

# Drug Policy

<b>Policy:</b>	<b>201312-MRx</b>	<b>Initial Effective Date: 04/01/2013</b>
<b>Code(s):</b>	<b>HCPCS J0881</b>	<b>Annual Review Date: 02/21/2025</b>
<b>SUBJECT:</b>	<b>Erythropoiesis Stimulating Agents - Darbepoetin Alfa (Aranesp®)</b>	<b>Last Revised Date: 02/21/2025</b>

Subject to:  Site of Care  
 Medication Sourcing

**Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.**

## POLICY STATEMENT

This policy involves the use of Aranesp. Prior authorization is recommended for medical benefit coverage of Aranesp. Approval is recommended for those who meet the conditions of coverage in the **Initial Approval and Renewal Criteria, Preferred Drug (when applicable), Dosing/Administration, Length of Authorization, and Site of Care (when applicable)** for the diagnosis provided. The requirement that the patient meet the Criteria and Preferred Drug for coverage of the requested medication applies to the initial authorization only. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy.

Please note this policy is subject to Medicare Part B step therapy. Please see the corporate medical policy titled **Medicare Part B Step Therapy** for a complete list of preferred therapies.

### I. Length of Authorization

- Coverage will be provided for 60 days and may be renewed every 6 months thereafter.

### II. Dosing Limits

**Max Units (per dose and over time) [HCPCS Unit]:**

- MDS: 500 billable units every 14 days
- MPN: 300 billable units every 7 days
- CKD (Non-Dialysis Patients): 600 billable units every 28 days
- Chemotherapy-induced: 600 billable units every 21 days

### III. Initial Approval Criteria <sup>1,4,5</sup>

Coverage is provided in the following conditions:

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- Patient is at least 18 years of age (unless otherwise specified); **AND**
- Initiation of therapy Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30%; **AND**

## Universal Criteria <sup>1,3,16,18</sup>

- Lab values are obtained within 30 days of the date of administration (unless otherwise indicated); **AND**
- Patient has adequate iron stores as demonstrated by serum ferritin  $\geq 100$  ng/mL (mcg/L) and transferrin saturation (TSAT)  $\geq 20\%$  (measured within the previous 3 months for renewal)\*; **AND**
- Other causes of anemia (e.g. hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out; **AND**
- Patient does not have uncontrolled hypertension; **AND**

## Anemia Due to Myelodysplastic Syndromes (MDS) ‡ <sup>2,4</sup>

- Patient has symptomatic anemia; **AND**
- Patient has a serum erythropoietin level  $\leq 500$  mU/mL; **AND**
  - Patient has lower risk disease (defined as IPSS-R [Very Low, Low, Intermediate]); **AND**
    - Used as a single agent for del(5q) mutation (*excluding use in patients with cytogenetic abnormality involving chromosome 7*); **OR**
    - Patient does not have del(5q) mutation; **AND**
      - Patient has ring sideroblasts < 15% (or <5% with an SF3B1 mutation); **AND**
        - Used as a single agent; **OR**
        - Used in combination with either lenalidomide or a granulocyte-colony stimulating factor (G-CSF); **AND**
          - Patient had no response\*\* (despite adequate iron stores) to or relapse after an erythropoiesis-stimulating agent (ESA) alone; **OR**
          - Patient had no response\*\* to or relapse after luspatercept; **OR**
      - Patient has ring sideroblasts  $\geq 15\%$  (or ring sideroblasts  $\geq 5\%$  with an SF3B1 mutation); **AND**
        - Used as a single agent; **AND**
          - Patient had no response\*\* to or relapse after luspatercept; **OR**
          - Patient has a serum erythropoietin level < 200 mU/mL; **OR**
        - Used in combination with a G-CSF; **AND**
          - Patient had no response\*\* to or relapse after luspatercept

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\*\* **Note:** No response defined as a lack of  $\geq 1.5$  gm/dL rise in hemoglobin OR lack of a decrease in RBC transfusion requirement (within 6-8 weeks when treated with ESAs or within 3-6 months when treated with luspatercept).

