TITLE: EPOETIN ALFA (EPOGEN®, PROCRIT®)

EFFECTIVE DATE: March 1, 2016

PRODUCT APPLICATION
This policy provides general information concerning Medica’s administrative processes. It applies to all fully insured Medica Health Plans, Medica Insurance Company, and Medica Health Plans of Wisconsin products, unless a specific limitation or exception exists. For self-insured plans, consult individual plan sponsor benefit documents. If there is a discrepancy between a Utilization Management Policy and a self-insured benefit plan, the provisions of the benefit plan will govern. With respect to Medicare and Medicaid members, this policy will apply unless Medicare or Medicaid policies require different coverage.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY
These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare, Medicaid and MinnesotaCare members, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE
To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determines the medical necessity of epoetin alfa (Epogen, Procrit). The Coverage issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA
I. Indications
   a. Anemia associated with chronic renal failure
   b. Anemia due to the effect of concomitantly administered chemotherapy
   c. Anemia in patients with myelodysplastic syndrome
   d. Anemia in zidovudine-treated HIV-infected patients
   e. Anemia in patients scheduled to undergo elective, noncardiac, nonvascular surgery
   f. Anemia of chronic disease*
   g. Anemia in low birth weight infants*
   h. Anemia in patients with Hepatitis-C being treated with interferon and ribavirin*

*non-FDA-approved indication

II. Written documentation from the medical record must include:
   a. Diagnosis
   b. Recent hemoglobin or hematocrit (result must be within the most recent 60 days)
COVERAGE ISSUES

1. Prior authorization is required.
2. Coverage may vary according to the terms of the member’s coverage document.
3. When submitting a request for clinical review, Medica must receive a completed General Prior Authorization Form. Complete all fields and fax the form to the MedImpact Prior Authorization Department at 1-858-790-7100 or call 1-800-788-2949.
4. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s coverage document.
5. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica administrative handbook.

References: