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Gateway Health
Prior Authorization Criteria
# Procrit

All requests for Drug Name require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Drug Name Prior Authorization Criteria:

All requests for Procrit (recombinant epoetin alfa) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Procrit (recombinant epoetin alfa) Prior Authorization Criteria**

- For Procrit, **ALL** of the following general criteria must be met in addition to the indication-specific criteria found in the section below:
  - Member's iron status has been evaluated prior to and during erythropoietin therapy. Supplemental iron therapy should be administered when transferrin saturation is < 20% or when serum ferritin is < 100 mcg/L to ensure iron stores are maintained
  - Blood pressure is adequately controlled and monitored before and during erythropoietin therapy
  - If hemoglobin exceeds a threshold listed below, prescriber must indicate erythropoietin will be held or titrated downward
- If the general criteria above are met, coverage for Procrit is provided for the following indications when the corresponding criteria are met:
  - Anemia secondary to chronic renal failure or chronic renal insufficiency in accord with the following:
    - Initial dose: 50 to 100 Units/kg three times weekly (adults) and 50 Units/kg three times weekly (children)
      - Maintenance dose should be individualized
      - IV route is recommended for patients on hemodialysis
    - Initial authorization: Hemoglobin < 10 g/dL
    - Reauthorization: Hemoglobin ≤ 10 g/dL for members not on dialysis OR Hemoglobin ≤ 11 g/dL for members on dialysis
    - Coverage duration is 6 months
  - Secondary to zidovudine therapy in HIV infected patients in accord with the following:
    - Dose: 100 Units/kg three times weekly
    - Initial authorization:
      - Hemoglobin < 10 g/dL
      - Member has a serum erythropoietin level ≤ 500 mUnits/mL
      - Member is receiving a dose of Zidovudine ≤ 4200 mg/week
    - Reauthorization:
      - Hemoglobin ≤ 12 g/dL
    - Coverage duration is 4 months

- Chemotherapy induced anemia in accord with the following:
  - Dose: 40,000 Units weekly or 150 Units/kg three times weekly (adults); 600 Units/kg IV weekly (children ≥ 5 years)
  - Initial authorization:
    - Patient will be receiving myelosuppresive chemotherapy for ≥ 2 months
    - Hemoglobin < 10 g/dL
  - Reauthorization:
    - Documentation of a minimum 2 more months of chemotherapy is planned
    - Hemoglobin ≤ 12g/dL
  - Coverage duration is 3 months
- Therapy to reduce the need for allogeneic blood transfusions in surgery patients in accord with the following:
  - Therapy must be for elective non-vascular or non-cardiac surgery
  - Patient refuses or cannot undergo autologous blood donation prior to surgery:
  - Dose: 300 Units/kg per day daily for 15 days or 600 Units/kg weekly
  - Hemoglobin must be > 10 gm/dL and ≤ 13 gm/dL
  - Coverage duration is 1 month

- Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

- When non-formulary criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.