Clinical Policy: Ferumoxytol (Feraheme)
Reference Number: CP.PHAR.165
Effective Date: 03.01.16
Last Review Date: 02.20
Line of Business: HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Ferumoxytol (Feraheme®) injection is an iron replacement product.

FDA Approved Indication(s)
Feraheme is indicated for the treatment of iron deficiency anemia (IDA) in adult patients
- who have intolerance to oral iron or have had unsatisfactory response to oral iron;
- who have chronic kidney disease (CKD).

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Feraheme is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Iron Deficiency Anemia associated with Chronic Kidney Disease (must meet all):
      1. Diagnosis of IDA and CKD;
      2. IDA is confirmed by either of the following:
         a. Transferrin saturation (TSAT) ≤ 30%;
         b. Serum ferritin ≤ 500 ng/mL;
      3. If CKD does not require hemodialysis or peritoneal dialysis, oral iron therapy is not optimal due to any of the following:
         a. TSAT < 12%;
         b. Hgb < 7 g/dL;
         c. Symptomatic anemia;
         d. Severe or ongoing blood loss;
         e. Oral iron intolerance;
         f. Unable to achieve therapeutic targets with oral iron;
         g. Co-existing condition that may be refractory to oral iron therapy;
      4. Dose does not exceed 510 mg elemental iron per infusion/injection.

Approval duration: 3 months

B. Iron Deficiency Anemia without Chronic Kidney Disease (must meet all):
   1. Diagnosis of IDA confirmed by any of the following:
      a. Serum ferritin < 15 ng/mL or < 30 ng/mL if pregnant;
      b. Serum ferritin ≤ 41 ng/mL and Hgb < 12 g/dL (women)/< 13 g/dL (men);
c. TSAT < 20%;
   d. Absence of stainable iron in bone marrow;
   e. Increased soluble transferring receptor (sTfR) or sTfR-ferritin index;
   f. Increased erythrocyte protoporphyrin level;
2. Oral iron therapy is not optimal due to any of the following:
   a. TSAT < 12%;
   b. Hgb < 7 g/dL;
   c. Symptomatic anemia;
   d. Severe or ongoing blood loss;
   e. Oral iron intolerance;
   f. Unable to achieve therapeutic targets with oral iron;
   g. Co-existing condition that may be refractory to oral iron therapy;
3. At the time of the request, member does not have CKD;
4. Dose does not exceed 510 mg elemental iron per infusion/injection.

Approval duration 3 months

C. Other diagnoses/indications:
   1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM.PHAR.21 for health insurance marketplace.

II. Continued Approval Criteria

A. Iron Deficiency Anemia with Chronic Kidney Disease (must meet all):
   1. Currently receiving the medication via Centene benefit or member has previously met all initial approval criteria;
   2. Documentation of one of the following laboratory results measured since the last IV iron administration:
      a. TSAT \leq 30%;
      b. Serum ferritin \leq 500 ng/mL;
   3. If request is for a dose increase, new dose does not exceed 510 mg elemental iron per infusion/injection.

Approval duration 3 months

B. Iron Deficiency Anemia without Chronic Kidney Disease (must meet all):
   1. Currently receiving the medication via Centene benefit or member has previously met all initial approval criteria;
   2. Documentation of one of the following laboratory results measured since the last IV iron administration:
      a. Serum ferritin < 15 ng/mL or < 30 ng/mL if pregnant;
      b. Serum ferritin \leq 41 ng/mL and Hb < 12 g/dL (women)/< 13 g/dL (men);
      c. TSAT < 20%;
      d. Absence of stainable iron in bone marrow;
      e. Increased sTfR or sTfR-ferritin index;
      f. Increased erythrocyte protoporphyrin level;
3. At the time of the request, member does not have CKD;
4. If request is for a dose increase, new dose does not exceed 510 mg elemental iron per infusion/injection.

Approval duration 3 months

C. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: Duration of request or 6 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM.PHAR.21 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CKD: chronic kidney disease
ESA: erythropoiesis stimulating agent
Hb: hemoglobin
IDA: iron deficiency anemia
TSAT: transferrin saturation
sTfR: soluble transferring receptor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of OTC Oral Iron Formulations*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ferrous fumarate (Ferretts, Ferrimin 150, Hemocyte)</td>
<td></td>
<td>Varies</td>
</tr>
<tr>
<td>Ferrous gluconate (Ferate)</td>
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<td></td>
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<tr>
<td>Ferrous sulfate (BProtected Pedia iron, Fer-In-Sol, FeroSul, FerrouSul, Iron Supplement, Iron Supplement Childrens, Slow Fe, Slow Iron)</td>
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<td></td>
</tr>
<tr>
<td>Polysaccharide-iron complex (EZFE 200, Ferrex 150, Ferrix x-150, Myferon 150, NovaFerrum 125, NovaFerrum 50, NovaFerrum Pediatric Drops, Nu-Iron, Poly-Iron 150)</td>
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<td></td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

*Oral formulations include elixirs, liquids, solutions, syrups, capsules, and tablets - including delayed/extended-release tablets.
Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): Known hypersensitivity to Feraheme or any of its components.
  History of allergic reaction to any intravenous iron product.
- Boxed warning(s): Serious hypersensitivity/anaphylaxis reactions.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDA with or without CKD (adults)</td>
<td>510 mg IV infusion followed by a second 510 mg IV infusion 3 to 8 days later. *For patients receiving hemodialysis, administer after at least one hour of hemodialysis.</td>
<td>510 mg per dose -Treatment course: 1020 mg -Treatment may be repeated</td>
</tr>
</tbody>
</table>

VI. Product Availability

Intravenous solution: 510 mg/17 mL (17 mL)

VII. References


Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0138</td>
<td>Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)</td>
</tr>
<tr>
<td>Q0139</td>
<td>Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)</td>
</tr>
</tbody>
</table>
**Clinical Policy**

Ferumoxytol

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy developed</td>
<td>01.16</td>
<td>03.16</td>
</tr>
<tr>
<td>Labeled and off-labeled use, and diagnostic/follow-up tests, are edited for consistency across ferumoxytol, ferric gluconate, iron sucrose, and ferric carboxymaltose policies, and are made broad enough to capture use in adults, children and pregnancy. The criteria also encompass iron maintenance and replenishment. Diagnostic hemoglobin for anemia in men changed from 13.5 to 13 based on WHO criteria. Age and dose are removed. Hypersensitivity removed as a contraindication.</td>
<td>02.17</td>
<td>03.17</td>
</tr>
<tr>
<td>1Q18 annual review:</td>
<td>12.01.17</td>
<td>02.18</td>
</tr>
<tr>
<td>- No significant changes</td>
<td></td>
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<tr>
<td>- Converted to the new template</td>
<td></td>
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<tr>
<td>- Dosing added</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- References reviewed and updated.</td>
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</tr>
<tr>
<td>1Q 2019 annual review; new indication for members without CKD changed from off-label to FDA-approved coverage; under IDA initial and continuation criteria, a serum ferritin of less than or equal to 500 is edited by deleting the additional requirement of receiving an ESA based on the KDIGO 2012 guidelines which do not include this restriction; under IDA and IDA with CKD continuation criteria, the greater than or equal to 4 week waiting period before retesting after the last IV iron administration is removed per the KDIGO 2012 guidelines which note that only one week need pass before retesting; references reviewed and updated.</td>
<td>11.13.18</td>
<td>02.19</td>
</tr>
<tr>
<td>1Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.</td>
<td>11.09.19</td>
<td>02.20</td>
</tr>
</tbody>
</table>

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.
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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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