

## epoetin alfa

### Commercial Medical Benefit Drug Policy

For oncology-related indications, medical necessity criteria can be found here: [Blue Shield Oncology-Related Medication Policies](#).

For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's [CarePro Provider Portal](#) to submit your request.

### epoetin alfa (Procrit, EpoGen)

### epoetin alfa-epbx (Retacrit)

#### Place of Service

Home Infusion Administration

Hospital Administration

Infusion Center Administration

Office Administration

Outpatient Facility Administration

Self-Administration - *May be provided by the Pharmacy Benefit*

#### Drug Details

**USP Category:** BLOOD PRODUCTS AND MODIFIERS

**Mechanism of Action:** erythropoiesis-stimulating agent (ESA)

#### HCPCS:

J0885:Injection, epoetin alfa, (for non-esrd use), 1000 units

Q5106:Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units

#### How Supplied:

- 2,000 Units/mL, 3,000 Units/mL, 4,000 Units/mL, 10,000 Units/mL, and 40,000 Units/mL (single-dose vials)
- 20,000 Units/2 mL (10,000 Units/mL) and 20,000 Units/mL (multiple-dose vials)

#### **Condition(s) listed in policy (see coverage criteria for details)**

- Anemia Due to Chronic Kidney Disease (CKD)
- Anemia Secondary to Zidovudine Therapy in HIV-Infected Patients
- Pre-Operative Prevention in Anemic Patients

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

#### **Special Instructions and Pertinent Information**

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

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For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

**This drug is managed under the outpatient Pharmacy Benefit for self-administration. Please contact the member's Pharmacy Benefit for information on how to obtain this drug.**

**Coverage Criteria**

**The following condition(s) require Prior Authorization/Preservice.**

**Anemia Due to Chronic Kidney Disease (CKD)**

**Meets medical necessity if all the following are met:**

Initial:

1. Hgb < 10 g/dL
2. NOT on hemodialysis or peritoneal dialysis (if patient is on hemodialysis or peritoneal dialysis, the dialysis center must supply and administer the drug)
3. Both Primary and Secondary ICD-10 codes (listed below) must be met

Reauthorization:

1. Not on hemodialysis or peritoneal dialysis
2. Hgb ≤ 11 g/dL

**Covered Doses:**

Initial: 100 units/kg given subcutaneously or intravenously 3 times per week

Maintenance: Individualize dosing to target a hemoglobin level of greater than 11 g/dL

**Coverage Period:**

yearly

**ICD-10:**

Primary: D63.1 (Anemia in ESRD), Secondary: N18.1-N18.9 (CRF)

**Anemia Secondary to Zidovudine Therapy in HIV-Infected Patients**

**Meets medical necessity if all the following are met:**

1. On zidovudine therapy for HIV
2. Hgb < 10 g/dL
3. Both Primary and Secondary ICD-10 codes must be met

**Covered Doses:**

900 units/kg given subcutaneously or intravenously weekly

**Coverage Period:**

yearly

**ICD-10:**

Primary: D61.1 (drug-induced aplastic anemia), Secondary: B20 (HIV disease)

## **Pre-Operative Prevention in Anemic Patients**

**Meets medical necessity if all the following are met:**

1. Hgb  $\leq$  13 g/dL
2. Patient is scheduled to undergo elective, non-cardiac, or non-vascular surgery
3. Patient is at high risk for perioperative transfusion with significant, anticipated blood loss (2 units of blood or more), and patient is not a candidate for blood transfusion

### **Covered Doses:**

600 units/kg given subcutaneously or intravenously weekly for 4 doses or 300 units/kg given subcutaneously or intravenously daily for 15 days

### **Coverage Period:**

For one surgery:

- 15-day regimen: given 10 days before surgery, on day of surgery, and 4 days after surgery
- 4-dose regimen: given once weekly at 21, 14, and 7 days prior to surgery and on day of surgery

### **ICD-10:**

D64.9

### **References**

1. AHFS. Available by subscription at <http://www.lexi.com>
2. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
3. EpoGen (epoetin alfa) [prescribing information]. Thousand Oaks, CA: Amgen; December 2024.
4. Procrit (epoetin alfa) [prescribing information]. Horsham, PA: Janssen; April 2024.
5. Retacrit ((epoetin alfa-eobx) [prescribing information]. Pfizer Inc., Lake Forest, IL. 6.2024
6. National Comprehensive Cancer Network. Hematopoietic Growth Factors (Version 1.2025). Available at <http://www.nccn.org>.
7. National Comprehensive Cancer Network. Myelodysplastic Syndromes (Version 2.2025). Available at <http://www.nccn.org>.
8. National Comprehensive Cancer Network. Myeloproliferative Neoplasms (Version 2.2025). Available at <http://www.nccn.org>.

### **Review History**

Date of Last Annual Review: 3Q2025

Changes from previous policy version:

- For oncology-related indications, medical necessity criteria can be found here: [Blue Shield Oncology-Related Medication Policies](#).
- For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's [CarePro Provider Portal](#) to submit your request.

*Blue Shield of California Medication Policy to Determine Medical Necessity  
Reviewed by P&T Committee*

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