blue california
Promise Health Plan

methoxy polyethylene glycol-epoetin beta (Mircera)

Medical Benefit Drug Policy

Place of Service
Home Infusion Administration
Infusion Center Administration
Office Administration
Outpatient Facility Administration
Self-Administration

Drug Details

USP Category: BLOOD PRODUCTS AND MODIFIERS
Mechanism of Action: Long-acting erythropoiesis-stimulating agent (ESA)
HCPCS:
J0888:Injection, epoetin beta, 1 microgram, (for non esrd use)
How Supplied:
30 mcg, 50 mcg, 75 mcg, 100 mcg, 120 mcg, 150 mcg, 200 mcg (in 0.3 mL solution in single-dose prefilled syringes)

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

- Anemia Due to Chronic Renal Failure

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 California Code of Regulations (CCR), Title 22, Section 51303 and 51313 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.

Retacrit is the BSC preferred erythropoiesis stimulating agent (ESA). For all indications, treatment failure, intolerance or contraindication to Retacrit (epoetin alfa-epbx) is required for members newly initiating ESA therapy.

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

Anemia Due to Chronic Renal Failure
Meets medical necessity if all the following are met:

1. Patient has failed, is intolerant to, or is contraindicated to Retacrit as defined by any one of the following:
   a. At the max dose of Retacrit for 8 weeks, patient does not meet Hgb target, or Hgb does not rise by at least 2g/dL
   b. Patient has a contraindication to Retacrit that is not also a contraindication of Mircera
   c. Patient has known side effects to Retacrit that would not be expected with Mircera
   d. Patient has a religious belief objecting to treatment with a drug containing human albumin
2. Hemoglobin is less than 10 g/dl
3. Both Primary and Secondary ICD-10 codes must be met

Covered Doses:
Up to 180 mcg IV/SC once every two weeks or 360 mcg IV/SC once monthly

Coverage Period:
Initial: 1 year
Reauthorization: Cover yearly if Hgb ≤ 11 g/dL

ICD-10:
Primary: D63.1 (Anemia in chronic kidney disease)
Secondary: N18.1-N18.9 (CRF)

References

1. AHFS. Available by subscription at http://www.lexi.com
   DrugDex. Available by subscription at
   http://www.micromedexsolutions.com/home/dispatch
2. Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Work Group. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. Kidney inter., Suppl. 2012; 2:279–335.
3. Mircera (methoxy polyethylene glycol-epoetin beta) Prescribing Information. Vifor (International) Inc., Gallen, Switzerland: 6/2024.

Review History

Date of Last Annual Review: 3Q2025
Changes from previous policy version:

- No clinical change following annual review.

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