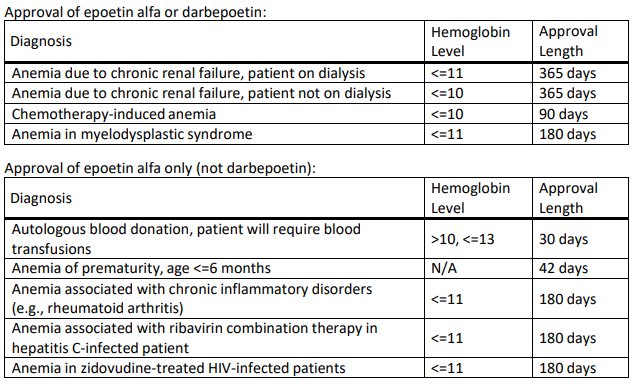
**Blood- Blood Products Hematopoietic Agents**

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| Criteria 1 | Preferred Agents- Epogen (PA), Mircera (PA), Retacrit (PA) |
| Criteria 2 | Non-Preferred Agents- Procrit |
| Criteria 3 | Non-Preferred Agents- Aranesp |

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| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents | | |
| **Criteria Subtitle** | Preferred Products - Epogen (PA), Mircera (PA), Retacrit (PA) | | |
| **Approval Level** | NDC-9 | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EPOGEN | 011740 | GCNSeqNo |
| EPOGEN | 011741 | GCNSeqNo |
| EPOGEN | 011742 | GCNSeqNo |
| EPOGEN | 015164 | GCNSeqNo |
| EPOGEN | 025708 | GCNSeqNo |
| EPOGEN | 058592 | GCNSeqNo |
| MIRCERA | 063115 | GCNSeqNo |
| MIRCERA | 063131 | GCNSeqNo |
| MIRCERA | 063132 | GCNSeqNo |
| MIRCERA | 063133 | GCNSeqNo |
| MIRCERA | 063134 | GCNSeqNo |
| MIRCERA | 064736 | GCNSeqNo |
| RETACRIT | 078432 | GCNSeqNo |
| RETACRIT | 078433 | GCNSeqNo |
| RETACRIT | 078434 | GCNSeqNo |
| RETACRIT | 078435 | GCNSeqNo |
| RETACRIT | 078436 | GCNSeqNo |
| RETACRIT | 081692 | GCNSeqNo |
| RETACRIT | 081714 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | What is the patient’s diagnosis? | Anemia due to chronic renal failure, patient on dialysis | 1001 |
| Anemia due to chronic renal failure, patient not on dialysis | 1001 |
| Chemotherapy-induced anemia | 1001 |
| Anemia in myelodysplastic syndrome | 1001 |
| Autologous blood donation, patient will require blood transfusions | 1001 |
| Anemia of prematurity, age less than or equal to 6 months | 1001 |
| Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis) | 1001 |
| Anemia associated with ribavirin combination therapy in hepatitis C-infected patient | 1001 |
| Anemia in zidovudine-treated HIV-infected patients | 1001 |
| Other | 1235 |
| 2 | 1001 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request | 1002 |
| Continuation (re-authorization request) | 1233 |
| 3 | 1002 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1234 |
| N | 1235 |
| 4 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 5 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s hemoglobin level?    Please note: hemoglobin is not required to be submitted for a diagnosis of anemia of prematurity, age less than or equal to 6 months. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:

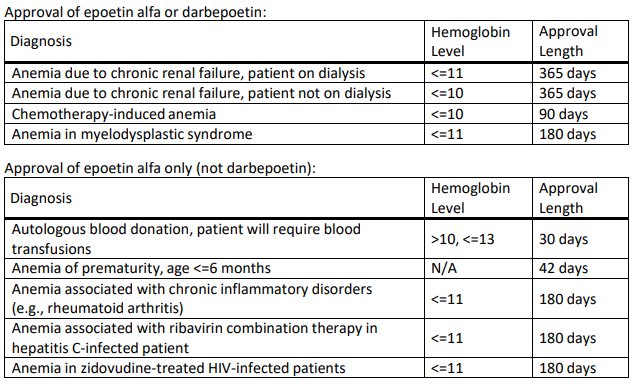


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| **Last Approved** | 5/17/2023 |
| **Other** |  |

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| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents | | |
| **Criteria Subtitle** | Non-Preferred Agent-Procrit | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| PROCRIT | 011740 | GCNSeqNo |
| PROCRIT | 011741 | GCNSeqNo |
| PROCRIT | 011742 | GCNSeqNo |
| PROCRIT | 015164 | GCNSeqNo |
| PROCRIT | 025708 | GCNSeqNo |
| PROCRIT | 041394 | GCNSeqNo |
| PROCRIT | 058592 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | What is the patient’s diagnosis? | Anemia due to chronic renal failure, patient on dialysis | 0999 |
| Anemia due to chronic renal failure, patient not on dialysis | 0999 |
| Chemotherapy-induced anemia | 0999 |
| Anemia in myelodysplastic syndrome | 0999 |
| Autologous blood donation, patient will require blood transfusion | 0999 |
| Anemia of prematurity, age less than or equal to 6 months | 0999 |
| Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis) | 0999 |
| Anemia associated with ribavirin combination therapy in hepatitis C-infected patient | 0999 |
| Anemia in zidovudine-treated HIV-infected patients | 0999 |
| Other | 1235 |
| 2 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request | 1000 |
| Continuation (re-authorization request) | 1233 |
| 3 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 5 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 6 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1234 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1234 |
| N | 1235 |
| 8 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s hemoglobin level?    Please note: hemoglobin is not required to be submitted for a diagnosis of anemia of prematurity, age less than or equal to 6 months. | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:

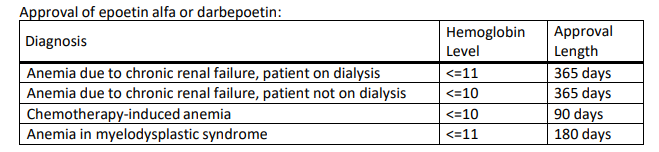


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| **Last Approved** | 5/17/2023 |
| **Other** |  |

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| --- | --- | --- | --- |
| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents | | |
| **Criteria Subtitle** | Non-preferred Agent- Aranesp | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ARANESP | 048583 | GCNSeqNo |
| ARANESP | 048584 | GCNSeqNo |
| ARANESP | 048585 | GCNSeqNo |
| ARANESP | 048586 | GCNSeqNo |
| ARANESP | 048587 | GCNSeqNo |
| ARANESP | 048908 | GCNSeqNo |
| ARANESP | 048911 | GCNSeqNo |
| ARANESP | 048913 | GCNSeqNo |
| ARANESP | 048914 | GCNSeqNo |
| ARANESP | 049630 | GCNSeqNo |
| ARANESP | 061006 | GCNSeqNo |
| ARANESP | 061269 | GCNSeqNo |
| ARANESP | 061270 | GCNSeqNo |
| ARANESP | 061271 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | What is the patient’s diagnosis? | Anemia due to chronic renal failure, patient on dialysis | 0999 |
| Anemia due to chronic renal failure, patient not on dialysis | 0999 |
| Chemotherapy-induced anemia | 0999 |
| Anemia in myelodysplastic syndrome | 0999 |
| Other | 1235 |
| 2 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request | 1000 |
| Continuation (re-authorization request) | 1233 |
| 3 | 1000 |  | Select and Free Text | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 5 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 6 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1234 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1234 |
| N | 1235 |
| 8 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s hemoglobin level? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:



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| **Last Approved** | 5/17/2023 |
| **Other** |  |