

# Feraheme® (ferumoxytol injection)

## (Intravenous)

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### I. Length of Authorization

Coverage will be provided for 35 days.

### II. Dosing Limits

**Max Units (per dose and over time) [HCPCS Unit]:**

- Q0138 (non-ESRD): 1020 billable units per 28 days
- Q0139 (ESRD on dialysis): 1020 billable units per 28 days

### III. Initial Approval Criteria <sup>1-14</sup>

Coverage is provided in the following conditions:

- Patient must have a contraindication, intolerance, or failure to **Ferrlecit®**, **INFeD®**, OR **Venofer®** prior to consideration of Feraheme®; **AND**
- must be at least 18 years of age; **AND**
- Other causes of anemia (e.g., vitamin B-12 deficiency, thalassemia, sideroblastic anemia, etc.) have been ruled out; **AND**
- Patient does not have a history of allergic reaction to any intravenous iron product; **AND**
- Other supplemental iron is to be discontinued prior to administration of ferumoxytol; **AND**
- Patient is not anticipated to require magnetic resonance imaging (MRI) during the 3-month period following the last ferumoxytol dose as it is known to alter these imaging studies; **AND**
- Laboratory values must be obtained within 28 days prior to the anticipated date of administration; **AND**

#### **Iron Deficiency Anemia due to Chronic Kidney Disease (CKD) † <sup>1,5-7,14-15</sup>**

- Patient has a transferrin saturation (TSAT)  $\leq 30\%$  AND ferritin is  $\leq 500$  ng/mL; **AND**
  - Patient is hemodialysis-dependent (HDD-CKD); **AND**
    - Patient has a hemoglobin (Hb)  $< 11.5$  g/dL; **OR**
  - Patient is not receiving dialysis (NDD-CKD); **AND**
    - Patient has a hemoglobin (Hb)  $< 11$  g/dL

## Iron Deficiency Anemia in patients intolerant to or who have had unsatisfactory response to oral iron †<sup>1,4</sup>

- Patient had an intolerance or inadequate response to a minimum of 14 days of oral iron; **AND**
- Patient has iron-deficiency anemia with a Hemoglobin (Hb) < 12 g/dL for females or < 14 g/dL for males; **AND**
  - Patient has a transferrin saturation (TSAT) ≤ 20%; **OR**
  - Patient has a ferritin ≤ 100 ng/mL

## Cancer- and Chemotherapy-Induced Anemia ‡<sup>11,12</sup>

- Used as a single agent; **AND**
  - Patient has absolute iron deficiency defined as ferritin < 30 ng/mL AND a TSAT < 20%; **OR**
  - Patient has functional iron deficiency defined as ferritin > 500 – 800 ng/mL AND a TSAT < 50% with the goal of avoiding allogenic transfusion; **OR**
- Used in combination with erythropoiesis-stimulating agents (ESAs); **AND**
  - Patient has absolute iron deficiency defined as ferritin < 30 ng/mL AND a TSAT < 20% and failed to demonstrate an increase in Hb after 4 weeks of IV or oral iron therapy; **OR**
  - Patient has functional iron deficiency defined as ferritin 30 – 500 ng/mL AND a TSAT < 50% and is receiving myelosuppressive chemotherapy without curative intent

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓢ Orphan Drug

## IV. Renewal Criteria<sup>1-14</sup>

Refer to initiation criteria.

## V. Dosage/Administration<sup>1,11,12,16</sup>

Indication	Dose
Cancer- and Chemotherapy-Induced Anemia	Administer 510 mg dose intravenously followed by a second 510 mg dose intravenously 3 to 8 days later <b>OR</b> Administer 1020 mg single dose intravenously
All other indications	Administer 510 mg dose intravenously followed by a second 510 mg dose intravenously 3 to 8 days later <ul style="list-style-type: none"><li>• Evaluate response at least one month following the second infusion</li></ul>

## VI. Billing Code/Availability Information

HCPCS Code(s):

- Q0138: Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD); 1 billable unit = 1 mg
- Q0139: Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis); 1 billable unit = 1 mg

NDC:

- Feraheme 510 mg/17 mL single-dose vial\*: 59338-0775-xx  
\*Available generically

## VII. References

1. Feraheme [package insert]. Waltham, MA; AMAG Pharmaceuticals, Inc. June 2022. Accessed March 2025.
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11. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) ferumoxytol. National Comprehensive Cancer Network, 2025. The NCCN

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12. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Hematopoietic Growth Factors 1.2025. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc.” To view the most recent and complete version of the Guidelines, go online to NCCN.org. Accessed March 2025.
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14. Macdougall IC, Strauss WE, McLaughlin J, Li Z, et al. A randomized comparison of ferumoxytol and iron sucrose for treating iron deficiency anemia in patients with CKD. Clin J Am Soc Nephrol. 2014;9(4):705-712. doi: 10.2215/CJN.05320513.
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## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D50.0	Iron deficiency anemia secondary to blood loss (chronic)
D50.1	Sideropenic dysphagia
D50.8	Other iron deficiency anemias
D50.9	Iron deficiency anemia, unspecified
D63.0	Anemia in neoplastic disease
D63.1	Anemia in chronic kidney disease
D63.8	Anemia in other chronic disease classified elsewhere
D64.81	Anemia due to antineoplastic chemotherapy
Z51.11	Encounter for antineoplastic chemotherapy
Z51.89	Encounter for other specified aftercare

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents:

<https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

<b>Medicare Part B Administrative Contractor (MAC) Jurisdictions</b>		
<b>Jurisdiction</b>	<b>Applicable State/US Territory</b>	<b>Contractor</b>
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC