Clinical Policy: Ferumoxytol (Feraheme)

Reference Number: LA.PHAR.165
Effective Date: 06.08.22
Last Review Date: ~~04.22~~06.02.23 Coding Implications
Line of Business: Medicaid Revision Log

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

****Please note: This policy is for medical benefit****

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
~~Prior authorization is required.~~ *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 Louisiana Healthcare Connections 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. Failure of both of the following agents: Ferrlecit® and Venofer®, unless clinically significant adverse effects are experienced or both are contraindicated;
~~4.~~5. 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. Failure of two of the following agents, unless clinically significant adverse effects are experienced or all are contraindicated: Ferrlecit®, Infed®, or Venofer®;
~~4.~~5. Dose does not exceed 510 mg elemental iron per infusion/injection.

Approval duration 3 months

~~C.~~ **Other diagnoses/indications**

C. ~~Refer to the off-label use policy if diagnosis~~ (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
~~1.~~2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized~~): LA~~) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53 ~~for Medicaid.~~

II. Continued Approval Criteria

A. Iron Deficiency Anemia with Chronic Kidney Disease (must meet all):
1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Documentation of one of the following laboratory results measured since the last IV iron administration:
   a. TSAT ≤ 30%;
   b. Serum ferritin ≤ 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 medication via Louisiana Healthcare Connections benefit or member has previously met 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 ≤ 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 Louisiana Healthcare Connections benefit and documentation supports positive response to therapy. Approval duration: Duration of request or 6 months (whichever is less); or~~

1. ~~Refer to the off-label use policy if~~If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized~~):~~ ~~LA.PMN.53 for Medicaid.~~) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53.

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 – LA.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 require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of OTC Oral Iron Formulations*		
Ferrous fumarate (Ferretts, Ferrimin 150~~, Hemocyte~~)	Varies	

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ferrous gluconate (Ferate)		
Ferrous sulfate (BProtected Pedia Iron, Fer-In-Sol, FeroSul, ~~FerrouSul,~~ Iron Supplement, Iron Supplement Childrens, Slow Fe, Slow Iron)		
Polysaccharide-iron complex (EZFE 200, Ferrex 150, Ferrix x-150, ~~Myferon~~IFerex 150, NovaFerrum 125, NovaFerrum ~~50~~, NovaFerrum Pediatric Drops, Nu-Iron, Poly-Iron 150)		
Injectable iron agents		
Sodium ferric gluconate (Ferrlecit)	Varies	
Infed (iron dextran)		
Venofer (iron sucrose)		

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~~; history of allergic reaction to any intravenous iron product.
- Boxed warning(s): Serious hypersensitivity/anaphylaxis reactions.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IDA with or without CKD (adults)	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.	510 mg per dose -Treatment course: 1020 mg -Treatment may be repeated

VI. Product Availability

Intravenous solution single-dose vial: 510 mg/17 mL (17 mL)

VII. References

1. Feraheme prescribing information. AMAG Waltham, MA: Pharmaceuticals, Inc.; ~~September 2020.~~June 2022. Available from https://www.feraheme.com. Accessed November ~~8, 2021~~9, 2022.
2. KDIGO 2012 clinical practice guideline for evaluation and management of chronic kidney disease. *Kidney International Supplements.* January 2013; 3(1): 1-136.
3. KDIGO 2012 clinical practice guideline for anemia in chronic kidney disease. *Kidney International Supplements.* August 2012; 2(4): 279-331.
4. Babitt JL, Eisenga MF, Haase VH, et al. Controversies in optimal anemia management: conclusions from a Kidney Disease: Improving Global Outcomes (KDIGO) Conference. Kidney Int. 2021;99(6):1280-1295.

~~4.~~5.Camaschella C. Iron-Deficiency Anemia. *N Engl J Med.* 2015; 372: 1832-43. DOI: 10.1056/NEJMra1401038.
~~5.~~6.Short MW, Domagalski JE. Iron Deficiency Anemia: Evaluation and Management. *Am Fam Physician.* 2013; 87(2): 98-104. http://www.aafp.org/afp/2013/0115/p98.pdf
~~6.~~7.Oral iron monographs. In: UpToDate (Lexicomp), Waltham, MA: Walters Kluwer Health. Updated periodically. Accessed November ~~8, 2021~~9, 2022.

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.

HCPCS Codes	Description
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	04.22	06.08.22
Template changes applied to other diagnoses/indications and continued therapy section. References reviewed and updated. Updated initial criteria to require failure of the following: for IDA and CKD Ferrlecit and Venofer; for IDA without CKD two of Ferrlecit, Infed, or Venofer. Added verbiage this policy is for medical benefit only.	06.02.23	

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. LHCC 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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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