Clinical Policy: Methoxy Polyethylene Glycol-Epoetin Beta (Mircera)

Reference Number: CP.PHAR.238
Effective Date: 07.01.16
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Methoxy polyethylene glycol-epoetin beta (Mircera®) is an erythropoiesis-stimulating agent (ESA).

FDA Approved Indication(s)

Mircera is indicated for the treatment of anemia associated with chronic kidney disease (CKD) in:

- Adult patients on dialysis and adult patients not on dialysis
- Pediatric patients 3 months to 17 years of age on dialysis or not on dialysis who are converting from another ESA after their hemoglobin level was stabilized with an ESA

Limitation(s) of use:

- Mircera is not indicated and is not recommended:
  - In the treatment of anemia due to cancer chemotherapy
  - As a substitute for red blood cell (RBC) transfusions in patients who require immediate correction of anemia.
- Mircera has not been shown to improve symptoms, physical functioning, or health-related quality of life.

Policy/Criteria

Provider must submit documentation (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 Mircera is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Anemia of Chronic Kidney Disease (must meet all)**:**

1. Diagnosis of anemia of CKD, and member meets one of the following (a or b):
   a. Age ≥ 18 years (dialysis status is irrelevant);
   b. Age 3 months to ≤ 17 years (dialysis status is irrelevant) and will be converting from another ESA agent (e.g., epoetin alfa, darbepoetin alfa);
2. Prescribed by or in consultation with a hematologist or nephrologist;
3. Adequate iron stores as indicated by current (within the last 3 months) serum ferritin level ≥ 100 mcg/L or serum transferrin saturation ≥ 20%;
4. Pretreatment hemoglobin < 10 g/dL;

5. Both of the following (a and b):*
   **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395.*
   a. Member must use Retacrit®, unless contraindicated, clinically significant adverse effects are experienced, or Retacrit is unavailable due to shortage;
      **Prior authorization may be required for Retacrit*
   b. If member is unable to use Retacrit, member must use Epogen®, unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization may be required for Epogen*
6. Dosing interval does not exceed one of the following (a or b):
   a. Adults: SC or IV once every two weeks;
   b. Pediatrics: SC or IV once every four weeks.

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to member's renewal period, whichever is longer

B. Other diagnoses/indications (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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Anemia of Chronic Kidney Disease (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Both of the following (a and b):*
   **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395.*

a. Member must use Retacrit, unless contraindicated, clinically significant adverse effects are experienced, or Retacrit is unavailable due to shortage;
**Prior authorization may be required for Retacrit*
b. If member is unable to use Retacrit, member must use Epogen, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for Epogen*

4. Current hemoglobin ≤ 12 g/dL;
5. Adequate iron stores as indicated by current (within the last 3 months) serum ferritin level ≥ 100 mcg/L or serum transferrin saturation ≥ 20%;
6. Dosing interval does not exceed one of the following (a or b):
   a. Adults: SC or IV once every two weeks;
   b. Pediatrics: SC or IV once every four weeks.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to member's renewal period, whichever is longer

B. Other diagnoses/indications (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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Anemia due to cancer chemotherapy;
B. 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 policies – CP.CPA.09 for commercial, HIM.PA.154 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
FDA: Food and Drug Administration
RBC: red blood cell

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Retacrit® (epoetin alfa-epbx), Epogen® (epoetin alfa)	**Anemia due to CKD:** Initial dose: 50 to 100 Units/kg 3 times weekly (adults) IV or SC and 50 Units/kg 3 times weekly (pediatric patients ages 1 month or older) IV or SC. Individualize maintenance dose. IV route recommended for patients on hemodialysis	Varies depending on indication, frequency of administration, and individual response

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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Uncontrolled hypertension
  - Pure red cell aplasia (PRCA) that begins after treatment with other erythropoietin protein drugs
  - Allergic reactions, anaphylaxis
- Boxed warning(s): ESAs increase the risk of death, myocardial infarction, stroke, venous thromboembolism, thrombosis of vascular access and tumor progression or recurrence

Appendix D: General Information

- The 2012 Kidney Disease Improving Global Outcomes (KDIGO) Clinical Practice Guideline for Anemia in Chronic Kidney Disease state that there is no evidence that any given ESA brand is superior to another in terms of patient outcomes. It is considered opinion of the Work Group that the likelihood of differences in clinical outcomes among ESA brands is low. The guideline recommends choosing an ESA based on the balance of pharmacodynamics, safety information, clinical outcome data, costs, and availability (Level 1, Grade D recommendation).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Anemia due to CKD	**Adult patients with CKD on dialysis** Initial treatment: 0.6 mcg/kg body weight SC or IV once every two weeks **Adult patients with CKD not on dialysis** Initial treatment: 1.2 mcg/kg body weight SC or IV once every month. Alternatively, 0.6 mcg/kg body weight SC or IV once every two weeks	Varies

Indication	Dosing Regimen	Maximum Dose
	Maintenance treatment: dose twice that of the every-two-week dose SC or IV once monthly Conversion from another ESA: dosed SC or IV once monthly or once every two weeks based on total weekly epoetin alfa or darbepoetin alfa dose at time of conversion **Pediatric patients with CKD on hemodialysis** Conversion from another ESA: dosed SC or IV once every four weeks based on total weekly epoetin alfa or darbepoetin alfa dose at time of conversion. In patients less than 6 years of age, maintain the same route of administration as the previous ESA when switching from another ESA to Mircera.	

VI. Product Availability

Injection (single-dose prefilled syringe): 30, 50, 75, 100, 120, 150, 200, or 250 mcg in 0.3 mL solution; 360 mcg in 0.6 mL solution

VII. References

1. Mircera Prescribing Information. South San Francisco, CA: Genentech USA; June 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125164s091lbl.pdf. Accessed January 17, 2025.
2. Kidney Disease Improving Global Outcomes (KDIGO) Clinical Practice Guideline for Anemia in Chronic Kidney Disease. Official Journal of the International Society of Nephrology – Kidney International Supplements August 2012. 2(4): 279-335.

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
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)
J0888	Injection, epoetin beta, 1 microgram, (for Non ESRD use)

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added Appendix D and reference to KDIGO guidelines that do not indicate preference for any ESA.	06.30.20	
Added to Section II for continued therapy redirection to Retacrit.	08.18.20	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: no significant changes; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	02.22.21	05.21
Per SDC and previously approved clinical guidance, added redirection to Epogen if Retacrit is unavailable due to shortage.	04.26.22	
2Q 2022 annual review: no significant changes; references reviewed and updated.	04.27.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.10.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.01.23	05.23
2Q 2024 annual review: added requirement for continuation requests that current hemoglobin ≤ 12 g/dL; updated dosing in Section V to include 1.2 mcg/kg once monthly dosing option for adult patients with CKD not on dialysis; references reviewed and updated.	01.09.24	05.24
RT4: updated to reflect expanded uses down to 3 months of age for pediatric patients on dialysis and added new use in pediatric patients not on dialysis per updated prescribing information; added option for SC route of administration in pediatrics.	06.04.24	
2Q 2025 annual review: extended continuation of therapy approval duration from 6 to 12 months for Medicaid/HIM; references reviewed and updated. Per March SDC, for all indications, revised Retacrit and Epogen redirection language from "failure of" to "member must use" and revised criteria from "member meets one of the following" to "member must meet both of the following", clarified members must use Epogen if member is unable to use Retacrit. Added step therapy bypass for IL HIM per IL HB 5395.	03.11.25	05.25

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.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.