

# Medicare Part B Step Therapy Programs

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[Instructions for Use](#)

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## Medicare Advantage Medical Policy

- [Medications/Drugs \(Outpatient/Part B\)](#)

## Application

This policy is applicable to most UnitedHealthcare Medicare Advantage plans offered by UnitedHealthcare and its affiliates. Refer to the **Plan Exceptions** below:

Plan Type	Excluded Plans
Non-Employer Group Medicare Advantage	<ul style="list-style-type: none"> <li>UnitedHealthcare Medicare Direct (Private Fee-For-Service, PFFS): H5435-001, H5435-024</li> <li>Certain UnitedHealthcare Dual Complete and Dual Choice plans: <ul style="list-style-type: none"> <li>Arizona: H0321-004</li> <li>District of Columbia: H2406-053, H7464-010</li> <li>Florida: H1045-063, H1045-065, H1889-026, H2509-001, H2509-003, H5420-016</li> <li>Hawaii: H6824-002</li> <li>Idaho: H4032-001</li> <li>Indiana: H2385-003, H2385-004</li> <li>Massachusetts: H2226-001, H2226-003, H4610-001, H4610-002</li> <li>Michigan: H2247-005</li> <li>New Jersey: H3113-005</li> <li>New Mexico: H0294-049</li> <li>New York: H3387-013</li> <li>Tennessee: H0251-004, H0251-008</li> <li>Texas: H3868-001</li> <li>Virginia: H0421-001, H2445-001, H2445-003, H2445-005</li> </ul> </li> </ul>
Employer Group Medicare Advantage	<ul style="list-style-type: none"> <li>All Group HMO plans</li> <li>Select Group PPO plans: <ul style="list-style-type: none"> <li>Bristol-Myers Squibb: H2001-869</li> <li>Johnson &amp; Johnson: H2001-869</li> <li>Kenvue: H2001-869</li> <li>United Auto Workers (UAW) Trust: H1537-869, H2001-870, H2001-850</li> <li>U.S. Government of the Virgin Islands (USGVI): H1537-868, H2001-859, H2001-868, H2001-896, H2001-897</li> <li>Verizon: H2001-869</li> </ul> </li> </ul>

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.

## Coverage Rationale

➔ See [Benefit Considerations](#)

This policy supplements Medicare NCDs, LCDs, and manuals for the purpose of determining coverage under Medicare Part B benefits. A member cannot be required under this policy to change a current drug/product. For the purposes of this policy, a current drug/product means the member has a paid claim for the drug/product within the past 365 days. For example, a new UnitedHealthcare plan member with claim history of a particular drug/product will not be required to switch to the preferred drug/product upon enrollment. Similarly, an existing UnitedHealthcare plan member with paid claims for a particular drug/product will not be required to change drugs/products in the event this policy is updated.

This policy applies to step therapy for the drugs/products in the tables below. Drugs/products must satisfy the step therapy criteria in this policy and, if approved, authorization will be provided for 12 months.

If a provider administers a non-preferred drug/product without obtaining prior authorization, UnitedHealthcare may deny claims for the non-preferred drug/product.

Classes of Medical Benefit Injectables		Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
<a href="#">Antiemetics for Oncology</a> [Neurokinin 1 Receptor Antagonist (NK1 RA), 5-hydroxytryptamine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA combination]		Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, Ondansetron	Akynzeo, Cinvanti, Focinvez, Posfrea, Sustol
<a href="#">Asthma Immunomodulators – Respiratory Interleukins</a>		Fasenra, Nucala	Cinqair
<a href="#">Bevacizumab</a>		Alymsys, Mvasi, Zirabev	Avastin, Avzivi, Jobevne, Vegzelma
<a href="#">Bone Density Agents – Oncology</a>		Jubbonti, Osenvelt, Prolia, Stoboclo, Wyost, Xgeva	Bomyntra, Conexence
<a href="#">Bone Density Agents – Osteoporosis</a>		Jubbonti, Prolia, Stoboclo	Conexence, Evenity
<a href="#">Botulinum Toxins A and B</a>		Botox, Xeomin	Daxxify, Dysport, Myobloc
<a href="#">Colony Stimulating Factors</a>	<a href="#">Short Acting</a>	Zarxio	Granix, Neupogen, Nivestym, Nypozi, Releuko
	<a href="#">Long Acting</a>	Neulasta, Fulphila, Udenyca	Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo
<a href="#">Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH)</a>		Bkemv, Epysqli, Soliris, Ultomiris	PiaSky
<a href="#">Gemcitabine</a>		Gemcitabine (HCPCS codes J9196 and J9201)	Avgemsi
<a href="#">Gonadotropin Releasing Hormone Analogs for Oncology</a>		HCPCS codes J1954 and J9217 (leuprolide acetate, 7.5mg)	HCPCS code J1950 (leuprolide acetate, 3.75mg)
<a href="#">Gout Agents</a> Non-Employer Group MAPD Plans only		Allopurinol, Febuxostat	Krystexxa
<a href="#">Hyaluronic Acid Polymers</a>		Durolane, Gelsyn-3, Synvisc, Synvisc-One	Euflexxa, Gel-One, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Supartz Fx, Synjojoynt, Triluron, TriVisc, Visco-3
<a href="#">Immune Globulins</a>		Bivigam, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Privigen, Xembify	Alyglo, Asceniv, Cutaquig, Panzyga, Yimmugo

<b>Classes of Medical Benefit Injectables</b>	<b>Preferred Drug(s)/Product(s)</b>	<b>Non-Preferred Drug(s)/Product(s)</b>
<a href="#"><u>Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG)</u></a>	Bkemv, Epysqli, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo	Imaavy, Rystiggo
<a href="#"><u>Inflammatory Bowel Disease Agents</u></a>	Entyvio, Steqeyma, Yesintek	Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, Wezlana
<a href="#"><u>Infliximab</u></a>	Avsola, Inflectra, Renflexis	Infliximab, Remicade
<a href="#"><u>Intravenous Iron Replacement Therapy</u></a>	Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Venofer (iron sucrose)	Injectafer, Monoferic
<a href="#"><u>Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Neovascular (Wet) Age-Related Macular Degeneration</u></a>	Repackaged Avastin, then Eylea or Eylea HD or Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo
<a href="#"><u>Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Retinal Conditions Other Than Neovascular (Wet) Age-Related Macular Degeneration</u></a>	Eylea, Eylea HD, Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo
<a href="#"><u>Irinotecan – Pancreatic Cancer</u></a>	Camptosar, generic Irinotecan products (HCPCS code J9206)	Onivyde
<a href="#"><u>Leucovorin/Levoleucovorin</u></a>	Leucovorin	Fusilev, Khapzory, Levoleucovorin
<a href="#"><u>Lipid Modifying Agents</u></a> Non-Employer Group MAPD plans only	Praluent, Repatha	Leqvio
<a href="#"><u>Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists</u></a> Non-Employer Group MAPD plans only	Aimovig, Ajovy, Emgality	Vyepti
<a href="#"><u>Multiple Sclerosis Agents</u></a>	Ocrevus, Ocrevus Zunovo	Briumvi
<a href="#"><u>Pemetrexed</u></a>	Alimta, generic Pemetrexed products (J9294, J9296, J9297, J9305, J9314)	Axtle, Pemfexy, Pemrydi RTU
<a href="#"><u>Rituximab</u></a>	Riabni, Ruxience, Truxima	Rituxan, Rituxan Hycela
<a href="#"><u>Systemic Lupus Erythematosus Agents</u></a>	Benlysta	Saphnelo
<a href="#"><u>Tocilizumab</u></a>	Tofidence, Tyenne	Actemra, Avtozma
<a href="#"><u>Trastuzumab</u></a>	Kanjinti, Ogivri, Trazimera	Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Ontruzant

<b>Classes of Medical Benefit Injectables</b>	<b>Indication(s)</b>	<b>Preferred Drug(s)/Product(s)</b>	<b>Non-Preferred Drug(s)/Product(s)</b>
<a href="#"><u>Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1)</u></a>	<a href="#"><u>Head and Neck Cancers: Cancer of the Nasopharynx, Recurrent, Unresectable, Oligometastatic, or Metastatic Disease</u></a>	Loqtorzi	Keytruda, Opdivo, Opdivo Qvantig, Tevimbra
	<a href="#"><u>Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive ≥ 50%</u></a>	Keytruda, Libtayo, Tecentriq, Tecentriq Hybreza	Opdivo plus Yervoy
<a href="#"><u>Bispecific T-Cell Engaging (BiTE) Antibody</u></a>	Multiple Myeloma	Tecvayli	Elrexfio

## Antiemetics for Oncology [Neurokinin 1 Receptor Antagonist (NK1 RA), 5-Hydroxytryptamine Receptor Antagonist (5HT<sub>3</sub> RA), NK1 RA/5HT<sub>3</sub> RA Combination] [Akynzeo, Aloxi (palonosetron), Cinvanti, Emend (fosaprepitant), Focinvez, Granisetron, Ondansetron, Posfrea, Sustol]

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, Ondansetron	Akynzeo, Cinvanti, Focinvez, Posfrea, Sustol

### Non-Preferred Product Step Therapy Criteria

Akynzeo, Cinvanti, Focinvez, Posfrea, or Sustol, may be covered when any of the criteria listed below are satisfied:

- History of use of Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, or Ondansetron resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, or Ondansetron; **or**
- Continuation of prior therapy within the past 365 days.

## Asthma Immunomodulators – Respiratory Interleukins (Cinqair, Fasenra, Nucala)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Fasenra, Nucala	Cinqair

### Non-Preferred Product Step Therapy Criteria

Cinqair, when used for the treatment of severe asthma, may be covered when any of the criteria listed below are satisfied:

- History of use of Fasenra or Nucala resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Fasenra or Nucala; **or**
- Continuation of prior therapy within the past 365 days.

## Bevacizumab (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev) – Oncology Uses Only

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Alymsys, Mvasi, Zirabev	Avastin, Avzivi, Jobevne, Vegzelma

### Non-Preferred Product Step Therapy Criteria

Avastin, Avzivi, Jobevne, or Vegzelma, when prescribed for a cancer condition, may be covered when any of the criteria listed below are satisfied:

- History of use of Alymsys, Mvasi or Zirabev resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Alymsys, Mvasi or Zirabev; **or**
- Continuation of prior therapy within the past 365 days.

## Bone Density Agents – Oncology (Bomyntra, Conexence, Jubbonti, Osenvelt, Prolia, Stoboclo, Wyost, Xgeva)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Jubbonti, Osenvelt, Prolia, Stoboclo, Wyost, Xgeva	Bomyntra, Conexence

### Bomyntra Non-Preferred Product Step Therapy Criteria

Bomyntra, when used for treatment of the following conditions, may be covered when any of the criteria listed below are satisfied:

- Conditions**
  - Prevention of skeletal related events in patients with multiple myeloma
  - Prevention of skeletal related events in patients with bone metastases from solid tumors
  - Hypercalcemia of malignancy
  - Osteopenia/osteoporosis in patients with systemic mastocytosis with bone pain

- **Criteria**

- History of use of Osenvelt, Wyost, or Xgeva resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to Osenvelt, Wyost, or Xgeva; **or**
- Continuation of prior therapy within the past 365 days.

### ***Conexxence Non-Preferred Product Step Therapy***

**Conexxence may be covered when any of the criteria listed below are satisfied:<sup>9</sup>**

- History of use of Jubbonti, Prolia, or Stoboclo resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to Jubbonti, Prolia, or Stoboclo; **or**
- Continuation of prior therapy within the past 365 days.

### **Bone Density Agents – Osteoporosis (Conexxence, Evenity, Jubbonti, Prolia, Stoboclo)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Jubbonti, Prolia, Stoboclo	Conexxence, Evenity

### ***Non-Preferred Product Step Therapy Criteria***

**Conexxence or Evenity may be covered when any of the criteria listed below are satisfied:**

- History of use of Jubbonti, Prolia, or Stoboclo resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to Jubbonti, Prolia, or Stoboclo; **or**
- Continuation of prior therapy within the past 365 days.

### **Botulinum Toxins A and B (Botox, Daxxify, Dysport, Myobloc, Xeomin)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Botox, Xeomin	Daxxify, Dysport, Myobloc

### ***Non-Preferred Product Step Therapy Criteria***

**Daxxify, Dysport, and Myobloc may be covered when any of the criteria listed below are satisfied:**

- History of use of Botox or Xeomin resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Botox or Xeomin; **or**
- Continuation of prior therapy within the past 365 days.

### **Colony Stimulating Factors**

#### ***Short-Acting (Granix, Neupogen, Nivestym, Nypozi, Releuko, Zarxio)***

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Zarxio	Granix, Neupogen, Nivestym, Nypozi, Releuko

### ***Non-Preferred Product Step Therapy Criteria***

**Granix, Neupogen, Nivestym, Nypozi, or Releuko may be covered when any of the criteria listed below are satisfied:**

- History of use of Zarxio resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Zarxio; **or**
- Continuation of prior therapy within the past 365 days.

#### ***Long-Acting (Fulphila, Fylnetra, Neulasta, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca, Ziextenzo)***

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Fulphila, Neulasta, Udenyca	Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo

### ***Non-Preferred Product Step Therapy Criteria***

**Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, or Ziextenzo may be covered when any of the criteria listed below are satisfied:**

- History of use of Fulphila, Neulasta, or Udenyca, resulting in minimal clinical response to therapy; **or**

- History of intolerance or adverse event(s) to Fulphila, Neulasta, or Udenyca; **or**
- Continuation of prior therapy within the past 365 days.

### **Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH) (Bkemv, Epysqli, PiaSky, Soliris, Ultomiris)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bkemv, Epysqli, Soliris, Ultomiris	PiaSky

#### ***Non-Preferred Product Step Therapy Criteria***

**PiaSky may be covered when any of the criteria listed below are satisfied:**

- History of use of Bkemv, Epysqli, Soliris, or Ultomiris resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Bkemv, Epysqli, Soliris, or Ultomiris; **or**
- Continuation of prior therapy within the past 365 days.

### **Gemcitabine (Avgems, Gemcitabine)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Gemcitabine (HCPCS codes J9196 and J9201)	Avgems

#### ***Non-Preferred Product Step Therapy Criteria***

**Avgems may be covered when any of the criteria listed below are satisfied:**

- History of use of Gemcitabine (HCPCS codes J9196 and J9201) resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Gemcitabine (HCPCS codes J9196 and J9201); **or**
- Continuation of prior therapy within the past 365 days.

### **Gonadotropin Releasing Hormone Analogs for Oncology (Leuprolide Acetate)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
HCPCS code J1954 [leuprolide acetate (lutrate depot), per 7.5mg], HCPCS code J9217 (leuprolide acetate, per 7.5mg)	HCPCS code J1950 (leuprolide acetate, per 3.75mg)

#### ***Non-Preferred Product Step Therapy Criteria***

**HCPCS code J1950 (leuprolide acetate, per 3.75mg) may be covered when the criteria listed below are satisfied:**

- Continuation of prior therapy within the past 365 days.

### **Gout Agents (Allopurinol, Febuxostat, Krystexxa) – Non-Employer Group MAPD Plans Only**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Allopurinol, Febuxostat	Krystexxa

#### ***Non-Preferred Product Step Therapy Criteria***

**Krystexxa may be covered when any of the criteria listed below are satisfied:**

- Both of the following:
  - Trial of at least 3 months of therapy (at the maximally medically appropriate dose) of Allopurinol resulting in minimal clinical response to therapy; **and**
  - Trial of at least 3 months of therapy (at the maximally medically appropriate dose) of Febuxostat resulting in minimal clinical response to therapy
- or**
- History of contraindication, intolerance or adverse event(s) to Allopurinol **and** Febuxostat; **or**
- Continuation of prior therapy within the past 365 days.



## Hyaluronic Acid Polymers (Durolane, Euflexxa, Gel-One, Gelsyn-3, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Supartz Fx, Synjoynt, Synvisc, Synvisc-One, Visco-3, Triluron, TriVisc)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Durolane, Gelsyn-3, Synvisc, Synvisc-One	Euflexxa, Gel-One, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Supartz Fx, Synjoynt, Triluron, TriVisc, Visco-3

### ***Non-Preferred Product Step Therapy Criteria***

Euflexxa, Gel-One, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Supartz FX, Synjoynt, Triluron, TriVisc, or Visco-3 may be covered when any of the criteria listed below are satisfied:

- Trial and failure of **all** of the following: Durolane, Gelsyn-3, **and** Synvisc/Synvisc-One, resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to **all** of the following: Durolane, Gelsyn-3, **and** Synvisc/Synvisc-One; **or**
- Continuation of prior therapy within the past 365 days.

## Immune Globulins (Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Panzyga, Privigen, Xembify, Yimmugo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bivigam, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Privigen, Xembify	Alyglo, Asceniv, Cutaquig, Panzyga, Yimmugo

### ***Non-Preferred Product Step Therapy Criteria***

Alyglo, Asceniv, Cutaquig, Panzyga, or Yimmugo may be covered when any of the criteria listed below are satisfied:

- History of use of at least **two** preferred Immune Globulin products (either IV or SC products), resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to at least **two** preferred Immune Globulin products (either IV or SC products); **or**
- Continuation of prior therapy within the past 365 days.

## Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG) (Bkemv, Epysqli, Imaavy, Rystiggo, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bkemv, Epysqli, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo	Imaavy, Rystiggo

### ***Non-Preferred Product Step Therapy Criteria***

Imaavy or Rystiggo may be covered when any of the criteria listed below are satisfied:

- History of use of **two** of the following resulting in minimal clinical response to therapy; **or**
  - Bkemv
  - Epysqli
  - Soliris
  - Ultomiris
  - Vyvgart
  - Vyvgart Hytrulo
- History of intolerance or adverse event(s) to **two** of the following; **or**
  - Bkemv
  - Epysqli
  - Soliris
  - Ultomiris
  - Vyvgart
  - Vyvgart Hytrulo

- Patient is anti-MuSK antibody positive (with medical records showing a positive serologic test for anti-MuSK antibodies); **or**
- Continuation of prior therapy within the past 365 days.

### **Inflammatory Bowel Disease Agents (Entyvio, Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, Wezlana, Yesintek)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Entyvio, Steqeyma, Yesintek	Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, Wezlana

#### ***Non-Preferred Product Step Therapy Criteria***

**Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, or Wezlana may be covered when any of the criteria listed below are satisfied:**

- History of use of **two** of the following resulting in minimal clinical response to therapy; **or**
  - Entyvio
  - Steqeyma
  - Yesintek
- History of intolerance or adverse event(s) to two of the following; **or**
  - Entyvio
  - Steqeyma
  - Yesintek
- Continuation of prior therapy within the past 365 days.

### **Infliximab (Avsola, Inflectra, Infliximab, Remicade, Renflexis)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Avsola, Inflectra, Renflexis	Infliximab, Remicade

#### ***Non-Preferred Product Step Therapy Criteria***

**Infliximab or Remicade may be covered when any of the criteria listed below are satisfied:**

- Trial of at least 14 weeks of Avsola, Inflectra, or Renflexis resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Avsola or Inflectra or Renflexis; **or**
- Continuation of prior therapy within the past 365 days.

### **Intravenous Iron Replacement Therapy [Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Injectafer, Monoferic, Venofer (iron sucrose)]**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Venofer (iron sucrose)	Injectafer, Monoferic

#### ***Non-Preferred Product Step Therapy Criteria***

**Injectafer or Monoferic may be covered for iron deficiency anemia without chronic kidney disease and iron deficiency anemia associated with chronic kidney disease (without End Stage Renal Disease) when any of the criteria listed below are satisfied:**

- Trial of at least 3 weeks of therapy, to at least **two** of the preferred intravenous iron therapies each, resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to at least **two** of the preferred intravenous iron therapies; **or**
- Continuation of prior therapy within the past 365 days.



## Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Neovascular (Wet) Age-Related Macular Degeneration (Repackaged Avastin, Beovu, Byooviz, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, Vabysmo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Repackaged Avastin, then Eylea or Eylea HD or Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

### Step Therapy Criteria

#### Eylea, Eylea HD, Pavblu

Eylea, Eylea HD, or Pavblu when prescribed for Neovascular (Wet) Age-Related Macular Degeneration, may be covered when any of the criteria listed below are satisfied:

- History of a trial of at least 3 consecutive doses given monthly, resulting in minimal clinical response to repackaged Avastin (bevacizumab); **or**
- History of contraindication or adverse event(s) to repackaged Avastin (bevacizumab); **or**
- Continuation of prior therapy within the past 365 days.

#### Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo, when prescribed for Neovascular (Wet) Age-Related Macular Degeneration, may be covered when any of the criteria listed below are satisfied:

- Both of the following:
  - Trial of at least 3 consecutive doses given monthly, resulting in minimal clinical response to repackaged Avastin (bevacizumab); **and**
  - History of use of **one** of the following, resulting in minimal clinical response to therapy:
    - Eylea
    - Eylea HD
    - Pavblu**or**
- History of contraindication, intolerance, or adverse event(s) to repackaged Avastin (bevacizumab) **and one** of the following: Eylea, Eylea HD, Pavblu; **or**
- Continuation of prior therapy within the past 365 days.

## Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Retinal Conditions Other Than Neovascular (Wet) Age-Related Macular Degeneration (Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, Vabysmo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Eylea, Eylea HD, Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

### Non-Preferred Product Step Therapy Criteria

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo, when prescribed for a retinal condition other than Neovascular (Wet) Age-Related Macular Degeneration, may be covered when any of the criteria listed below are satisfied:

- History of use of **one** of the following, resulting in minimal clinical response to therapy: Eylea, Eylea HD, Pavblu; **or**
- History of contraindication or adverse event(s) to **one** of the following: Eylea, Eylea HD, Pavblu; **or**
- Continuation of prior therapy within the past 365 days.

## Irinotecan – Pancreatic Cancer (Camptosar, Irinotecan, Onivyde)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Camptosar, generic Irinotecan products (HCPCS code J9206)	Onivyde

### Non-Preferred Product Step Therapy Criteria

Onivyde, when prescribed for pancreatic cancer, may be covered when any of the criteria listed below are satisfied:

- History of use of Camptosar/generic Irinotecan resulting in minimal clinical response to therapy and residual disease activity; **or**

- History of intolerance or adverse event(s) to Camptosar/generic Irinotecan; **or**
- Continuation of prior therapy within the past 365 days.

### **Leucovorin/Levoleucovorin (Fusilev, Khapzory, Leucovorin, Levoleucovorin)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Leucovorin	Fusilev, Khapzory, Levoleucovorin

#### ***Non-Preferred Product Step Therapy Criteria***

**Fusilev, Khapzory, or Levoleucovorin may be covered when any of the criteria listed below are satisfied:**

- History of use of Leucovorin resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Leucovorin; **or**
- Continuation of prior therapy within the past 365 days.

### **Lipid Modifying Agents (Leqvio, Praluent, Repatha) (for Non-Employer Group MAPD Plans Only)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Praluent, Repatha	Leqvio

#### ***Non-Preferred Product Step Therapy Criteria***

**Leqvio may be covered when any of the criteria listed below are satisfied:**

- Trial of at least 12 consecutive weeks of either Praluent or Repatha, resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to Praluent or Repatha; **or**
- Continuation of prior therapy within the past 365 days.

### **Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (Aimovig, Ajovy, Emgality, Vyepti) (for Non-Employer Group MAPD Plans Only)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Aimovig, Ajovy, Emgality	Vyepti

#### ***Non-Preferred Product Step Therapy Criteria***

**Vyepti may be covered when any of the criteria listed below are satisfied:**

- Trial of at least 3 months of therapy each, to **two** of the preferred drugs (e.g. Aimovig, Emgality), resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to two of the preferred drugs (e.g. Aimovig, Emgality); **or**
- Continuation of prior therapy within the past 365 days.

### **Multiple Sclerosis Agents (Briumvi, Ocrevus, Ocrevus Zunovo)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Ocrevus, Ocrevus Zunovo	Briumvi

#### ***Non-Preferred Product Step Therapy Criteria***

**Briumvi may be covered when any of the criteria listed below are satisfied:**

- History of use of Ocrevus or Ocrevus Zunovo resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Ocrevus or Ocrevus Zunovo; **or**
- Continuation of prior therapy within the past 365 days.

### **Pemetrexed (Alimta, Axtle, Pemetrexed, Pemfexy, Pemrydi RTU)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Alimta, generic Pemetrexed products (J9294, J9296, J9297, J9305, J9314)	Axtle, Pemfexy, Pemrydi RTU

### ***Non-Preferred Product Step Therapy Criteria***

**Axtle, Pemfexy or Pemrydi RTU may be covered when any of the criteria listed below are satisfied:**

- History of use of Alimta/generic Pemetrexed resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Alimta/generic Pemetrexed; **or**
- Continuation of prior therapy within the past 365 days.

### **Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Riabni, Ruxience, Truxima	Rituxan, Rituxan Hycela

### ***Non-Preferred Product Step Therapy Criteria***

**Rituxan or Rituxan Hycela may be covered when any of the criteria listed below are satisfied:**

- History of use of Riabni, Ruxience, or Truxima resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Riabni, Ruxience, or Truxima; **or**
- Continuation of prior therapy within the past 365 days.

### **Systemic Lupus Erythematosus Agents (Benlysta, Saphnelo)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Benlysta	Saphnelo

### ***Non-Preferred Product Step Therapy Criteria***

**Saphnelo may be covered when any of the criteria listed below are satisfied:**

- History of use of Benlysta resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to Benlysta; **or**
- Continuation of prior therapy within the past 365 days.

### **Tocilizumab (Actemra, Avtozma, Tofidence, Tyenne)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Tofidence, Tyenne	Actemra, Avtozma

### ***Non-Preferred Product Step Therapy Criteria***

**Actemra or Avtozma may be covered when any of the criteria listed below are satisfied:**

- History of use of Tofidence or Tyenne resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to Tofidence or Tyenne; **or**
- Continuation of prior therapy within the past 365 days.

### **Trastuzumab (Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera)**

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Kanjinti, Ogivri, Trazimera	Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Ontruzant

### ***Non-Preferred Product Step Therapy Criteria***

**Herceptin, Herceptin Hylecta, Hercessi, Herzuma, or Ontruzant, when prescribed for a cancer condition, may be covered when any of the criteria listed below are satisfied:**

- History of use of Kanjinti, Ogivri, or Trazimera resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Kanjinti or Ogivri or Trazimera; **or**
- Continuation of prior therapy within the past 365 days.

## Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1)

### Head and Neck Cancers: Cancer of the Nasopharynx, Recurrent, Unresectable, Oligometastatic, or Metastatic Disease

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Loqtorzi	Keytruda, Opdivo, Opdivo Qvantig, Tevimbra

#### Non-Preferred Product Step Therapy Criteria

Keytruda, Opdivo, Opdivo Qvantig, or Tevimbra, when prescribed for nasopharyngeal carcinoma, may be covered when any of the criteria listed below are satisfied:

- History of use of Loqtorzi resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Loqtorzi; **or**
- Continuation of prior therapy within the past 365 days.

### Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive $\geq 50\%$

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Keytruda, Libtayo, Tecentriq, Tecentriq Hybreza	Opdivo plus Yervoy

#### Non-Preferred Product Step Therapy Criteria

Opdivo plus Yervoy, when prescribed for non-small cell lung cancer, may be covered when any of the criteria listed below are satisfied:

- History of use of Keytruda, Libtayo, Tecentriq, or Tecentriq Hybreza resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Keytruda, Libtayo, Tecentriq, or Tecentriq Hybreza; **or**
- Continuation of prior therapy within the past 365 days.

## Bispecific T-Cell Engaging (BiTE) Antibody – Multiple Myeloma

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Tecvayli	Elrexio

#### Non-Preferred Product Step Therapy Criteria

Elrexio, when prescribed for multiple myeloma, may be covered when any of the criteria listed below are satisfied:

- History of use of Tecvayli resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Tecvayli; **or**
- Continuation of prior therapy within the past 365 days.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

### Antiemetics for Oncology [Neurokinin 1 Receptor Antagonist (NK1 RA), 5-Hydroxytryptamine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA Combination] (Akynzeo [palonosetron], Aloxi, Cinvanti, Emend [fosaprepitant], Focinvez, Granisetron, Ondansetron, Posfrea, Sustol)

HPCS Code	Description
<b>Preferred</b>	
J1453	Injection, fosaprepitant, 1 mg

HCPCS Code	Description
<b>Preferred</b>	
J1456	Injection, fosaprepitant (teva), not therapeutically equivalent to j1453, 1 mg
J1626	Injection, granisetron hydrochloride, 100 mcg
J2405	Injection, ondansetron hydrochloride, per 1 mg
J2469	Injection, palonosetron HCl, 25 mcg
Q0162	Ondansetron 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q0166	Granisetron hydrochloride, 1 mg oral, FDA-approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen
<b>Non-Preferred</b>	
J0185	Injection, aprepitant, 1 mg
J1434	Injection, fosaprepitant (focinvez), 1 mg
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg
J1627	Injection, granisetron, extended-release, 0.1mg
J2468	Injection, palonosetron hydrochloride (avyxa), not therapeutically equivalent to j2469, 25 micrograms

### Asthma Immunomodulators – Respiratory Interleukins (Cinqair, Fasenra, Nucala)

HCPCS Code	Description
<b>Preferred</b>	
J0517	Injection, benralizumab, 1 mg
J2182	Injection, mepolizumab, 1 mg
<b>Non-Preferred</b>	
J2786	Injection, reslizumab, 1 mg

### Bevacizumb (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev)

HCPCS Code	Description
<b>Preferred</b>	
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
<b>Non-Preferred</b>	
J9035	Injection, bevacizumab, 10 mg
J9999	Not otherwise classified, antineoplastic drugs
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg

### Bone Density Agents – Oncology and Osteoporosis (Bomyntra, Conexxence, Evenity, Jubbonti, Osenvelt, Prolia, Stoboclo, Wyost, Xgeva)

HCPCS Code	Description
<b>Preferred</b>	
J0897	Injection, denosumab, 1 mg
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg
Q5157	Injection, denosumab-bmwo (Stoboclo/Osenvelt), biosimilar, 1 mg
<b>Non-Preferred</b>	
J3111	Injection, romosozumab-aqqg, 1 mg

HCPSC Code	Description
<b>Non-Preferred</b>	
Q5158	Injection, denosumab-bnht (bomynta/conexence), biosimilar, 1 mg

## Botulinum Toxins A and B (Botox, Daxxify, Dysport, Myobloc, Xeomin)

HCPSC Code	Description
<b>Preferred</b>	
J0585	Injection, onabotulinumtoxinA, 1 unit
J0588	Injection, incobotulinumtoxinA, 1 unit
<b>Non-Preferred</b>	
J0586	Injection, abobotulinumtoxinA, 5 units
J0587	Injection, rimabotulinumtoxinB, 100 units
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit

## Colony Stimulating Factors

### Short-Acting (Granix, Neupogen, Nivestym, Nypozi, Releuko, Zarxio)

HCPSC Code	Description
<b>Preferred</b>	
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio) 1 microgram
<b>Non-Preferred</b>	
J1442	Injection, filgrastim (G-CSF), (Neupogen) excludes biosimilars, 1 mcg
J1447	Injection, tbo-filgrastim, (Granix)1 microgram
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram
Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg
Q5148	Injection, filgrastim-txid (Nypozi), biosimilar, 1 mcg

### Long-Acting (Fulphila, Fylnetra, Neulasta, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca, Ziextenzo)

HCPSC Code	Description
<b>Preferred</b>	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg
Q5108	Injection, pegfilgrastim-jmdb (Fulphila), biosimilar, 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg
<b>Non-Preferred</b>	
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg
Q5120	Injection, pegfilgrastim-bmez, (Ziextenzo), biosimilar, 0.5 mg
Q5122	Injection, pegfilgrastim-apgf (Nyvepria), biosimilar, 0.5 mg
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg

## Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH) (Bkemv, Epysqli, Piasky, Soliris, Ultomiris)

HCPSC Code	Description
<b>Preferred</b>	
J1299	Injection, eculizumab, 2 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg



HCPSC Code	Description
<b>Preferred</b>	
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg
<b>Non-Preferred</b>	
J1307	Injection, crovalimab-akkz, 10 mg

### Gemcitabine (Avgemsi, Gemcitabine)

HCPSC Code	Description
<b>Preferred</b>	
J9196	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg
J9201	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg
<b>Non-Preferred</b>	
J9999	Not otherwise classified, antineoplastic drugs

### Gonadotropin Releasing Hormone Analogs for Oncology

HCPSC Code	Description
<b>Preferred</b>	
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
<b>Non-Preferred</b>	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg

### Gout Agents (Krystexxa)

HCPSC Code	Description
<b>Preferred</b>	
N/A	N/A
<b>Non-Preferred</b>	
J2507	Injection, pegloticase, 1 mg

### Hyaluronic Acid Polymers (Durolane, Euflexxa, Gel-One, Gelsyn-3, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Supartz Fx, Synjoynt, Synvisc, Synvisc-One, Visco-3, Triluron, TriVisc)

HCPSC Code	Description
<b>Preferred</b>	
J7318	Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
J7328	Hyaluronan or derivative, Gelsyn-3, for intra-articular injection, 0.1 mg
<b>Non-Preferred</b>	
J7320	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
J7329	Hyaluronan or derivative, TriVisc, for intra-articular injection, 1 mg
J7331	Hyaluronan or derivative, Synjoynt, for intra-articular injection, 1mg
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1mg

**Immune Globulins (Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Panzyga, Privigen, Xembify, Yimmugo)**

HCP Code	Description
<b>Preferred</b>	
90283	Immune globulin (IgIV), human, for intravenous use
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each
J1459	Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1555	Injection, immune globulin (Cuvitru), 100 mg
J1556	Injection, immune globulin (Bivigam), 500 mg
J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1558	Injection, immune globulin (Xembify), 100 mg
J1559	Injection, immune globulin (Hizentra), 100 mg
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), intravenous, nonlyophilized, (e.g., liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1575	Injection, immune globulin/hyaluronidase, (Hyqvia), 100 mg immune globulin
<b>Non-Preferred</b>	
J1551	Injection, immune globulin (cutaquig), 100 mg
J1552	Injection, immune globulin (alyglo), 100 mg
J1554	Injection, immune globulin (Asceniv), 500 mg
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg

**Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG) (Bkemv, Epysqli, Imaavy, Rystiggo, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo)**

HCP Code	Description
<b>Preferred</b>	
J1299	Injection, eculizumab, 2 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
J9332	Injection, efgartigimod alfa-fcab, 2mg
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg
<b>Non-Preferred</b>	
C9305	Injection, nipocalimab-aahu, 3 mg
J3490	Unclassified drugs
J3590	Unclassified biologics
J9333	Injection, rozanolixizumab-noli, 1 mg

## Inflammatory Bowel Disease Agents (Entyvio, Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, Wezlana, Yesintek)

HCPCS Code	Description
<b>Preferred</b>	
J3380	Injection, vedolizumab, intravenous, 1 mg
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg
<b>Non-Preferred</b>	
C9399	Unclassified drugs or biologicals
J1628	Injection, guselkumab, 1 mg
J2267	Injection, mirikizumab-mrkz, 1 mg
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
J3490	Unclassified drugs
J3590	Unclassified biologics
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg
Q9999	Injection, ustekinumab-aaaz (otulfi), biosimilar, 1 mg

## Infliximab (Avsola, Inflectra, Infliximab, Remicade, Renflexis)

HCPCS Code	Description
<b>Preferred</b>	
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10mg
<b>Non-Preferred</b>	
J1745	Injection, infliximab, excludes biosimilar, 10 mg

## Intravenous Iron Replacement Therapy [Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Injectafer, Monoferic, Venofer (iron sucrose)]

HCPCS Code	Description
<b>Preferred</b>	
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)
<b>Non-Preferred</b>	
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg

## Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors (Repackaged Avastin, Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, Vabysmo)

HCPCS Code	Description
<b>Preferred</b>	
C9257	Injection, bevacizumab (Avastin), 0.25mg

HCPCS Code	Description
<b>Preferred</b>	
J0177	Injection, aflibercept hd, 1 mg
J0178	Injection, aflibercept, 1 mg
J7999	Compounded drug, not otherwise classified
J9035	Injection, bevacizumab (Avastin), 10mg
Q5147	Injection, aflibercept-ayyh (Pavblu), biosimilar, 1 mg
<b>Non-Preferred</b>	
J0179	Injection, brolucizumab-dblI, 1 mg
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
J2779	Injection, ranibizumab, via intravitreal implant (Susvimo), 0.1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg
Q5128	Injection, ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg

Diagnosis Code	Description
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
H35.3290	Exudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3291	Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization
H35.3292	Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization
H35.3293	Exudative age-related macular degeneration, unspecified eye, with inactive scar

## Irinotecan – Pancreatic Cancer (Camptosar, Irinotecan, Onivyde)

HCPCS Code	Description
<b>Preferred</b>	
J9206	Injection, irinotecan, 20 mg
<b>Non-Preferred</b>	
J9205	Injection, irinotecan liposome, 1 mg

## Leucovorin/Levoleucovorin (Fusilev, Khapzory, Leucovorin, Levoleucovorin)

HCPCS Code	Description
<b>Preferred</b>	
J0640	Injection, leucovorin calcium, per 50 mg
<b>Non-Preferred</b>	
J0641	Injection, levoleucovorin, not otherwise specified, 0.5 mg

HCPCS Code	Description
<b>Non-Preferred</b>	
J0642	Injection, levoleucovorin (Khapzory), 0.5 mg

## Lipid Modifying Agents (Leqvio)

HCPCS Code	Description
<b>Preferred</b>	
N/A	N/A
<b>Non-Preferred</b>	
J1306	Injection, inclisiran, 1 mg

## Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (Vyepti)

HCPCS Code	Description
<b>Preferred</b>	
N/A	N/A
<b>Non-Preferred</b>	
J3032	Injection, eptinezumab-jjmr, 1 mg

## Multiple Sclerosis Agents (Briumvi, Ocrevus, Ocrevus Zunovo)

HCPCS Code	Description
<b>Preferred</b>	
J2350	Injection, ocrelizumab, 1 mg
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq
<b>Non-Preferred</b>	
J2329	Injection, ublituximab-xiyy, 1mg

## Pemetrexed (Alimta, Axtle, Pemetrexed, Pemfexy, Pemrydi RTU)

HCPCS Code	Description
<b>Preferred</b>	
J9294	Injection, pemetrexed (hospira), not therapeutically equivalent to j9305, 10 mg
J9296	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg
J9297	Injection, pemetrexed (sandoz), not therapeutically equivalent to j9305, 10 mg
J9305	Injection, pemetrexed, not otherwise specified, 10 mg
J9314	Injection, pemetrexed (teva), not therapeutically equivalent to j9305, 10 mg
<b>Non-Preferred</b>	
J9292	Injection, pemetrexed dipotassium, 10 mg
J9304	Injection, pemetrexed (pemfexy), 10 mg
J9324	Injection, pemetrexed (pemrydi rtu), 10 mg

## Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima)

HCPCS Code	Description
<b>Preferred</b>	
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg
<b>Non-Preferred</b>	
J9311	Injection, rituximab 10 mg and hyaluronidase

HCPCS Code	Description
<b>Non-Preferred</b>	
J9312	Injection, rituximab, 10 mg

### Systemic Lupus Erythematosus Agents (Benlysta, Saphnelo)

HCPCS Code	Description
<b>Preferred</b>	
J0490	Injection, belimumab, 10 mg
<b>Non-Preferred</b>	
J0491	Injection, anifrolumab-fnia, 1 mg

### Tocilizumab (Actemra, Avtozma, Tofidence, Tyenne)

HCPCS Code	Description
<b>Preferred</b>	
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg
<b>Non-Preferred</b>	
J3262	Injection, tocilizumab, 1 mg
Q5156	Injection, tocilizumab-anoh (Avtozma), biosimilar, 1 mg

### Trastuzumab (Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera)

HCPCS Code	Description
<b>Preferred</b>	
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg
<b>Non-Preferred</b>	
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg
Q5146	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg

### Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) (Head and Neck Cancers: Cancer of the Nasopharynx, Recurrent, Unresectable, Oligometastatic, or Metastatic Disease)

HCPCS Code	Description
<b>Preferred</b>	
J3263	Injection, toripalimab-tpzi, 1 mg
<b>Non-Preferred</b>	
J9271	Injection, pembrolizumab, 1 mg
J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy
J9299	Injection, nivolumab, 1 mg
J9329	Injection, tislelizumab-jsgr, 1mg



## Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) (Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive ≥50%)

HCPSC Code	Description
<b>Preferred</b>	
J9022	Injection, atezolizumab, 10 mg
J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs
J9119	Injection, cemiplimab-rwlc, 1 mg
J9271	Injection, pembrolizumab, 1 mg
<b>Non-Preferred</b>	
J9228	Injection, ipilimumab, 1 mg
J9299	Injection, nivolumab, 1 mg

## Bispecific T-Cell Engaging (BiTE) Antibody (Multiple Myeloma)

HCPSC Code	Description
<b>Preferred</b>	
J9380	Injection, teclistamab-cqyv, 0.5 mg
<b>Non-Preferred</b>	
J1323	Injection, elranatamab-bcmm, 1 mg

## Background/Description of Services

Certain classes of medications covered under Medicare Part B will include non-preferred therapies. A non-preferred therapy will generally require history of use of a preferred therapy within the same class, among other criteria. This step therapy requirement will apply to some, but not all, Medicare Advantage Plans. Refer to the [Plan Exceptions](#) table.

Ten classes of medications (Bevacizumab, Colony Stimulating Factors, Denosumab, Eculizumab, Infliximab, Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, Rituximab, Tocilizumab, Trastuzumab, and Ustekinumab) covered under Medicare Part B that will include preferred and non-preferred drugs/products are biosimilar products.

A biosimilar product is a biologic product that is approved based on demonstrating that it is highly similar to an FDA-approved biologic product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

## Benefit Considerations

Before using this policy, check the member's EOC/SB and any federal or state mandates, if applicable.

Experimental and investigational procedures, items and medications are not covered. Investigational Device Exemption Studies (IDE) are only covered when Medicare requirements are met. For coverage requirements, refer to [www.cms.gov](http://www.cms.gov).

## References

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6. <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-part-d-drug-pricing-final-rule-cms-4180-f>.
7. <https://www.federalregister.gov/documents/2019/05/23/2019-10521/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses>.
8. For CMS Memorandum titled *Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage*, dated August 7, 2018; refer to: [https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA\\_Step\\_Therapy\\_HPMS\\_Memo\\_8\\_7\\_2018.pdf](https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf).
9. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®). Breast Cancer. Version 4.2023. Available at [www.nccn.org](http://www.nccn.org).

## Policy History/Revision Information

Date	Summary of Changes
01/01/2026	<p><b>Notice of Revision:</b> The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the amended updates to be applied on <b>Jan. 1, 2026</b>.</p> <p><b>Application</b></p> <ul style="list-style-type: none"> <li>• Revised list of plans excluded from this policy:               <p><b>Non-Employer Group Medicare Advantage</b></p> <ul style="list-style-type: none"> <li>○ Added the following UnitedHealthcare Dual Complete and Dual Choice plans:                   <ul style="list-style-type: none"> <li>▪ Hawaii: H6824-002</li> <li>▪ Idaho: H4032-001</li> <li>▪ Indiana: H2385-003 and H2385-004</li> <li>▪ Massachusetts: H2226-001, H2226-003, H4610-001, and H4610-002</li> <li>▪ Michigan: H2247-005</li> <li>▪ Tennessee: H0251-008</li> <li>▪ Texas: H3868-001</li> </ul> </li> <li>○ Removed:                   <ul style="list-style-type: none"> <li>▪ <b>Erickson Advantage® plans: H5652-001 through H5652-008</b></li> <li>▪ UnitedHealthcare Dual Complete and Dual Choice plans in:                       <ul style="list-style-type: none"> <li>– Alabama: H2802-064</li> <li>– Hawaii: H2406-132</li> </ul> </li> <li>▪ UnitedHealthcare Connected plans (Medicare-Medicaid) in:                       <ul style="list-style-type: none"> <li>– Massachusetts: H9239-001</li> <li>– Ohio: H2531-001</li> <li>– Texas: H7833-001</li> </ul> </li> <li>▪ UnitedHealthcare Senior Care Options in Massachusetts: H2226-001 and H2226-003</li> </ul> </li> </ul> <p><b>Employer Group Medicare Advantage</b></p> <ul style="list-style-type: none"> <li>○ Added the following Group PPO plans:                   <ul style="list-style-type: none"> <li>▪ Kenvue: H2001-869</li> <li>▪ United Auto Workers (UAW) Trust: H2001-850</li> <li>▪ U.S. Government of the Virgin Islands (USGVI): H2001-896 and H2001-897</li> </ul> </li> </ul> </li> </ul> <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>• Added list of applicable drugs/products for:               <p><b>Bispecific T-Cell Engaging (BiTE) Antibody for Multiple Myeloma</b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>○ Tecvayli</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>○ Elrexfio</li> </ul> <p><b>Botulinum Toxins A and B</b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>○ Botox and Xeomin</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>○ Daxxify, Dysport, and Myobloc</li> </ul> </li> </ul>

