

Medical Policy

Erythropoiesis Stimulating Agents (ESA)

Last review date: **1/1/2026**

Prior review date: **10/1/2025**

Applicable Products

Aranesp (darbepoetin alfa)

Procrit (epoetin alfa)

Epogen (epoetin alfa)

Retacrit (epoetin alfa-epbx)

Initial Approval Criteria

Coverage may be approved if all of the following are met:

- Drug specific criteria; **AND**
- If applicable: Trial and failure, intolerance, or a contraindication to the preferred products as listed in the medical drug list.

Epogen, Procrit, Retacrit

- Initiation of therapy: Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30%; **AND**
- Diagnosis of one of the following:
 - Anemia secondary to chemotherapy treatment; **AND**
 - Patient is receiving concurrent myelosuppressive chemotherapy; **AND**
 - Patient's chemotherapy is not intended to cure their disease (i.e., palliative treatment); **AND**
 - There is a minimum of two additional months of planned chemotherapy; **OR**
 - Anemia secondary to chronic kidney disease (dialysis and non-dialysis patients); **OR**
 - Reduction of allogeneic blood transfusions in elective, non-cardiac, non-vascular surgery
 - Hemoglobin (Hb) > 10 g/dL and < 13 g/dL and/or Hematocrit(Hct) > 30% and < 39%; **AND**
 - Patient is at high-risk of blood-loss from surgery that is elective, non-cardiac and nonvascular; **AND**
 - Patient is unwilling or unable to participate in an autologous blood donation program prior to surgery; **OR**
 - Anemia secondary to zidovudine treated, HIV-infected patients
 - Endogenous serum erythropoietin level of ≤ 500 mUnits/mL; **AND**
 - Patient is receiving zidovudine administered at ≤ 4200 mg/week

Aranesp

- Initiation of therapy: Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30%; **AND**
- Diagnosis of one of the following:

- Anemia secondary to chemotherapy treatment; **AND**
 - Patient is receiving concurrent myelosuppressive chemotherapy; **AND**
 - Patient's chemotherapy is not intended to cure their disease (i.e., palliative treatment); **AND**
 - There is a minimum of two additional months of planned chemotherapy; **OR**
- Anemia secondary to chronic kidney disease (dialysis and non-dialysis patients)

Renewal Criteria

Coverage may be renewed if all of the following are met:

- Patient continues to meet Initial Approval Criteria; **AND**
- Absence of unacceptable toxicity

Length of Authorization

- All indications EXCEPT Allogenic Blood Transfusions in Surgery
 - **6 months**
- Reduction of Allogenic Blood Transfusions in Elective, Non-Cardiac, Non- Vascular Surgery
 - **3 months**

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical or other circumstances may warrant individual consideration, based on review of applicable medical records, as well as other regulatory, contractual and/or legal requirements.

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.