Aranesp® (darbepoetin alfa)
(Subcutaneous/Intravenous)

NON-ESRD

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I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 45 days
- Renewal: Prior authorization validity may be renewed every 45 days thereafter.

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

- MDS: 500 billable units every 14 days
- MPN: 300 billable units every 7 days
- CKD (Non-ESRD Patients [i.e., Non-Dialysis]): 600 billable units every 28 days
- Chemotherapy-induced: 600 billable units every 21 days

III. Initial Approval Criteria [1,4,5]

Prior authorization validity is provided in the following conditions:

- Patient is at least 18 years of age (unless otherwise specified); **AND**
- Initiation of therapy Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30%; **AND**

Universal Criteria [1,3,16,18]

- Lab values are obtained within 30 days of the date of administration (unless otherwise indicated); **AND**

- Patient has adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% (measured within the previous 3 months for renewal); **OR**
- Patient is receiving concurrent intravenous iron; **AND**

- Other causes of anemia (e.g. hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out; **AND**
- Patient does not have uncontrolled hypertension; **AND**

Anemia Due to Myelodysplastic Syndromes (MDS) ‡ [2,4]

- Patient has symptomatic anemia; **AND**
- Patient has a serum erythropoietin level ≤ 500 mU/mL (unless otherwise specified); **AND**
- Patient has lower risk disease (defined as IPSS-R [Very Low, Low, Intermediate]); **AND**
  - Used as a single agent for del(5q) mutation *(excluding use in patients with cytogenetic abnormality involving chromosome 7)*; **OR**
  - Patient does not have del(5q) mutation; **AND**
    - Patient has ring sideroblasts < 15% (or <5% with an SF3B1 mutation); **AND**
      - Used as a single agent; **OR**
      - Used in combination with either lenalidomide or a granulocyte-colony stimulating factor (G-CSF); **AND**
        - Patient had no response** (despite adequate iron stores) to or relapse after an erythropoiesis-stimulating agent (ESA) alone; **OR**
        - Patient had no response** to or relapse after luspatercept; **OR**
    - Patient has ring sideroblasts ≥15% (or ring sideroblasts ≥5% with an SF3B1 mutation); **AND**
      - Used as a single agent; **AND**
        - Patient had no response** to or relapse after luspatercept; **OR**
        - Patient has a serum erythropoietin level < 200 mU/mL; **OR**
      - Used in combination with a G-CSF; **AND**
        - Patient had no response** to or relapse after luspatercept

** ***Note:*** *No response defined as a lack of ≥1.5 gm/dL rise in hemoglobin OR lack of a decrease in RBC transfusion requirement (within 6-8 weeks when treated with ESAs or within 3-6 months when treated with luspatercept).*

Anemia Due to Myeloproliferative Neoplasms (MPN) - Myelofibrosis ‡ [2,5]

- Patient has myelofibrosis-associated anemia with serum erythropoietin level of < 500 mU/mL; **AND**

- Patient has splenomegaly and constitutional symptoms currently controlled on a JAK inhibitor; **AND**
  - Used in combination with a JAK inhibitor; **OR**
- Patient has no splenomegaly or constitutional symptoms; **AND**
  - Used as a single agent

Anemia Due to Chemotherapy Treatment † ‡ [1-3]

- Patient has anemia due to concomitant myelosuppressive chemotherapy for a non-myeloid malignancy; **AND**
- Patient is receiving chemotherapy that is not intended to cure their disease (i.e., palliative treatment) **±**; **AND**
- There are a minimum of two additional months of planned chemotherapy

± *Note:* *Patients who are not undergoing palliative treatment and refuse blood transfusions may be reviewed on a case-by-case basis*

Anemia Due to Chronic Kidney Disease (Non-ESRD Patients [i.e., Non-Dialysis]) † [1,16,18]

- Patient at least 1 month of age

† FDA Approved Indications; **‡** Compendia Recommended Indication(s); **Φ** Orphan Drug

IV. Renewal Criteria [1,4,5,19]

Prior authorization validity can be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Previous dose was administered within the past 60 days; **AND**
- Disease response with treatment as defined by improvement in anemia compared to pretreatment baseline; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: pure red cell aplasia, severe allergic reactions (anaphylaxis, angioedema, bronchospasm, etc.), severe cardiovascular events (stroke, myocardial infarction, congestive heart failure, thromboembolism, etc.), uncontrolled hypertension, seizures, severe cutaneous reactions (erythema multiforme, Stevens-Johnson Syndrome [SJS]/Toxic Epidermal Necrolysis [TEN], etc.), etc.; **AND**

Anemia Due to Myelodysplastic Syndrome (MDS):

- Hemoglobin (Hb) < 12 g/dL and/or Hematocrit (Hct) < 36%

Anemia Due to Myeloproliferative Neoplasms (MPN) – Myelofibrosis:

- Hemoglobin (Hb) < 10 g/dL and/or Hematocrit (Hct) < 30%

Anemia Due to Chemotherapy Treatment:

- *Refer to Section III for criteria*

Anemia Due to Chronic Kidney Disease (Non-ESRD Patients [i.e., Non-Dialysis]):

- **Pediatric patients:** Hemoglobin (Hb) < 12 g/dL and/or Hematocrit (Hct) < 36%
- **Adult patients:** Hemoglobin (Hb) < 11 g/dL and/or Hematocrit (Hct) < 33%

V. Dosage/Administration [1,3-5,7,17]

Indication	Dose
Anemia due to chemotherapy **§**	Administer 2.25 mcg/kg subcutaneously every 7 days. May increase up to 4.5 mcg/kg subcutaneously every 7 days for insufficient response **-OR-** Administer 500 mcg subcutaneously every 21 days **Alternative regimens:** Administer 100 mcg subcutaneously every 7 days. May increase up to 200 mcg subcutaneously every 7 days for insufficient response **-OR-** Administer 200 mcg subcutaneously every 14 days. May increase up to 300 mcg subcutaneously every 14 days for insufficient response **-OR-** Administer 300 mcg subcutaneously every 21 days. May increase up to 500 mcg subcutaneously every 21 days for insufficient response
Anemia due to Chronic Kidney Disease – Non-ESRD (i.e., Non-Dialysis) **§**	**Pediatric patients:** Administer 0.45 mcg/kg intravenously or subcutaneously every 7 days **-OR-** Administer 0.75 mcg/kg intravenously or subcutaneously every 14 days **Adult patients:** Administer 0.45 mcg/kg intravenously or subcutaneously every 28 days. May increase to a maximum dose of 600 mcg every 28 days.
Anemia due to MDS **§**	Administer 150 to 300 mcg subcutaneously every 14 days. May increase up to 500 mcg every 14 days
Anemia due to MPN **§**	Administer 150 mcg subcutaneously every 7 days. May increase up to 300 mcg every 7 days

Chapter 1 § Dose Adjustments and Discontinuation Guidance

– For patients with CKD:
  - Dose increases of 25% can be considered if after 4 weeks of initial therapy the hemoglobin has increased less than 1 g/dL and the current hemoglobin level is less than the indication specific level noted above.
  - Dose decreases of 25% or more can be considered if the hemoglobin rises rapidly by more than 1 g/dL in any 2-week period.
  - Dose and frequency requested are the minimum necessary for the patient to avoid RBC transfusions.
  - Avoid frequent dose adjustments. Do not increase the dose more frequently than once every 4 weeks; decreases can occur more frequently.
  - If patients fail to respond over a 12-week dose escalation period, further dose increases are unlikely to improve response and discontinuation of therapy should be considered.

– For patients with MDS:
  - After 8 weeks of therapy, if there is no response as measured by at least a 1.5 g/dL increase in hemoglobin or a decrease in RBC transfusions, change of regimen or discontinuation of therapy should be considered.

– For patients with MPN:
  - After 3 months of therapy, if there is no response as measured by at least a 2 g/dL increase in hemoglobin or a decrease in RBC transfusions, discontinuation of therapy should be considered.

– For patients on Cancer Chemotherapy:
  - After 8 weeks of therapy, if there is no response as measured by hemoglobin levels or if RBC transfusions are still required, or following completion of a chemotherapy course, discontinue therapy.

VI. Billing Code/Availability Information

HCPCS code:

- J0881 – Injection, darbepoetin alfa, 1 microgram (non-ESRD use); 1 billable unit = 1 mcg

NDC(s):

Single-dose Vial		Single-dose Prefilled Syringe	
1 Vial/Pack, 4 Packs/Case		*1 Syringe/Pack, 4 Packs/Case*	
200 mcg/1 mL	55513-0006-xx	200 mcg/0.4 mL	55513-0028-xx
		300 mcg/0.6 mL	55513-0111-xx
		500 mcg/1 mL	55513-0032-xx
4 Vials/Pack, 10 Packs/Case		*4 Syringes/Pack, 10 Packs/Case*	
25 mcg/1 mL	55513-0002-xx	10 mcg/0.4 mL	55513-0098-xx
40 mcg/1 mL	55513-0003-xx	25 mcg/0.42 mL	55513-0057-xx
60 mcg/1 mL	55513-0004-xx	40 mcg/0.4 mL	55513-0021-xx
100 mcg/1 mL	55513-0005-xx	60 mcg/0.3 mL	55513-0023-xx
		100 mcg/0.5 mL	55513-0025-xx
		150 mcg/0.3 mL	55513-0027-xx

VII. References

1. Aranesp [package insert] Thousand Oaks, CA; Amgen Inc.; December 2024. Accessed January 2026.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) darbepoetin alfa. National Comprehensive Cancer Network, 2026. The NCCN

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3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Hematopoietic Growth Factors Version 3.2026. National Comprehensive Cancer Network, 2026. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed January 2026.
4. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Myelodysplastic Syndromes Version 3.2026. National Comprehensive Cancer Network, 2026. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed January 2026.
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Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime's assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	Yes: Consider for PA
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C93.10	Chronic myelomonocytic leukemia, not having achieved remission
C94.40	Acute panmyelosis with myelofibrosis not having achieved remission
C94.41	Acute panmyelosis with myelofibrosis in remission
C94.42	Acute panmyelosis with myelofibrosis in relapse
C94.6	Myelodysplastic disease, not classified
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes
D47.1	Chronic myeloproliferative disease

D47.4	Osteomyelofibrosis
D63.0	Anemia in neoplastic disease
D63.1	Anemia in chronic kidney disease
D64.81	Anemia due to antineoplastic chemotherapy
D64.9	Anemia unspecified
D75.81	Myelofibrosis
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
N18.30	Chronic kidney disease, stage 3 (moderate), unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
Z51.11	Encounter for antineoplastic chemotherapy
Z51.89	Encounter for other specified aftercare

Dual coding requirements:

- Anemia due to CKD (not on dialysis): must bill D63.1 AND I12.9, I13.0, I13.10, N18.30, N18.31, N18.32, N18.4, or N18.5

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes		
Jurisdiction	**NCD/LCA/LCD Document (s)**	**Contractor**
All	110.21	All
J,M	A58982	Palmetto GBA
15	A56462	CGS Administrators, LLC
5,8	A56795	Wisconsin Physicians Service Insurance Corp (WPS)

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC