene glycol-epoetin beta) • Retacrit (epoetin alfa-epbx)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred products.

Anemia Due to Chronic Kidney Disease (CKD)

Epogen or Retacrit

Coverage for Epogen or Retacrit is provided when both of the following criteria are met:

- Member has had a documented intolerable adverse event with Procrit, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (e.g., known adverse reaction for both the reference product and biosimilar product).
- Member has a documented inadequate response or intolerable adverse event with the preferred product, Aranesp.

Mircera

Coverage for Mircera is provided when the member has a documented inadequate response or intolerable adverse event with both of the preferred products, Aranesp and Procrit.

Anemia Due to Myelosuppressive Chemotherapy in Cancer

Epogen or Retacrit

Coverage for Epogen or Retacrit is provided when both of the following criteria are met:

- Member has had a documented intolerable adverse event with Procrit, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (e.g., known adverse reaction for both the reference product and biosimilar product).
- Member has a documented inadequate response or intolerable adverse event with the preferred product, Aranesp.

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Anemia Due to Zidovudine in Patients with Human Immunodeficiency Virus (HIV) Infection and To Reduce Need for Allogeneic Red Blood Cell (RBC) Transfusions

Epogen or Retacrit

Coverage for Epogen or Retacrit is provided when the member has had a documented intolerable adverse event with Procrit, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (e.g., known adverse reaction for both the reference product and biosimilar product).

References

1. Aranesp [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.
2. Epogen [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.
3. Procrit [package insert]. Horsham, PA: Janssen Products, LP; July 2018.
4. Mircera [package insert]. St. Gallen, Switzerland: Vifor (International) Inc.; June 2024.
5. Retacrit [package insert]. New York, NY: Pfizer Labs; June 2024.