Drug Class Prior Authorization Criteria

Erythropoiesis Stimulating Agents (ESA)

Line of Business: Medicaid
P & T Approval Date: May 7, 2021 **Effective Date:** June 18, 2021

These criteria have been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutics Subcommittee.

Prior Authorization criteria is available for: Aranesp (darbepoetin alfa)

ARANESP (DARBEPOETIN ALFA)

Covered Uses:	Anemia due to chronic kidney disease (CKD)
Exclusion Criteria:	N/A
Required Medical Information:	Must meet all of the following requirements: a. Baseline hemoglobin level is less than 10 g/dL b. Baseline adequate iron store should be demonstrated by all of the following requirements: 1. Serum transferrin saturation is greater than or equal to 20 percent 2. Serum ferritin is greater than or equal to 100 ng/mL
Age Restrictions:	N/A
Prescriber Restrictions:	N/A
Other Criteria:	Duration of Therapy: 180 days Reauthorization Criteria: Must meet all of the following requirements: a. Positive clinical response (e.g. improvement in hemoglobin level) b. If hemoglobin level is greater than 11 g/dL, dosage should be reduced or interrupted Duration of Reauthorization: 180 days

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Erythropoiesis Stimulating Agents (ESA)

Covered Uses: Anemia due to concomitant myelosuppressive chemotherapy in patients with non-myeloid malignancies

Exclusion Criteria: N/A

Required Medical Information: Must meet all of the following requirements:

a. Baseline hemoglobin level is less than 10 g/dL
b. At least two additional months of planned chemotherapy
c. Baseline adequate iron store should be demonstrated by all of the following requirements:
    1. Serum transferrin saturation is greater than or equal to 20 percent
    2. Serum ferritin is greater than or equal to 100 ng/mL

Age Restrictions: N/A

Prescriber Restrictions: N/A

Other Criteria: Duration of Therapy: 180 days

Reauthorization Criteria: Must meet all of the following requirements:

a. Positive clinical response (e.g. improvement in hemoglobin level)
b. If hemoglobin level is greater than or equal to 12 g/dL, dosage should be reduced or interrupted

Duration of Reauthorization: 180 days

Change Control		
Date	**Change**	**RPH**
05/07/2021	• Renew with no changes	TL
08/28/2020	• Renew with no changes	RR
05/15/2019	• Retire PA criteria for non-formulary agents: Procrit, Mircera, Epogen, Retacrit • Remove criteria for off-labeled indications: myeloblastic syndrome for Aranesp	ND
06/29/2018	• Changed Format	IK
05/16/2018	• Reformatted document	HC