POLICY – MPP – Intravenous Iron for the Treatment of Iron Deficiency Anemia in Adults without Chronic Kidney Disease

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<th>Department/Team</th>
<th>Medical Management/Medical Payment Policy (MPP)</th>
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PURPOSE

This policy outlines guidelines and criteria for coverage determination of iron infusion for the treatment of iron deficiency anemia in members age 18 years or older without chronic kidney disease.

DEFINITIONS

*** All laboratory values must be obtained within 30 days of request for authorization ***

Anemia is defined as:
- Hemoglobin <13 g/dL for males and post-menopausal females
- Hemoglobin <12 g/dL for premenopausal females
- In pregnancy: Hemoglobin < 11 g/dL in the first trimester, Hemoglobin < 10.5 g/dL in the second trimester, and hemoglobin < 11 g/dL in the third trimester

Iron deficiency is defined as:
- A serum ferritin < 30 ng/mL or transferrin saturation (TSAT) < 15% (obtained within the last 30 days).
- For members with functional iron deficiency or anemia of chronic disease: a serum ferritin >200 ng/mL and TSAT <20%.

DESCRIPTION

Iron is an essential component for the production of hemoglobin. Initial therapy for iron deficiency is an oral iron medication for a minimum of 1 months, while attempting to identify and correct the underlying cause. For uncomplicated iron deficiency without comorbidity, oral iron is readily available, inexpensive, effective, safe, and convenient. The benefit of treating iron deficiency before the development of anemia remains uncertain. Intravenous iron products provide supplemental iron, thereby increasing iron and ferritin levels while decreasing the total iron binding capacity. Intravenous iron products are used for the treatment of iron deficiency with or without anemia.

For those patients intolerant of oral iron, who are unable to absorb oral iron, who have increasing anemia despite adequate doses of oral iron, or with conditions where oral iron is likely to be ineffective or harmful, the
IV route is preferred. Parenteral iron therapy is as effective but somewhat more dangerous and considerably more expensive than oral therapy. Nevertheless, failure of oral therapy is to be expected in certain clinical situations. According to Wintrobe's Clinical Hematology (1999), a history of failure to respond to oral iron, however, is not by itself an indication for parenteral therapy. The reasons for failure must be analyzed.

GUIDELINES/INSTRUCTIONS

Iron infusion is considered medically necessary for members who have tried and failed a one-month trial of oral therapy and have any one of the following indications:

1. For members needing iron supplementation who are unable to tolerate compounds given orally (D50.9)
2. For members who are losing iron (blood) at a rate too rapid for oral intake to compensate for the loss (D50.0)
3. For members with a disorder of the gastrointestinal tract, such as inflammatory bowel disease (ulcerative colitis and Crohn's disease), in which symptoms may be aggravated by oral iron therapy (K50.—through K52.—)
4. For members who are incapable of accepting or following instructions for oral iron supplementation
5. For members with iron deficiency and chemotherapy-induced anemia (D64.81)
6. For members with heart failure and iron deficiency with or without anemia (I30-I52)
7. For members with iron deficiency following gastric bypass surgery and/or subtotal gastric resection and who exhibited decreased absorption of oral iron. (D50.8)

Iron infusion is considered experimental and investigational for all other indications.

CODING

HCPCS codes covered when medical necessity criteria are met:

J1439  Injection, ferric carboxymaltose, 1 mg
J1443  Injection, ferric pyrophosphate citrate solution, 0.1mg of iron
J1750  Injection, iron dextran, 50 mg
J1756  Injection, iron sucrose, 1 mg
J2916  Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg
Q0138  Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)

REFERENCES

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<tr>
<td>3/16/21</td>
<td>Tamar Springel</td>
<td>Annual review</td>
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