Generic Name: N/A

Therapeutic Class or Brand Name:
Erythropoiesis-Stimulating Agents (ESAs)

Applicable Drugs (if Therapeutic Class):
Aranesp (darbepoetin alfa), Epogen (epoetin alfa), Procrit (epoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), Retacrit (epoetin alfa-epbx).

Preferred: Retacrit (epoetin alfa-epbx)

Non-preferred: Aranesp (darbepoetin alfa), Epogen (epoetin alfa), Mircera (methoxy polyethylene glycol-epoetin beta), Procrit (epoetin alfa)

Date of Origin: 2/1/2013

Date Last Reviewed / Revised: 3/13/2026

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 (CKD):

1. Documented baseline hemoglobin level less than 10 g/dL.
2. Documentation of one of the following (a or b):
    a. Baseline adequate iron stores (ie, serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20%).
    b. Concomitant iron supplementation while on ESA.
3. For Mircera: patients are converting from another ESA after their hemoglobin was stabilized with an ESA.

B. Anemia due to Zidovudine in HIV-infected patients:

1. Documented baseline hemoglobin level less than 10 g/dL.
2. Documented endogenous serum erythropoietin level of less than or equal to 500 mUnits/mL.
3. Documentation of one of the following (a or b):
    a. Baseline adequate iron stores (ie, serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20%).
    b. Concomitant iron supplementation while on ESA.

C. Anemia due to concomitant myelosuppressive chemotherapy:

1. Documented treatment plan of two or more additional months of chemotherapy.
2. Documentation of one of the following (a or b):
    a. Baseline adequate iron stores (ie, serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20%).

b. Concomitant iron supplementation while on ESA.

D. Reduction of allogeneic red blood cell transfusions in patients undergoing elective, nonvascular, or noncardiac surgery:

1. Documented perioperative hemoglobin level between 10 and 13 g/dL.
2. Documentation that the patient is expected to require at least 2 units of blood.

II. Minimum age requirement:

A. Refer to Table 1 in Appendix.

III. Treatment must be prescribed by or in consultation with a hematologist, oncologist, nephrologist, gastroenterologist, or infectious disease specialist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- N/A

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:**
  - Surgery: One time approval only.
  - All other indications: 6 months.
- **Re-Authorization:** 12 months. An updated letter of medical necessity or progress notes showing improvement or maintenance with medication, and recent hemoglobin level remains less than 11 g/dL.

APPENDIX

Table 1. FDA-Approved Indications and Minimum Age Requirements for Erythropoiesis-Stimulating Agents

Medication	Chronic Kidney Disease (CKD)	Zidovudine in HIV	Cancer Chemotherapy	Reduction of Blood Transfusions for Surgery
Epogen	1 month	8 months	5 years	18 years
Procrit	1 month	8 months	5 years	18 years
Retacrit	1 month	8 months	5 years	18 years
Aranesp	1 month	N/A	18 years	N/A
Mircera	3 months	N/A	N/A	N/A

REFERENCES

1. Epogen. Prescribing Information. Amgen; 2024. Accessed March 13, 2026. http://pi.amgen.com/united_states/epogen/epogen_pi_hcp_english.pdf.
2. Procrit. Prescribing Information. Janssen Products; 2024. Accessed March 13, 2026. https://www.jnjlabels.com/package-insert/product-monograph/prescribing-information/PROCRIT-pi.pdf.
3. Retacrit. Prescribing Information. Pfizer; 2024. Accessed March 13, 2026. http://labeling.pfizer.com/ShowLabeling.aspx?id=10738.
4. Aranesp. Prescribing Information. Amgen; 2024. Accessed March 13, 2026. http://pi.amgen.com/united_states/aranesp/ckd/aranesp_pi_hcp_english.pdf.
5. Mircera. Prescribing Information. Vifor (International); 2024. Accessed March 13, 2026. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=22c56f2a-f73c-60e7-e054-00144ff88e88

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.