

## PRIOR AUTHORIZATION POLICY

**POLICY:** Iron Replacement – INFeD Prior Authorization Policy

- INFeD® (iron dextran injection for intravenous or intramuscular use – Actavis Pharma)

**REVIEW DATE:** 12/16/2020

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### OVERVIEW

INFeD, an iron replacement product, is indicated for the treatment of patients with documented **iron deficiency in whom oral administration is unsatisfactory or impossible**.<sup>1</sup>

### Guidelines

The KDIGO guidelines for anemia in CKD (2012) make various recommendations regarding iron therapy.<sup>2</sup> For adults with CKD and anemia not on iron or erythropoietic stimulating agent (ESA) therapy, a trial of intravenous (IV) iron (or in non-dialysis patients with CKD, alternatively, a 1 to 3 month trial of oral iron therapy) is recommended if an increase in Hb concentration without starting ESA treatment is desired and transferrin saturation (TSAT) is  $\leq 30\%$  and ferritin is  $\leq 500$  ng/mL. For adults with CKD on ESA therapy who are not receiving iron supplementation, a trial of IV iron (or in non-dialysis CKD patients, alternatively, a 1 to 3 month trial of oral iron therapy) is recommended if an increase in Hb concentration or a decrease in ESA dose is desired and TSAT is  $\leq 30\%$  and ferritin is  $\leq 500$  ng/mL. For all pediatric patients with CKD with anemia not on iron or ESA therapy, oral iron (or IV iron in patients receiving hemodialysis) is recommended when TSAT is  $\leq 20\%$  and ferritin is  $\leq 100$  ng/mL. For all pediatric patients with CKD who are receiving ESA therapy but not receiving iron supplementation, it is recommended to administer oral iron (or IV iron for patients receiving hemodialysis) to maintain TSAT  $> 20\%$  and ferritin  $> 100$  ng/dL.

The National Comprehensive Cancer Network guidelines on Hematopoietic Growth Factors (version 2.2020 – January 27, 2020) discuss the management of cancer- and chemotherapy-induced anemia.<sup>3</sup> IV iron therapy is considered an option for patients with absolute iron deficiency (ferritin  $< 30$  ng/mL and TSAT  $< 20\%$ ), functional iron deficiency (ferritin = 30 to 500 ng/mL and TSAT  $< 50\%$ ), and possible functional iron deficiency (ferritin = 501 to 800 ng/mL and TSAT  $< 50\%$ ).

A 2017 focused update of the 2013 American College of Cardiology Foundation/American Heart Association guideline for the management of heart failure.<sup>4</sup> It states that in patients with New York Heart Association class II or III heart failure, absolute iron deficiency (ferritin  $< 100$  ng/mL) or functional iron deficiency (ferritin = 100 to 300 mg/mL if transferrin saturation is  $< 20\%$ ), and with or without anemia, IV iron replacement may be reasonable to improve function status and quality of life.<sup>4</sup> Benefits noted with IV iron therapies included improvement in functional capacity, improvements in the six-minute walk test and improved functional capacity.

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of INFeD. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with INFeD as well as the monitoring required for adverse events and long-term efficacy, approval requires INFeD to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

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Coverage of INFED is recommended in those who meet the following criteria:

### **FDA-Approved Indications**

- 1. Iron Deficiency Anemia, Other.** Approve for 1 year if the patient meets one of the following (A, B, C, or D):
  - A)** Patient meets both of the following (i and ii):
    - i.** Patient has tried oral iron supplementation; **AND**
    - ii.** According to the prescriber, oral iron supplementation was ineffective or intolerable; **OR**
  - B)** Patient has a condition which, per the prescriber, will interfere with oral iron absorption (e.g., inflammatory bowel disease, Crohn's disease); **OR**
  - C)** Patient is currently receiving an erythroid stimulating agent; **OR**  
Note: Examples of erythroid stimulating agents include an epoetin alfa product, a darbepoetin alfa product, or a methoxy polyethylene glycol-epoetin beta product.
  - D)** The medication is being requested for cancer- or chemotherapy-related anemia.

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

- 2. Iron Deficiency Anemia in Patients with Chronic Kidney Disease who are on Dialysis.** Approve for 3 years.
- 3. Iron Deficiency Anemia in Patients with Chronic Kidney Disease who are not on Dialysis.** Approve for 1 year if the medication is prescribed by, or in consultation with a nephrologist or hematologist.
- 4. Iron Deficiency Associated with Heart Failure.** Approve for 1 year if the medication is being prescribed by, or in consultation with a cardiologist or hematologist.

### **CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of INFED is not recommended in the following situations:

- 1.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

### **REFERENCES**

1. INFED® [prescribing information]. Parsippany, NJ: Actavis Pharma; September 2020.
2. Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Work Group. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. *Kidney Int.* 2012;2(Suppl):279-335.
3. The NCCN® Hematopoietic Growth Factors Guidelines in Oncology (Version 2.2020 – January 27, 2020). 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org/clinical.asp>. Accessed on December 1, 2020.
4. Yancy CW, Jessup M, Bozkurt B, et al. 2017 ACC/AHA/HFSA focused update of the 2013 ACCF/AHA guideline for the management of heart failure. *J Am Coll Cardiol.* 2017;70(6):776-803.