Date	Summary of Changes
	<p><b>Complement Inhibitors - Paroxysmal Nocturnal Hemoglobinuria (PNH)</b>  Preferred  ○ Bkernv, Epysqli, Soliris, and Ultomiris  Non-Preferred  ○ PiaSky</p> <p><b>Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG)</b>  Preferred  ○ Bkernv, Epysqli, Soliris, Ultomiris, Vyvgart, and Vyvgart Hytrulo  Non-Preferred  ○ Imaavy and Rystiggo</p> <p><b>Inflammatory Bowel Disease Agents</b>  Preferred  ○ Entyvio, Steqeyma, and Yesintek  Non-Preferred  ○ Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, and Wezlana</p> <p><b>Irinotecan – Pancreatic Cancer</b>  Preferred  ○ Camptosar and generic Irinotecan products (HCPCS code J9206)  Non-Preferred  ○ Onivyde</p> <p><b>Multiple Sclerosis Agents</b>  Preferred  ○ Ocrevus and Ocrevus Zunovo  Non-Preferred  ○ Briumvi</p> <ul style="list-style-type: none"> <li>Revised list of applicable drugs/products for: <p><b>Bevacizumab</b>  Non-Preferred  ○ Added Jobevne</p> <p><b>Gemcitabine</b>  Non-Preferred  ○ Added Avgemsi  ○ Removed Infugem</p> <p><b>Immune Globulins</b>  Non-Preferred  ○ Added Yimmugo</p> <p><b>Intravenous Iron Replacement Therapy</b>  Preferred  ○ Replaced “Venofer” with “Venofer (iron sucrose)”</p> <p><b>Rituximab</b>  ○ Changed Riabni from “non-preferred” to “preferred”</p> <p><b>Tocilizumab</b>  Non-Preferred  ○ Added Avtozma</p> </li> <li>Updated classes of medical benefit injectables; replaced “Antineoplastic Monoclonal Antibodies” with “Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1)” (no change to indications or applicable drug products)</li> <li>Added non-preferred step therapy criteria for: <p><b>Bispecific T-Cell Engaging (BiTE) Antibody for Multiple Myeloma</b>  ○ Added language to indicate Elrexfio, when prescribed for multiple myeloma, may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>History of use of Tecvayli resulting in minimal clinical response to therapy and residual disease activity</li> </ul> </p> </li> </ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>▪ History of intolerance or adverse event(s) to Tecvayli</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> <p><b>Botulinum Toxins A and B</b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate Daxxify, Dysport, and Myobloc may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of Botox or Xeomin resulting in minimal clinical response to therapy</li> <li>▪ History of intolerance or adverse event(s) to Botox or Xeomin</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> </ul> <p><b>Complement Inhibitors - Paroxysmal Nocturnal Hemoglobinuria (PNH)</b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate PiaSky may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of Bkemv, Epysqli, Soliris, or Ultomiris resulting in minimal clinical response to therapy</li> <li>▪ History of intolerance or adverse event(s) to Bkemv, Epysqli, Soliris, or Ultomiris</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> </ul> <p><b>Gemcitabine</b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate Avgemsi may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of Gemcitabine (HCPCS codes J9196 and J9201) resulting in minimal clinical response to therapy and residual disease activity</li> <li>▪ History of intolerance or adverse event(s) to Gemcitabine (HCPCS codes J9196 and J9201)</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> <li>○ Removed language indicating Infugem may be covered when any of the criteria listed [in the policy] are satisfied</li> </ul> <p><b>Immune Globulins</b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate Yimmugo may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of at least two preferred immune globulin products (either IV or SC products), resulting in minimal clinical response to therapy</li> <li>▪ History of contraindication, intolerance, or adverse event(s) to at least two preferred immune globulin products (either IV or SC products)</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> </ul> <p><b>Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG)</b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate <b>Imaavy</b> or Rystiggo may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of <b>two</b> of the following resulting in minimal clinical response to therapy: <ul style="list-style-type: none"> <li>– Bkemv</li> <li>– Epysqli</li> <li>– Soliris</li> <li>– Ultomiris</li> <li>– Vyvgart</li> <li>– Vyvgart Hytrulo</li> </ul> </li> <li>▪ History of intolerance or adverse event(s) to <b>two</b> of the following: <ul style="list-style-type: none"> <li>– Bkemv</li> <li>– Epysqli</li> <li>– Soliris</li> <li>– Ultomiris</li> <li>– Vyvgart</li> <li>– Vyvgart Hytrulo</li> </ul> </li> <li>▪ Patient is anti-MuSK antibody positive (with medical records showing a positive serologic test for anti-MuSK antibodies)</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> </ul> <p><b>Inflammatory Bowel Disease Agents</b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, or Wezlana may be covered when any of the criteria listed below are satisfied:</li> </ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>▪ History of use of <b>two</b> of the following resulting in minimal clinical response to therapy: <ul style="list-style-type: none"> <li>– Entyvio</li> <li>– Steqeyma</li> <li>– Yesintek</li> </ul> </li> <li>▪ History of intolerance or adverse event(s) to two of the following: <ul style="list-style-type: none"> <li>– Entyvio</li> <li>– Steqeyma</li> <li>– Yesintek</li> </ul> </li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> <p><b><i>Irinotecan – Pancreatic Cancer</i></b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate Onivyde, when prescribed for pancreatic cancer, may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of Camptosar/generic Irinotecan resulting in minimal clinical response to therapy and residual disease activity</li> <li>▪ History of intolerance or adverse event(s) to Camptosar/generic Irinotecan</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> </ul> <p><b><i>Multiple Sclerosis Agents</i></b></p> <ul style="list-style-type: none"> <li>○ Added language to indicate Briumvi may be covered when any of the criteria listed below are satisfied: <ul style="list-style-type: none"> <li>▪ History of use of Ocrevus or Ocrevus Zunovo resulting in minimal clinical response to therapy</li> <li>▪ History of intolerance or adverse event(s) to Ocrevus or Ocrevus Zunovo</li> <li>▪ Continuation of prior therapy within the past 365 days</li> </ul> </li> </ul> <p><b>Applicable Codes</b></p> <p><b><i>Bispecific T-Cell Engaging (BiTE) Antibody (Multiple Myeloma)</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS code J9380</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS code J1323</li> </ul> <p><b><i>Botulinum Toxins A and B</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS codes J0585 and J0588</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS codes J0586, J0587, and J0589</li> </ul> <p><b><i>Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH)</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS codes J1299, J1303, Q5151, and Q5152</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS code J1307</li> </ul> <p><b><i>Gemcitabine</i></b></p> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS code J9999</li> <li>● Removed HCPCS code J9198</li> </ul> <p><b><i>Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG)</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS codes <b>C9305</b>, J1299, J1303, <b>J3490</b>, <b>J3590</b>, J9332, J9334, Q5151, and Q5152</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS code J9333</li> </ul> <p><b><i>Inflammatory Bowel Disease Agents</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS codes J3380, Q5099, and Q5100</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>● Added HCPCS codes C9399, J1628, J2267, J2327, J3358, J3490, J3590, Q5098, Q5138, Q9997, Q9998, and Q9999</li> </ul>

Date	Summary of Changes
	<p><b><i>Irinotecan – Pancreatic Cancer</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>Added HCPCS code J9206</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>Added HCPCS code J9205</li> </ul> <p><b><i>Multiple Sclerosis Agents</i></b></p> <p>Preferred</p> <ul style="list-style-type: none"> <li>Added HCPCS codes J2350 and J2351</li> </ul> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>Added HCPCS code J2329</li> </ul> <p><b><i>Rituximab</i></b></p> <ul style="list-style-type: none"> <li>Changed HCPCS code Q5123 from “non-preferred” to “preferred”</li> </ul> <p><b><i>Tocilizumab</i></b></p> <p>Non-Preferred</p> <ul style="list-style-type: none"> <li>Added HCPCS code Q5156</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Updated <i>Background/Description of Services</i> section to reflect the most current information</li> <li>Archived previous policy version IAP.001.27</li> </ul>

## Instructions for Use

This Drug Policy is provided for informational purposes only and does not constitute medical advice. Treating physicians and health care providers are solely responsible for making any decisions about medical care.

Each benefit plan contains its own provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision(s) will govern.

In the event of a conflict between this policy and Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Medicare manuals, the Medicare NCD/LCD/manual will apply.