Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Jesduvroq (daprodustat)**

Effective: December 9, 2025

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Jesduvroq (daprodustat) is a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor indicated for the treatment of anemia due to chronic kidney disease in adults who have been receiving dialysis for at least four months.

Not shown to improve quality of life, fatigue, or patient well-being.

Not indicated for use as a substitute for red blood cell transfusions in patients requiring immediate correction of anemia, or for treatment of anemia in chronic kidney disease in patients who are not on dialysis.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Jesduvroq for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of anemia due to chronic kidney disease

AND

2. Documentation the patient has been receiving dialysis for at least four months prior to treatment initiation with Jesduvroq

AND

3. Patient is 18 years of age or older

AND

4. Documentation patient is hyporesponsive to erythropoiesis-stimulating agent therapy, defined as a hemoglobin level between 8.0 to 11.5 g/dL following treatment with either of epoetin alfa or darbepoetin

AND

5. Documentation of adequate iron stores (serum ferritin greater than or equal to 100 mcg/mL or serum transferrin saturation greater than or equal to 20% within the prior three months, or currently receiving iron therapy)

Reauthorization Criteria

1. Documented diagnosis of anemia due to chronic kidney disease

AND

2. Patient is 18 years of age or older

AND

3. Documentation the patient has experienced a therapeutic response as defined by an increase in hemoglobin from baseline

Limitations

1. Initial approval of Jesduvroq will be authorized for six (6) months. Reauthorization of Jesduvroq will be provided in 12-month intervals.
2. Members new to plan stable on Jesduvroq should be reviewed against Reauthorization Criteria.

3. For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

Codes

None

References

1. Jesduvroq (daprodustat) [prescribing information]. Durham, NC: GlaxoSmithKline.; August 2023.
2. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. 2012. https://kdigo.org/guidelines/anemia-in-ckd/.

Approval And Revision History

November 14, 2023: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- November 12, 2024: No changes.
- December 9, 2025: No changes.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.