

<b>Department:</b>	Pharmacy Management	<b>Original Approval:</b>	01/10/2017
<b>Policy No:</b>	PM140	<b>Last Approval:</b>	05/15/2026
<b>Policy Title:</b>	Darbepoetin alfa (Aranesp®) injection Clinical Coverage Criteria		
<b>Approved By:</b>	UM Criteria Subcommittee		
<b>Applicable Line(s) of Business:</b>	<input checked="" type="checkbox"/> <b>Washington Apple Health (Medicaid)</b> <input type="checkbox"/> <b>Behavioral Health Services Only</b> <input checked="" type="checkbox"/> <b>Apple Health Expansion</b> <input checked="" type="checkbox"/> <b>Medicare Advantage/Special Needs Plan</b> <input checked="" type="checkbox"/> <b>Medicare Advantage Only</b> <input checked="" type="checkbox"/> <b>Cascade Select</b>		

### Required Clinical Documentation for Review

Documentation required to determine medical necessity for Darbepoetin alfa: History and/or physical examination notes and relevant specialty consultation notes that address the problem and need for the service -Diagnosis -Labs/Diagnostics -Dosing and duration requested - Initial/Extended approval -Medical records from the last 6 months showing the patient’s problems, history, prior treatments, response to treatment, imaging and laboratory studies, details of the skilled needs, details of any specific needs related to risk/trauma/cultural etc., assessment and plan -Prescribed by or in consultation with a specialist, when indicated.

### Background

Endogenous erythropoietin (EPO) is used to stimulate red blood cell (RBC) production in the bone marrow. Suppression of erythropoietin production or suppression of the bone marrow response to erythropoietin results in anemia in several disease processes, including chronic kidney disease (CKD), many types of cancer treatment, other chronic diseases, and use of certain drugs.

**For Medicare:** This policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), as well as in companion policy articles and other guidance applicable to the relevant service areas. These documents are cited in the References section of this policy. In some cases, this guidance includes specific lists of HCPCS and ICD-10 codes to help inform the coverage determination process. The Articles that include specific lists for billing and coding purposes will be included in the Reference section of this policy. However, to the extent that this policy cites such lists of HCPCS and ICD-10 codes, they should be used for reference purposes only. The presence of a

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specific HCPCS or ICD-10 code in a chart or companion article to an LCD is not by itself sufficient to approve coverage. Similarly, the absence of such a code does not necessarily mean that the applicable condition or diagnosis is excluded from coverage.

Note: Conditions for coverage outlined in this Medicare Advantage Medical Policy may be less restrictive than those found in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles. Examples of situations where this clinical policy may be less restrictive include, but are not limited to, coverage of additional indications supported by CMS-approved compendia and the exclusion from this policy of additional coverage criteria requirements outlined in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles.

## Definitions

None.

## Indications/Criteria

<p><b>Medicaid Members</b></p>	<p><b><i>Continue to criteria for approval below.</i></b></p> <p><b><i>Criteria based on Washington State Health Care Authority Medical policy no. 82.40.10 Hematopoietic Agents :Erythropoiesis-Stimulating Agents (ESAs)</i></b></p> <p><b><i>Please note: Prior authorization is NOT required if the requested medication is being administered at a kidney center/dialysis center.</i></b></p>
<p><b>Individual &amp; Family (Cascade Select) Members</b></p>	<p><b><i>Preferred Products: Aranesp, Procrit, Retacrit</i></b></p> <p><b><i>Non-Preferred Products: Epogen, Mircera</i></b></p>
<p><b>Medicare Members</b></p>	<p><b><i>Preferred Products: Aranesp, Procrit, Retacrit</i></b></p> <p><b><i>Non-Preferred Products: Epogen, Mircera</i></b></p>

## Recommended Authorization Criteria

Erythropoiesis-Stimulating Agents may be considered medically necessary when used for ONE of the following conditions:

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1. Treatment of anemia of prematurity for less than 6 months of age; OR
2. Treatment of anemia associated with chronic kidney disease (CKD) – (including patients on dialysis and not on dialysis); OR
3. Anemia associated with zidovudine-treated HIV-infected patients; OR
4. Treatment of anemia of cancer patients on chemotherapy, where the intent of treatment is palliative; OR
5. Treatment of anemia associated with myelodysplastic syndrome to reduce transfusion dependency; OR
6. Treatment of patients after allogeneic bone marrow transplantation; OR
7. Treatment of anemia due to ribavirin in patients who did not experience an improvement in hemoglobin level with ribavirin dose reduction; OR
8. To reduce the need for blood transfusions in anemic patients scheduled to undergo high-risk surgery who are at increased risk or intolerant to transfusions; OR
9. Special circumstance patients who will not or cannot receive whole blood or components as replacement for traumatic or surgical loss

#### **Medicaid Criteria**

**Note:** Prior authorization is NOT required if the requested medication is being administered at a kidney center/dialysis center.

1. Approve the requested medication for 1 year if the medication is being used for an FDA-approved indication or an indications supported by Centers for Medicare and Medicaid Services (CMS) Compendia

#### **Cascade Select Criteria**

1. **Anemia in a Patient with Chronic Kidney Disease who is on Dialysis.** Approve for 1 year.
2. **Anemia in a Patient with Chronic Kidney Disease who is not on Dialysis.** Approve for 1 year if the patient meets the following (A or B):
  - A) **Initial Therapy.** Approve if the patient meets the following (i and ii):
    - i. Patient meets one of the following (a or b):
      - a) Patient is  $\geq 18$  years of age with a hemoglobin  $< 10.0$  g/dL; OR
      - b) Patient is  $< 18$  years of age with a hemoglobin  $\leq 11.0$  g/dL; AND
    - ii. Patient meets one of the following (a or b):
      - a) Patient is currently receiving iron therapy; OR
      - b) Patient has adequate iron stores according to the prescriber; OR
  - B) **Patient is Currently Receiving an Erythropoiesis-Stimulating Agent.** Approve if the patient meets the following (i and ii):

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Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit), a darbepoetin alfa product (e.g., Aranesp), or a methoxy polyethylene glycol-epoetin beta product (e.g., Mircera).

- i. Patient has a hemoglobin  $\leq 12.0$  g/dL; AND
- ii. Patient meets one of the following (a or b):
  - a) Patient is currently receiving iron therapy; OR
  - b) Patient has adequate iron stores according to the prescriber.

**Dosing.** Approve one of the following dosing regimens (A or B):

- A) Patient is  $\geq 18$  years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is  $\leq 0.45$  mcg/kg; AND
  - ii. Each dose is given no more frequently than once every 4 weeks; OR
- B) Patient is  $< 18$  years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is  $\leq 0.75$  mcg/kg; AND
  - ii. Each dose is given no more frequently than once every 2 weeks.

**3. Anemia in a Patient with Cancer due to Cancer Chemotherapy.** Approve for 6 months if the patient meets the following (A or B):

- A) Initial Therapy. Approve if the patient meets the following (i, ii, and iii):
  - i. Patient has a hemoglobin  $< 10.0$  g/dL; AND
  - ii. Patient meets BOTH of the following (a and b):
    - a) Patient is currently receiving myelosuppressive chemotherapy; AND
    - b) According to the prescriber, myelosuppressive chemotherapy is considered non-curative; AND
  - iii. Patient meets one of the following (a or b):
    - a) Patient is currently receiving iron therapy; OR
    - b) Patient has adequate iron stores according to the prescriber; OR

B) Patient is Currently Receiving an Erythropoiesis-Stimulating Agent. Approve if the patient meets the following (i, ii, and iii):

Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit) or a darbepoetin alfa product (e.g., Aranesp).

- i. Patient has a hemoglobin  $\leq 12.0$  g/dL; AND
- ii. Patient meets BOTH of the following (a and b):
  - a) Patient is currently receiving myelosuppressive chemotherapy; AND
  - b) According to the prescriber, myelosuppressive chemotherapy is considered non-curative; AND
- iii. Patient meets one of the following (a or b):
  - a) Patient is currently receiving iron therapy; OR
  - b) Patient has adequate iron stores according to the prescriber.

**Dosing.** Approve one of the following dosing regimens (A or B):

- A) Patient is ≥ 18 years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is ≤ 500 mcg; AND
  - ii. Each dose is given no more frequently than once every week; OR
- B) Patient is < 18 years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is ≤ 2.25 mcg/kg; AND
  - ii. Each dose is given no more frequently than once every week.

#### **Other Uses with Supportive Evidence**

**4. Anemia Associated with Myelodysplastic Syndrome.** Approve for 1 year if the patient meets the following (A or B):

- A) Initial Therapy. Approve if the patient meets the following (i, ii, iii, and iv):
  - i. Patient is ≥ 18 years of age; AND
  - ii. Patient meets one of the following (a or b):
    - a) Patient has a hemoglobin < 10.0 g/dL; OR
    - b) Patient has a serum erythropoietin level ≤ 500 mU/mL; AND
  - iii. Patient meets one of the following (a or b):
    - a) Patient is currently receiving iron therapy; OR
    - b) Patient has adequate iron stores according to the prescriber; AND
  - iv. The medication is prescribed by or in consultation with a hematologist or oncologist.
- B) Patient is Currently Receiving an Erythropoiesis-Stimulating Agent. Approve if the patient meets the following (i, ii, iii, and iv):

Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit) or a darbepoetin alfa product (e.g., Aranesp).

  - i. Patient is ≥ 18 years of age; AND
  - ii. Patient has a hemoglobin ≤ 12.0 g/dL; AND
  - iii. Patient meets one of the following (a or b):
    - a) Patient is currently receiving iron therapy; OR
    - b) Patient has adequate iron stores according to the prescriber; AND
  - iv. The medication is prescribed by or in consultation with a hematologist or oncologist.

**Dosing.** Approve if the dose meets the following (A and B):

- A) Each dose is ≤ 500 mcg; AND
- B) Each dose is given no more frequently than once every 2 weeks.

**5. Anemia Associated with Myelofibrosis.** Approve for the duration noted below if the patient meets the following (A or B):

- A) Initial Therapy. Approve for 3 months if the patient meets the following (i, ii, and iii):
  - i. Patient meets one of the following (a or b):

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- a) Patient has a hemoglobin < 10.0 g/dL; OR
- b) Patient has a serum erythropoietin level ≤ 500 mU/mL; AND
- ii. Patient meets one of the following (a or b):
  - a) Patient is currently receiving iron therapy; OR
  - b) Patient has adequate iron stores according to the prescriber; AND
- iii. The medication is prescribed by or in consultation with a hematologist or oncologist.
- B) Patient is Currently Receiving an Erythropoiesis-Stimulating Agent.** Approve for 1 year if the patient meets the following (i, ii, iii, and iv):
 

Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit) or a darbepoetin alfa product (e.g., Aranesp).

  - i. Patient has a hemoglobin ≤ 12.0 g/dL; AND
  - ii. Patient meets one of the following (a or b):
    - a) Patient is currently receiving iron therapy; OR
    - b) Patient has adequate iron stores according to the prescriber; AND
  - iii. According to the prescriber, patient has responded to therapy defined as hemoglobin ≥ 10 g/dL or a hemoglobin increase of ≥ 2 g/dL; AND
  - iv. The medication is prescribed by or in consultation with a hematologist or oncologist.

**Dosing.** Approve if the dose meets the following (A and B):

- A)** Each dose is ≤ 500 mcg; AND
- B)** Each dose is given no more frequently than once every 2 weeks.

### **Medicare Criteria**

- 1. Anemia in Patients with Chronic Kidney Disease (CKD) who are on Dialysis.** Approve for 1 year.
- 2. Anemia in Patients with Chronic Kidney Disease (CKD) who are not on dialysis.** Approve for 1 year if the patient meets the following criteria (A or B):
  - A) Initial Therapy.** Approve if the patient meets the following criteria (i, ii, and iii):
    - i. The patient meets one of the following (a or b):
      - a) The patient is ≥ 18 years of age with a hemoglobin < 10.0 g/dL; OR
      - b) The patient is < 18 years of age with a hemoglobin ≤ 11.0 g/dL; AND
    - ii. The patient meets one of the following (a or b):
      - a) Patient is currently receiving iron therapy; OR
      - b) The patient has adequate iron stores according to the prescriber; OR
  - B) Patient is currently receiving an erythropoiesis-stimulating agent (ESA).** Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit), a darbepoetin alfa product (e.g., Aranesp), or a methoxy

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polyethylene glycol-epoetin beta product (e.g., Mircera). Approve if the patient meets the following criteria (i and ii):

- i. Patient has hemoglobin  $\leq$  12.0 g/dL; AND
- ii. The patient meets one of the following (a or b):
  - a) The patient is currently receiving iron therapy; OR
  - b) The patient has adequate iron stores according to the prescriber; AND

**Dosing.** Approve the following dosing regimen (A or B):

- A) Patients  $\geq$  18 years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is  $\leq$  0.45 mcg/kg; AND
  - ii. Each dose is given no more frequently than once every 4 weeks; OR
- B) Patients  $<$  18 years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is  $\leq$  0.45 mcg/kg; AND
  - ii. Each dose is given no more frequently than once every 2 weeks.

**3. Anemia in Patients with Cancer due to Cancer Chemotherapy.** Approve if the patient meets the following criteria (A or B):

**A) Initial Therapy.** Approve for 6 months if the patient meets the following criteria (i, ii, and iii):

- i. The patient has a hemoglobin  $<$  10.0 g/dL (or hematocrit  $<$ 30%); AND
- ii. The patient is currently receiving myelosuppressive chemotherapy; AND
- iii. The patient meets one of the following (a or b):
  - a) Patient is currently receiving iron therapy; OR
  - b) Patient has adequate iron stores according to the prescriber; OR

**B) Patient is currently receiving an erythropoiesis-stimulating agent (ESA).** Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit), or a darbepoetin alfa product (e.g., Aranesp). Approve for 6 months if the patient meets the following criteria (i, ii, and iii):

- i. The patient has a hemoglobin  $\leq$  12.0 g/dL (or hematocrit  $<$ 30%); AND
- ii. The patient is currently receiving myelosuppressive chemotherapy; AND
- iii. The patient meets one of the following (a or b):
  - a) Patient is currently receiving iron therapy; OR
  - b) Patient has adequate iron stores according to the prescriber; AND

**Dosing.** Approve the following dosing regimen (A or B):

- A) Patients  $\geq$  18 years of age. Approve if the dose meets the following (i and ii):
  - i. Each dose is  $\leq$  500 mcg; AND

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- ii. Each dose is given no more frequently than once every week; OR
- B) Patients < 18 years of age. Approve if the dose meets the following (i and ii):**
  - i. Each dose is  $\leq 2.25$  mcg/kg; AND
  - ii. Each dose is given no more frequently than once every 2 weeks.

#### Uses with Supportive Evidence

- 4. Anemia Associated with Myelodysplastic Syndrome (MDS).** Approve for 1 year if the patient meets the following criteria (A or B):
- A) Initial Therapy.** Approve if the patient meets the following criteria (i, ii, and iii):
- i. The patient meets one of the following (a or b):
    - a) The patient has a hemoglobin  $<10.0$  g/dL; OR
    - b) The patient has a serum erythropoietin level is  $\leq 500$  mU/mL; AND
  - ii. The patient  $\geq 18$  years of age; AND
  - iii. The patient meets one of the following (a or b):
    - a) Patient is currently receiving iron therapy; OR
    - b) Patient has adequate iron stores according to the prescriber; OR
- B) Patient is currently receiving an erythropoiesis-stimulating agent (ESA).** Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit), or a darbepoetin alfa product (e.g., Aranesp). Approve if the patient meets the following criteria (i, ii, and iii):
- i. The patient has a hemoglobin  $<12.0$  g/dL; OR
  - ii. The patient  $\geq 18$  years of age; AND
  - iii. The patient meets one of the following (a or b):
    - a) Patient is currently receiving iron therapy; OR
    - b) Patient has adequate iron stores according to the prescriber; AND

