Epogen, Procrit (epoetin alfa), **Retacrit** (epoetin alfa – epbx)

Preferred product: Retacrit
Epogen is neither preferred nor non-preferred

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Anemia associated with chronic renal failure
    a. Serum ferritin ≥ 100 ng/ml (labs must have been taken within the last 3 months)

AND ONE of the following:

If patient is NOT on dialysis

a. Initial treatment: Hemoglobin < 11 g/dl***** (labs must have been taken within the last 3 months)
b. Continuing treatment: Hemoglobin ≤ 11 g/dl***** (labs must have been taken within the last 3 months)

If patient is ON dialysis

a. Initial treatment: Hemoglobin < 10 g/dl***** (labs must have been taken within the last 3 months)
b. Continuing treatment: Hemoglobin ≤ 11 g/dl***** (labs must have been taken within the last 3 months)

***** if the hemoglobin level exceeds this level then the prescribing physician must confirm that the dose will be held or reduced until the hemoglobin level returns to the required level.

2. Anemia secondary to chemotherapy
    a. Concomitant myelosuppressive therapy
    b. There is a minimum of two additional months of planned chemotherapy
    c. Prescriber agrees to discontinue use of Epogen/Procrit upon completion of the chemotherapy

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   d. Prescriber agrees that transfusions are **NOT** an option for treatment (i.e., end organ failure, CKD, high risk bacterial infections)

3. Anemia secondary to zidovudine-treated Human Immunodeficiency Virus (HIV) patients
   a. Endogenous serum erythropoietin levels ≤ 500 mUnits/mL

4. Anemia in patients scheduled to undergo elective, non-cardiac, nonvascular surgery
   a. Hemoglobin >10 and ≤ 13 g/dl

5. Myelodysplastic syndrome

6. Allogeneic bone marrow transplantation

7. Anemia associated with Hepatitis C (HCV) treatment

8. Anemia associated with rheumatoid arthritis (RA)/ rheumatic disease

AND ALL of the following for **ALL** diagnoses:
   a. **NOT** used in combination with another erythropoiesis stimulating agent
   b. **Procrit only:** Patient **MUST** have tried the preferred product (Retacrit) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Duration 6 months

Prior – Approval *Renewal* Requirements

Same as above

Prior – Approval *Renewal* Limits

Same as above