

Clinical Policy: Paricalcitol Injection (Zemplar)

Reference Number: CP.PHAR.270

Effective Date: 08.01.16

Last Review Date: 08.25

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Paricalcitol (Zemplar[®]) is a synthetically manufactured active vitamin D₂ analog.

FDA Approved Indication(s)

Paricalcitol injection (Zemplar) is indicated for the prevention and treatment of secondary hyperparathyroidism (HPT) in patients 5 years of age and older with chronic kidney disease (CKD) on dialysis.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Zemplar and paricalcitol injection are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Secondary Hyperparathyroidism in Chronic Kidney Disease (must meet all):

1. Diagnosis of secondary HPT due to CKD;
 2. Prescribed by or in consultation with a nephrologist or endocrinologist;
 3. Age \geq 5 years;
 4. Member is on dialysis;
 5. One of the following (a or b):
 - a. Lab results over the previous 3-6 months show trending increase in iPTH level;
 - b. Current (within the last 30 days) labs show iPTH above the normal levels;
 6. For brand Zemplar requests, member must use generic paricalcitol, unless contraindicated or clinically significant adverse effects are experienced;
 7. Failure of generic doxercalciferol injection at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
- *For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
8. Paricalcitol is not prescribed concurrently with other vitamin D derivatives/analog (e.g., doxercalciferol);
 9. Dose does not exceed 0.24 mcg/kg every other day.

Approval duration:

Medicaid/HIM – 6 months

Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Approval

A. Secondary Hyperparathyroidism in Chronic Kidney Disease (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy as evidenced by a decrease in iPTH;
3. Paricalcitol is not prescribed concurrently with other vitamin D derivatives/analogues (e.g., doxercalciferol);
4. For brand Zemplar requests, member must use generic paricalcitol, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, new dose does not exceed 0.24 mcg/kg every other day.

Approval duration:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

B. Other diagnoses/indications (1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CKD: chronic kidney disease

FDA: Food and Drug Administration

HPT: hyperparathyroidism

iPTH: intact parathyroid hormone

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
doxercalciferol (Hectorol [®]) injection	4 mcg/day IV 3 times weekly; may increase at 8-week intervals by 1 mcg to 2 mcg if intact PTH is not lowered by 50% and fails to reach the target range	18 mcg/week

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypercalcemia, vitamin D toxicity, hypersensitivity to paricalcitol or any of the inactive ingredients in Zemlar
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Secondary HPT in CKD	<u>Adults:</u> Initial: 0.04 mcg/kg to 0.1 mcg/kg (2.8 – 7 mcg) administered as a bolus dose no more frequently than every other day at any time during dialysis. The dose may be increased by 2 to 4 mcg at 2- to 4- week intervals.	Adults: 0.24 mcg/kg Pediatric: see dosing regimen

Indication	Dosing Regimen	Maximum Dose
	<p><u>Pediatric age ≥ 5 years:</u> Initial: 0.04 mcg/kg if baseline intact PTH is < 500 pg/mL, or 0.08 mcg/kg if baseline intact PTH is ≥ 500 pg/mL administered three times per week, no more frequently than every other day, at any time during dialysis. The dose may be increased by 0.04 mcg/kg at 2- to 4- week intervals.</p>	

VI. Product Availability

- Single-dose vials for injection: 2 mcg/mL, 5 mcg/mL
- Multiple-dose vial for injection: 10 mcg/2 mL

VII. References

1. Zemplar Injection Prescribing Information. North Chicago, IL: AbbVie Inc.; November 2018. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/020819s030lbl.pdf. Accessed April 14, 2025.
2. Hectorol Prescribing Information. Cambridge, MA: Genzyme Corporation; April 2023. Available at https://products.sanofi.us/hectorol_injection/hectorol_injection.pdf. Accessed April 14, 2025.
3. Kidney Disease: Improving Global Outcomes (KDIGO) CKD–MBD Work Group. KDIGO 2017 clinical practice guideline update for the diagnosis, evaluation, prevention, and treatment of chronic kidney disease–mineral and bone disorder (CKD–MBD). *Kidney International Supplements* 2017; 7:1–59. Available at: <http://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf>.
4. Shroff R, Wan M, Nagler EV, et al. Clinical practice recommendations for treatment with active vitamin D analogues in children with chronic kidney disease stages 2-5 and on dialysis. *Nephrol Dial Transplant* 2017;32:1114-27.
5. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Truven Health Analytics. Updated periodically. Accessed April 29, 2025.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2501	Injection, paricalcitol, 1 mcg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2021 annual review: no significant changes; added redirection for brand Zemplar requests to generic paricalcitol to both initial and continued therapy sections; references reviewed and updated.	05.10.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.17.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.20.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.11.23	08.23
Replaced redirection to IV calcitriol with redirection to IV doxercalciferol since IV calcitriol is no longer commercially available.	09.15.23	02.24
3Q 2024 annual review: no significant changes; references reviewed and updated.	05.10.24	08.24
3Q 2025 annual review: revised Commercial approval duration to 6 months or member’s renewal date, whichever is longer; added reference to generic in Policy/Criteria description; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	06.26.25	08.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene[®] and Centene Corporation[®] are registered trademarks exclusively owned by Centene Corporation.