**Dosing.** Approve the following dosing regimen (A or B):

- A)** Each dose is  $\leq 500$  mcg; AND
- B)** Each dose is given no more frequently than once every 2 week

- 5. Anemia Associated with Myelofibrosis.** Approve for the duration noted below if the patient meets the follow criteria (A or B):
- A) Initial Therapy.** Approve for 3 months if the patient meets the following criteria (i, and ii):
- i. The patient meets one of the following (a or b):
    - a) The patient has a hemoglobin  $<10.0$  g/dL; OR

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2. **Anemia Associated with Acute Myelogenous Leukemia (AML), Chronic Myelogenous Leukemia (CML), or other Myeloid Cancers.** Aranesp is indicated for use in non-myeloid cancers. AML and CML are examples of myeloid cancers.<sup>1</sup>
3. **Anemia Associated with Radiotherapy in Cancer.** Aranesp is not indicated for use in cancer patients who are given only radiation therapy.<sup>1</sup>
4. **To Enhance Athletic Performance.** Aranesp is not recommended for approval because this indication is excluded from coverage in a typical pharmacy benefit.
5. **Anemia in Patients due to Acute Blood Loss.** Use of Aranesp is not appropriate in these types of situations.
6. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

### Special Considerations

BOXED WARNING: ESAs INCREASE THE RISK OF DEATH, MYOCARDIAL INFARCTION, STROKE, VENOUS THROMBOEMBOLISM, THROMBOSIS OF VASCULAR ACCESS AND TUMOR PROGRESSION OR RECURRENCE. See full prescribing information for complete boxed warning.<sup>1</sup>

Contraindications include<sup>1</sup>:

1. Uncontrolled hypertension
2. Pure red cell aplasia (PRCA) that begins after treatment with Aranesp or other erythropoietin protein drugs
3. Serious allergic reactions to Aranesp

### Limitations/Exclusions

Please see link to member coverage documents below:

Line of Business	Link to Member Coverage Documents
Medicare Advantage Plans (Including D-SNP)	<a href="https://medicare.chpw.org/">https://medicare.chpw.org/</a> Select the appropriate plan from the “Plans” drop down on the top navigation bar.
Apple Health	<a href="https://www.chpw.org/for-members/benefits-and-coverage-imc/">https://www.chpw.org/for-members/benefits-and-coverage-imc/</a>
Individual & Family (Cascade Select)	<a href="https://chnwhealthinsurance.chpw.org/member-center/plan-benefits/">https://chnwhealthinsurance.chpw.org/member-center/plan-benefits/</a>

### List of Appendices

None.

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## Citations & References

<b>CFR</b>	<a href="#">42 CFR § 438.210</a>	
<b>WAC</b>	<a href="#">WAC 284-43-2050</a>	
<b>RCW</b>		
<b>LOB &amp; Contract Citation</b>	<input type="checkbox"/> <b>WAHIMC</b>	
	<input type="checkbox"/> <b>BHSO</b>	
	<input type="checkbox"/> <b>Wraparound</b>	
	<input type="checkbox"/> <b>SMAC</b>	
	<input type="checkbox"/> <b>HH</b>	
	<input type="checkbox"/> <b>AHE</b>	
	<input checked="" type="checkbox"/> <b>MA/DSNP</b>	P&P supports all LOB requirements
<input checked="" type="checkbox"/> <b>CS</b>	P&P supports all LOB requirements	
<b>Other Requirements</b>		
<b>NCQA Elements</b>		
<b>References</b>	<ol style="list-style-type: none"> <li>1. Product Information: ARANESP® intravenous injection, subcutaneous injection, darbepoetin alfa intravenous injection, subcutaneous injection. Amgen Inc (per FDA), Thousand Oaks, CA, March 2026.</li> <li>2. Product Information: Epogen® intravenous injection, subcutaneous injection, epoetin alfa intravenous injection, subcutaneous injection. Amgen Inc (per FDA), Thousand Oaks, CA, November 2025.</li> <li>3. Product Information: Procrit® intravenous injection, subcutaneous injection, epoetin alfa intravenous injection, subcutaneous injection. Janssen Products LP (per FDA), Horsham, PA, April 2025.</li> <li>4. Product Information: RETACRIT™ intravenous, subcutaneous injection, epoetin alfa-epbx intravenous, subcutaneous injection. Hospira, Inc (per FDA), Lake Forest, IL, June 2025.</li> <li>5. Product Information: Mircera® intravenous injection, subcutaneous injection, methoxy polyethylene glycol epoetin beta intravenous injection, subcutaneous injection. CSL Vifor, Switzerland, June 2024.</li> <li>6. KDIGO Clinical Practice Guidelines for Anemia in Chronic Kidney Disease. Kidney International Supplements. 2012; 2(4): 279-335.</li> <li>7. Centers for Medicare and Medicaid Services. National Coverage Determination (NCD) for Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (110.21). [Version Number 1, Effective date of version: 7/30/2007. Accessed August 28, 2023].</li> </ol>	

