JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS175
		Effective Date	04/17/2024
		Approval Date	04/17/2024
	Subject **Jesduvroq**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Jesduvroq

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I. POLICY

A. Jesduvroq (daprodustat) will require prior authorization to ensure it is used only when clinically appropriate. The process for initiating a prior authorization request can be found in policy PHARM 20.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. **Jesduvroq** may be approved for patients who meet the following:
   1. Patient is 18 years of age or older
   2. Documentation has been submitted showing the following:
      a. Diagnosis of anemia due to chronic kidney disease (CKD)
      b. Patient has been receiving dialysis for at least four months
      c. Patient meet one of the following:
         I. Patient is not currently being treated with an Erythropoiesis-Stimulating Agent (ESA) and has a baseline hemoglobin level less than 11 g/dL
         II. Patient is being switched from a current ESA regimen [such as Epogen, Procrit, Retacrit, Aranesp, or Mircera] and has an on-treatment hemoglobin level of less than or equal to 12.0 g/dL
      d. Patient is receiving iron supplementation therapy, or has been documented to have adequate iron stores to support therapy
   3. Prescriber is, or has consulted with, a nephrologist

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be restricted to 12 months of therapy.
B. Approval for continuation of therapy can be extended in 12-month intervals with clinical documentation supporting that the patient has had a beneficial response to treatment.

IV. EXCLUSIONS

A. Jesduvroq will not be approved for the following:
   1. Pediatric patients
   2. Patients with severe hepatic impairment (Child-Pugh Class C)
   3. Patients with uncontrolled hypertension
   4. Patients that are not on dialysis
   5. Concurrent use with strong cytochrome P450 2C8 (CYP2C8) inhibitors (such as gemfibrozil)
   6. As a substitute for transfusion in patients requiring immediate correction of anemia
   7. Any indications or uses that are not FDA-approved or guideline-supported

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. RECOMMENDED DOSE

A. Please refer to the FDA-approved prescribing information for indication-specific dosing details.

VI. REFERENCES

1. Jesduvroq [prescribing information]. Durham, NC: GlaxoSmithKline; August 2023.

VII. APPROVALS

Signature on file at JHHP

DATE OF REVISION	SUMMARY OF CHANGE
04/17/2024	Policy Creation

Review Date: 04/17/2024

Revision Date: