Epoetin Alfa-epbx for non-ESRD (non-dialysis)

DESCRIPTION

Erythropoietin is a glycoprotein produced in the kidneys responsible for the stimulation of red blood cell production.

Epoetin alfa-epbx is a biosimilar to Epogen/Procrit (epoetin alfa) an erythropoiesis-stimulating agent (ESA). Epoetin alfa-epbx is a 165-amino acid erythropoiesis-stimulating glycoprotein manufactured by recombinant DNA technology. The product contains the identical amino acid sequence of isolated natural erythropoietin. Like the endogenous hormone, it stimulates increased production of red blood cells in individuals with functioning erythropoiesis and is referred to as an erythropoietin-stimulating agent or an ESA.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:

POLICY

- Epoetin Alfa-epbx for the treatment of anemia is considered **medically necessary** if the medical appropriateness criteria are met. *(See Medical Appropriateness below.)*
- Epoetin Alfa-epbx for the treatment of other conditions/diseases is considered **investigational**.

MEDICAL APPROPRIATENESS

INITIAL APPROVAL

- Epoetin Alfa-epbx is considered **medically appropriate** if **ALL** of the following criteria are met:
  - Lab values are obtained within 30 days of the date of administration (unless otherwise indicated)
  - Adequate iron stores are demonstrated prior to therapy by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% (Intravenous iron supplementation may be taken into account when evaluating iron status)
  - Initiation of therapy Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30% (unless otherwise specified)
  - Causes of anemia other than the following covered diagnoses have been ruled out (e.g. hemolysis, bleeding, vitamin deficiency, etc.)
  - Individual does not have uncontrolled hypertension
  - Diagnosis of **ANY ONE** of the following:
    - Anemia secondary to chemotherapy treatment with **ALL** of the following:
      - Individual is 5 years of age or older
      - Individual receiving concurrent myelosuppressive chemotherapy not intended as curative (i.e. palliative therapy)
      - Minimum of two additional months of planned chemotherapy
    - Anemia secondary to Chronic Kidney Disease (non-dialysis patients) and individual is 1 month of age or older.
    - Anemia secondary to Hepatitis C treatment and individual is receiving interferon AND ribavirin
    - Anemia secondary to myelodysplastic syndrome (MDS) and **ALL** of the following:
      - Treatment of lower risk disease associated with symptomatic anemia
      - Endogenous serum erythropoietin level of ≤ 500 mUnits/mL
      - Individual has lower risk disease (i.e., defined as IPSS-R [Very Low, Low, Intermediate], IPSS [Low/Intermediate-1], WPSS [Very Low, Low, Intermediate]) and **ANY ONE** of the following:
        - Used for treatment of symptomatic anemia, as an alternative to lenalidomide, in individuals with del(5q)
        - Used for treatment of symptomatic anemia in individuals without del(5q) and **ANY ONE** of the following:
• Individual has ring sideroblasts < 15% and used as a single agent or in combination with lenalidomide in patients who have failed single agent therapy
• Individual has ring sideroblasts ≥ 15% and used in combination with a granulocyte colony stimulating factor (G-CSF)

• Anemia secondary to Myeloproliferative Neoplasms (MPN) - Myelofibrosis and endogenous serum erythropoietin level of < 500 mUnits/mL
• Anemia of Prematurity and used in combination with iron supplementation
• Anemia secondary to Rheumatoid Arthritis
• Anemia secondary to zidovudine treated, HIV-infected patients with ALL of the following:
  • Endogenous serum erythropoietin level of ≤ 500 mUnits/mL
  • Individual is receiving zidovudine administered at ≤ 4200 mg/week
• Reduction of allogeneic blood transfusions in elective, non-cardiac, non-vascular surgery if ALL of the following:
  • Hemoglobin (Hb) between 10 g/dL and 13 g/dL and/or Hematocrit (Hct) between 30% and 39%
  • Surgery must be elective, non-cardiac and non-vascular
  • Individual is at high-risk of blood-loss from surgery that is elective, non-cardiac and nonvascular;
  • Individual is unwilling or unable to participate in an autologous blood donation program prior to surgery

RENEWAL CRITERIA

• Epoetin Alfa-epbx is considered medically appropriate for renewal if ALL of the following criteria are met:
  o Last dose less than 60 days ago
  o Disease response
  o Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: severe cardiovascular events (stroke, myocardial infarction, thromboembolism, uncontrolled hypertension), tumor progression or recurrence in patients with cancer, seizures, pure red cell aplasia, severe cutaneous reactions (erythema multiforme, Stevens-Johnson syndrome/toxic epidermal necrolysis), “gasp syndrom” (central nervous system depression, metabolic acidosis, gasping respirations) due to benzyl alcohol preservative, etc.
  o Lab values are obtained within 30 days of the date of administration (unless otherwise indicated)
  o Adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% measured within the previous 3 months (Intravenous iron supplementation may be taken into account when evaluating iron status)
  o Other causes of anemia (e.g. hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out
  o Diagnosis of ANY ONE of the following:
    • Anemia secondary to chemotherapy treatment with ALL of the following:
      • Hemoglobin (Hb) <10 g/dL and/or Hematocrit (Hct) < 30%
      • Individual is receiving concurrent myelosuppressive chemotherapy
      • There is a minimum of two additional months of planned chemotherapy
    • Anemia secondary to chronic kidney disease and ANY ONE of the following:
      • Pediatric patients: Hemoglobin (Hb) < 12 g/dL and/or Hematocrit (Hct) < 36%
      • Adults: Hemoglobin (Hb) < 11 g/dL and/or Hematocrit (Hct) < 33%
    • Anemia secondary to Hepatitis C treatment with ALL of the following:
      • Hemoglobin (Hb) < 11 g/dL and/or Hematocrit (Hct) < 33%
      • Individual must be receiving interferon AND ribavirin
    • Anemia secondary to myelodysplastic syndrome (MDS) and Hemoglobin (Hb) <12 g/dL and/or Hematocrit (Hct) <36%
    • Anemia secondary to myeloproliferative neoplasms (MF, post-PV myelofibrosis, post-ET myelofibrosis) and Hemoglobin (Hb) <10 g/dL and/or Hematocrit (Hct) <30%
    • Anemia secondary to zidovudine treated, HIV-infected individuals with ALL of the following:

This document has been classified as public information
### Indication(s)

**Anemia due to CKD – non-dialysis**
- Adults: 50-100 units/kg intravenously or subcutaneously three times weekly
- Pediatric patients (1 month or older): 50 units/kg intravenously or subcutaneously three times weekly

**Anemia due to HIV on zidovudine**
- 100 units/kg three times weekly
- May titrate up to 300 units/kg

**Anemia due to chemotherapy**
- Adults: 150 units/kg intravenously or subcutaneously three times weekly or 40,000 units once weekly
  - May titrate up to 300 units/kg three times weekly or 60,000 units once weekly
- Pediatric patients (5-18 years): 600 units/kg intravenously or subcutaneously once weekly
  - May titrate up to 900 units/kg once weekly

**Perioperative use**
- 300 units/kg/day subcutaneously for 10 days before surgery, on the day of surgery, and for 4 days after surgery (15 days total)
- 600 units/kg/dose subcutaneously on days 21, 14, and 7 before surgery plus 1 dose on the day of surgery (4 total doses)

**Anemia due to HCV**
- 40,000 units intravenously or subcutaneously once weekly
- May titrate up to 60,000 units weekly

**Anemia due to MDS/MPN**
- 150-300 units/kg intravenously or subcutaneously three times weekly
- 40,000 to 60,000 units once to twice weekly

**All other indications**
- Dosing varies; generally up to 150 units/kg intravenously or subcutaneously three times weekly

**Most commonly initiated dose**
- 40,000 units weekly

---

**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.**
- **For patients with CKD,**
  - 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 doses increases are unlikely to improve response and 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, discontinue therapy
  - For zidovudine treated HIV infected patients
  - If the patient fails to respond after 8 weeks of therapy, increase dose by approximately 50-100 U/kg at 4- to 8-week until the hemoglobin reaches levels need to avoid transfusion or max dosing reached.
  - If the hemoglobin exceeds the indication specific level noted above, withhold therapy and resume therapy once level declines to <11 g/dL, at a dose 25% below the previous dose.
LENGTH OF AUTHORIZATION

Coverage will be provided for 45 days and may be renewed.

Refer to DOSAGE LIMITS below

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee’s Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member’s health plan must be reviewed. If there is a conflict between the Medical Policy and a health plan, the express terms of the health plan will govern.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

SOURCES


EFFECTIVE DATE

ID_MRx