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## Revision History

Revision Date	Revision Description	Revision Made By
01/09/2017	NEW	Sophia Yun, PharmD
01/10/2017	Approval	MMLT
03/06/2017	Medication name formatting revision	Sophia Yun, PharmD
03/06/2017	Approval	MMLT
02/12/2018	Updated review	Catherine Vu, PharmD
03/01/2018	Approval	MMLT
03/09/2018	Reassigned from UM to Pharmacy	Cindy Bush
07/16/2018	Minor revisions	Jennifer Farley, PharmD
03/08/2019	Approval	UM Pharmacy Subcommittee
03/12/2019	Minor revisions	Ivan Figueira, PharmD
07/05/2019	Criteria revised to match HCA Medical policy no.82.40.1	Jennifer Farley, PharmD
07/11/2019	Approval	UM Pharmacy Subcommittee
06/09/2020	Annual review- No changes	Jennifer Farley, PharmD
06/18/2020	Approval	UM Pharmacy Subcommittee
04/23/2021	Annual review- No changes	Jennifer Farley, PharmD
05/06/2021	Approval	UM Pharmacy Subcommittee
02/28/2022	Annual review- No changes	Alan Gabot, PharmD
03/02/2022	Approval	UM Pharmacy Subcommittee
11/30/2022	Early update. New criteria added to apply to Medicare LOB.	Alan Gabot, PharmD
12/02/2022	Approval	UM Pharmacy Subcommittee

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09/06/2023	Annual review. Updated dosage and quantity limit for Medicaid to be more aligned with the HCA policy. For “Anemia in a Patient with Chronic Kidney Disease who is not on Dialysis” under Medicare, the hemoglobin requirement for patients currently receiving an erythropoiesis-stimulating agent is now ≤ 12.0 g/dL for all ages.	Alan Gabot, PharmD
09/07/2023	Approval	UM Pharmacy Subcommittee
12/12/2023	Early update. Added description noting that the policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).	Alan Gabot, PharmD
12/18/2023	Approval	UM Pharmacy Subcommittee
02/26/2024	Early update. Created separate criteria for Cascade Select. Aranesp is now listed as preferred product for both Cascade Select and Medicare.	Alan Gabot, PharmD
02/28/2024	Approval	UM Criteria Subcommittee
09/10/2024	Early update. Removed “and Cascade Select” from the Medicaid Criteria section.	Alan Gabot, PharmD
09/11/2024	Approval	UM Criteria Subcommittee
07/03/2025	Annual review. Noted that requests under Medicaid do not require prior authorization if the medication is administered at a kidney/dialysis center.	Alan Gabot, PharmD
07/09/2025	Approval	UM Criteria Subcommittee
05/14/2026	For Medicaid, updated criteria where the requested medication may be approved if the medication is being used for an FDA-approved indication.	Alan Gabot, PharmD
05/15/2026	Approval	UM Criteria Subcommittee