Erythropoiesis-Stimulating Agents (for Ohio Only)

Policy Number: CSOH2025D0028.B
Effective Date: March 1, 2025

➲ Instructions for Use

Table of Contents **Page**

Related Policy

- Oncology Medication Clinical Coverage (for Ohio Only)

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

This policy addresses the following erythropoiesis-stimulating agents (ESAs) for **non-oncology** conditions:

- Aranesp® (darbepoetin alfa)
- Epogen® (epoetin alfa)
- Mircera® [methoxy polyethylene glycol-epoetin beta (MPG-epoetin beta)]
- Procrit® (epoetin alfa)
- Retacrit® (epoetin alfa)

Aranesp, Epogen, Mircera, Procrit, and Retacrit are considered medically necessary in certain circumstances. For medical necessity clinical coverage criteria for non-oncology conditions, refer to the Ohio Department of Medicaid Unified Preferred Drug List Criteria.

For **oncology** indications, refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage (for Ohio Only) for updated information based on the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®).

Applicable Codes

The following list(s) of procedure codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use)
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)

HCPCS Code	Description
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)
Q5105	Injection, epoetin alfa-epbx, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units
Q5106	Injection, epoetin alfa-epbx, biosimilar, (Retacrit) (for non-ESRD use), 1000 units

Policy History/Revision Information

Date	Summary of Changes
04/01/2025	• Updated reference link to the *Ohio Department of Medicaid Unified Preferred Drug List Criteria* (no change to policy guidelines)
03/01/2025	**Coverage Rationale** • Added language to indicate Aranesp®, Epogen®, Mircera®, Procrit®, and Retacrit® are considered medically necessary in certain circumstances; for medical necessity clinical coverage criteria for non-oncology indications, refer to the *Ohio Department of Medicaid Unified Preferred Drug List Criteria* • Removed language indicating Aranesp® (darbepoetin alfa), Epogen® (epoetin alfa), Mircera® [methoxy polyethylene glycol-epoetin beta (MPG-epoetin beta)], Procrit® (epoetin alfa), and Retacrit® (epoetin alfa) are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria for non-oncology indications, refer to the current release of the InterQual® CP: Specialty Rx Non-Oncology: ○ Darbepoetin alfa (Aranesp) ○ Epoetin alfa (Epogen, Procrit) ○ Epoetin alfa (Epogen, Procrit) ○ Epoetin alfa-epbx (Retacrit) ○ Methoxy polyethylene glycol-epoetin beta (Mircera) **Supporting Information** • Archived previous policy version CSOH2024D0028.A

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]), or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.