## **Anemia Due to Myeloproliferative Neoplasms (MPN) - Myelofibrosis ‡<sup>2,5</sup>**

- Patient has myelofibrosis-associated anemia with serum erythropoietin level of < 500 mU/mL; **AND**
  - Patient has symptomatic splenomegaly and/or constitutional symptoms currently controlled on a JAK inhibitor; **AND**
    - Used in combination with ruxolitinib; **OR**
  - Patient has no symptomatic splenomegaly and/or constitutional symptoms; **AND**
    - Used as a single agent

## **Anemia Due to Chemotherapy Treatment † ‡<sup>1-3</sup>**

- Patient has anemia due to concomitant myelosuppressive chemotherapy for a non-myeloid malignancy; **AND**
- Patient is receiving chemotherapy that is not intended to cure their disease (i.e., palliative treatment)  $\pm$ ; **AND**
- There are a minimum of two additional months of planned chemotherapy

$\pm$  **Note:** Patients who are not undergoing palliative treatment and refuse blood transfusions may be reviewed on a case-by-case basis

## **Anemia Due to Chronic Kidney Disease (Non-Dialysis Patients) †<sup>1,16,18</sup>**

- Patient at least 1 month of age

## **Anemia Due to Chronic Kidney Disease (Dialysis Patients) †<sup>1-6</sup>**

- Patient at least 1 month of age; **AND**
- Patient does not have end stage renal disease (ESRD) or stage 5 chronic kidney disease

† FDA Approved Indications; ‡ Compendia Recommended Indication(s);  $\Phi$  Orphan Drug

## **IV. Renewal Criteria<sup>1,4,5,19</sup>**

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria identified in section III; **AND**
- Previous dose was administered within the past 60 days; **AND**
- Disease response with treatment as defined by improvement in anemia compared to pretreatment baseline; **AND**

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- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: pure red cell aplasia, severe allergic reactions (anaphylaxis, angioedema, bronchospasm, etc.), severe cardiovascular events (stroke, myocardial infarction, congestive heart failure, thromboembolism, etc.), uncontrolled hypertension, seizures, increased risk of tumor progression/recurrence in patients with cancer, severe cutaneous reactions (erythema multiforme, Stevens-Johnson Syndrome [SJS]/Toxic Epidermal Necrolysis [TEN], etc.), etc.; **AND**

**Anemia Due to Myelodysplastic Syndrome (MDS):**

- Hemoglobin (Hb) < 12 g/dL and/or Hematocrit (Hct) < 36%

**Anemia Due to Myeloproliferative Neoplasms (MPN) – Myelofibrosis:**

- Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30%

**Anemia Due to Chemotherapy Treatment:**

- *Refer to Section III for criteria*

**Anemia Due to Chronic Kidney Disease (Non-Dialysis Patients):**

- **Pediatric patients:** Hemoglobin (Hb) < 12 g/dL and/or Hematocrit (Hct) ≤ 36%
- **Adult patients:** Hemoglobin (Hb) < 11 g/dL and/or Hematocrit (Hct) ≤ 33%

**Anemia Due to Chronic Kidney Disease (Dialysis):**

- **Pediatric patients:** Hemoglobin (Hb) < 12 g/dL and/or Hematocrit (Hct) < 36%
- **Adult patients:** Hemoglobin (Hb) < 11 g/dL and/or Hematocrit (Hct) < 33%

*\* Intravenous iron supplementation may be considered when evaluating iron status*

- Functional iron deficiency (i.e., adequate iron stores with an insufficient supply of available iron) may occur in patients with chronic diseases, cancer, and/or in those currently receiving ESAs.
- Iron is not generally recommended in anemic patients with a Ferritin >500 ng/mL.
- Anemic patients with a Ferritin ≤500 ng/mL AND TSAT <50% may derive benefit from IV iron therapy in conjunction with ESA.

**V. Dosage/Administration** <sup>1,3-5,7,17</sup>

Indication	Dose
Anemia due to chemotherapy §	Administer 2.25 mcg/kg subcutaneously every 7 days. May increase up to 4.5 mcg/kg subcutaneously every 7 days for insufficient response <b>-OR-</b>

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	<p>Administer 500 mcg subcutaneously every 21 days</p> <p><b>Alternative regimens:</b></p> <p>Administer 100 mcg subcutaneously every 7 days. May increase up to 200 mcg subcutaneously every 7 days for insufficient response</p> <p><b>-OR-</b></p> <p>Administer 200 mcg subcutaneously every 14 days. May increase up to 300 mcg subcutaneously every 14 days for insufficient response</p> <p><b>-OR-</b></p> <p>Administer 300 mcg subcutaneously every 21 days. May increase up to 500 mcg subcutaneously every 21 days for insufficient response</p>
Anemia due to Chronic Kidney Disease – Non-dialysis §	<p><b><u>Pediatric patients:</u></b></p> <p>Administer 0.45 mcg/kg intravenously or subcutaneously every 7 days</p> <p><b>-OR-</b></p> <p>Administer 0.75 mcg/kg intravenously or subcutaneously every 14 days</p> <p><b><u>Adult patients:</u></b></p> <p>Administer 0.45 mcg/kg intravenously or subcutaneously every 28 days. May increase to a maximum dose of 600 mcg every 28 days.</p>
Anemia due to MDS §	Administer 150 to 300 mcg subcutaneously every 14 days. May increase up to 500 mcg every 14 days
Anemia due to MPN §	Administer 150 mcg subcutaneously every 7 days. May increase up to 300 mcg every 7 days
Anemia due to Chronic Kidney Disease – Dialysis §	Initiate at 0.45 mcg/kg intravenously or subcutaneously every 7 days or 0.75 mcg/kg every 14 days

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## § Dose Adjustments and Discontinuation Guidance

- For patients with CKD:
  - Dose increases of 25% can be considered if after 4 weeks of initial therapy the hemoglobin has increased less than 1 g/dL and the current hemoglobin level is less than the indication specific level noted above.
  - Dose decreases of 25% or more can be considered if the hemoglobin rises rapidly by more than 1 g/dL in any 2-week period.
  - Dose and frequency requested are the minimum necessary for the patient to avoid RBC transfusions.
  - Avoid frequent dose adjustments. Do not increase the dose more frequently than once every 4 weeks; decreases can occur more frequently.
  - If patients fail to respond over a 12-week dose escalation period, further dose increases are unlikely to improve response and discontinuation of therapy should be considered.
- For patients with MDS:
  - After 8 weeks of therapy, if there is no response as measured by at least a 1.5 g/dL increase in hemoglobin or a decrease in RBC transfusions, change of regimen or discontinuation of therapy should be considered.
- For patients with MPN:
  - After 3 months of therapy, if there is no response as measured by at least a 2 g/dL increase in hemoglobin or a decrease in RBC transfusions, discontinuation of therapy should be considered.
- For patients on Cancer Chemotherapy:
  - After 8 weeks of therapy, if there is no response as measured by hemoglobin levels or if RBC transfusions are still required or following completion of a chemotherapy course discontinue therapy.

## VI. Billing Code/Availability Information

### HCPCS code:

- J0881 – Injection, darbepoetin alfa, 1 microgram (non-ESRD use); 1 billable unit = 1 mcg

### NDC(s):

Single-dose Vial		Single-dose Prefilled Syringe	
<i>1 Vial/Pack, 4 Packs/Case</i>		<i>1 Syringe/Pack, 4 Packs/Case</i>	
200 mcg/1 mL	55513-0006-xx	200 mcg/0.4 mL	55513-0028-xx
		300 mcg/0.6 mL	55513-0111-xx
		500 mcg/1 mL	55513-0032-xx
<i>4 Vials/Pack, 10 Packs/Case</i>		<i>4 Syringes/Pack, 10 Packs/Case</i>	
25 mcg/1 mL	55513-0002-xx	10 mcg/0.4 mL	55513-0098-xx
40 mcg/1 mL	55513-0003-xx	25 mcg/0.42 mL	55513-0057-xx
60 mcg/1 mL	55513-0004-xx	40 mcg/0.4 mL	55513-0021-xx

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100 mcg/1 mL	55513-0005-xx	60 mcg/0.3 mL	55513-0023-xx
		100 mcg/0.5 mL	55513-0025-xx
		150 mcg/0.3 mL	55513-0027-xx

## VII. References

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2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) darbepoetin alfa. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed January 2025.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Hematopoietic Growth Factors Version 1.2025. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed January 2025.
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## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C93.10	Chronic myelomonocytic leukemia, not having achieved remission
C94.40	Acute panmyelosis with myelofibrosis not having achieved remission
C94.41	Acute panmyelosis with myelofibrosis in remission
C94.42	Acute panmyelosis with myelofibrosis in relapse
C94.6	Myelodysplastic disease, not classified
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality

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D46.Z	Other myelodysplastic syndromes
D47.1	Chronic myeloproliferative disease
D47.4	Osteomyelofibrosis
D63.0	Anemia in neoplastic disease
D63.1	Anemia in chronic kidney disease
D64.81	Anemia due to antineoplastic chemotherapy
D64.9	Anemia unspecified
D75.81	Myelofibrosis
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
N18.30	Chronic kidney disease, stage 3 (moderate), unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
Z51.11	Encounter for antineoplastic chemotherapy
Z51.89	Encounter for other specified aftercare

**Dual coding requirements:**

- Anemia due to CKD (not on dialysis): must bill D63.1 AND I12.9, I13.0, I13.10, N18.30, N18.31, N18.32, N18.4, or N18.5

**Appendix 2 – Centers for Medicare and Medicaid Services (CMS)**

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes		
Jurisdiction	NCD/LCA/LCD Document (c)	Contractor
All	110.21	All

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Medicare Part B Covered Diagnosis Codes		
Jurisdiction	NCD/LCA/LCD Document (c)	Contractor
J,M	A58982	Palmetto GBA
15	A56462	CGS Administrators, LLC
5,8	A56795	Wisconsin Physicians Service Insurance Corp (WPS)

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

## Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or

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performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

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