

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	- UnitedHealthcare Medicare Direct (Private Fee-For-Service, PFFS): H5435-001, H5435-024 - Certain UnitedHealthcare Dual Complete and Dual Choice plans: - Arizona: H0321-002, H0321-004 - District of Columbia: H2406-053, H7464-010 - Florida: , H1045-073, H1889-002, H1889-026, H2509-001, H2509-003 - Hawaii: H6824-002, H6824-003 - Idaho: H4032-001, H4032-003 - Indiana: H2385-003, H2385-004 - Massachusetts: H2226-001, H2226-003, H4610-001, H4610-002 - Michigan: H2247-006 - New Jersey: H3113-005 - New Mexico: H0294-052 - New York: H3387-013 - Tennessee: H0251-004, H0251-009 - Texas: H3868-001 - Virginia: H0421-001, H2445-001, H2445-003
Employer Group Medicare Advantage	- All Group HMO plans - Select Group PPO plans: - Bristol-Myers Squibb: H2001-869 - Johnson & Johnson: H2001-869 - Kenvue: H2001-869 - United Auto Workers (UAW) Trust: H1537-869, H2001-850, H2001-870 - U.S. Government of the Virgin Islands (USGVI): H1537-868, H1537-870, H1537-872, H2001-859, H2001-868, H2001-896, H2001-897 - Verizon: H2001-869

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 history of use of the drug/product (e.g., medical records, paid claim) within the past 365 days. For example, a new UnitedHealthcare plan member with medical records or 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 medical records or 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)
Antiemetics for Oncology [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, Navitrox, Posfrea, Sustol
Asthma Immunomodulators – Respiratory Interleukins		Fasenra, Nucala	Cinqair, Exdensusur
ATTR-Mediated Amyloidosis With Cardiomyopathy Non-Employer Group MAPD Plans only		Attruby, Vyndamax	Amvuttra
Bevacizumab		Mvasi, Vegzelma, Zirabev	Alymsys, Avastin, Avzivi, Jobevne
Bone Density Agents – Oncology		Bildyos, Bilprevda, Jubereq, Osenvelt, Osvyrti, Prolia, Stoboclo, Xgeva	Aukelso, Bomynta, Boncresa, Bosaya, Conexence, Enoby, Jubbonti, Ospomyv, Oziltus, Ponlimsi, Wyost, Xbryk, Xtrenbo
Bone Density Agents – Osteoporosis		Bildyos, Osvyrti, Prolia, Stoboclo	Boncresa, Bosaya, Conexence, Enoby, Evenity, Jubbonti, Ospomyv, Ponlimsi
Bortezomib		Generic Bortezomib, Velcade (HCPCS codes J9041, J9049, and J9051)	Boruzu
Botulinum Toxins A and B		Botox, Xeomin	Daxxify, Dysport, Myobloc
Carboplatin		Generic Carboplatin (HCPCS code J9045)	Kyxata
Colony Stimulating Factors	Short Acting	Zarxio	Filkri, Granix, Neupogen, Nivestym, Nypozi, Releuko
	Long Acting	Fulphila, Neulasta, Udenyca	Armluppeg, Ennumo, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo
Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH)		Bkemv, Epysqli, Soliris, Ultomiris	PiaSky
Cyclophosphamide		Generic Cyclophosphamide (HCPCS codes J9071, J9073, and J9075)	Frindovyx, Generic Cyclophosphamide (HCPCS codes J9074 and J9076)

Classes of Medical Benefit Injectables	Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
<u>Docetaxel</u>	Generic Docetaxel (HCPCS code J9171)	Beizray, Docivyx
<u>Gemcitabine</u>	Gemcitabine (HCPCS codes J9196 and J9201)	Avgemsi
<u>Gonadotropin Releasing Hormone Analogs for Oncology</u>	HCPCS codes J1954 and J9217 (leuprolide acetate, 7.5mg)	HCPCS code J1950 (leuprolide acetate, 3.75mg)
<u>Gout Agents</u> Non-Employer Group MAPD Plans only	Allopurinol, Febuxostat	Krystexxa
<u>Hyaluronic Acid Polymers</u>	Durolane, Gelsyn-3, Synvisc, Synvisc-One	Euflexxa, Gel-One, Genvisc 850, Hyalgan, Hymovis, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz Fx, Synjoynt, Triluron, TriVisc, Visco-3
<u>Immune Globulins</u>	Bivigam, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammplex, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Alyglo, Asceniv, Cutaquig, HyQvia, Panzyga, Qivigy, Yimmugo
<u>Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG)</u>	Bkemv, Epysqli, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo	Imaavy, Rystiggo
<u>Inflammatory Bowel Disease Agents</u>	Entyvio, Steqeyma, Yesintek	Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, Wezlana
<u>Infliximab</u>	Avsola, Inflectra, Renflexis	Infliximab, Remicade
<u>Intravenous Iron Replacement Therapy</u>	Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Venofer (iron sucrose)	Injectafer (ferric carboxymaltose), Monoferic
<u>Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Neovascular (Wet) Age-Related Macular Degeneration</u>	Repackaged Avastin, then Eylea or Eylea HD or Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo
<u>Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Retinal Conditions Other Than Neovascular (Wet) Age-Related Macular Degeneration</u>	Eylea, Eylea HD, Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo
<u>Irinotecan – Pancreatic Cancer</u>	Camptosar, generic Irinotecan products (HCPCS code J9206)	Onivyde
<u>Leucovorin/Levoleucovorin</u>	Leucovorin	Fusilev, Khapzory, Levoleucovorin, Vykoura
<u>Lipid Modifying Agents</u> Non-Employer Group MAPD plans only	Praluent, Repatha	Leqvio
<u>Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists</u> Non-Employer Group MAPD plans only	Aimovig, Ajovy, Emgality	Vyepti
<u>Multiple Sclerosis Agents</u>	Ocrevus, Ocrevus Zunovo	Briumvi

Classes of Medical Benefit Injectables	Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Pemetrexed	Alimta, generic Pemetrexed products (HCPCS codes J9294, J9296, J9297, J9305, and J9314)	Axtle, Pemfexy, Pemrydi RTU
Rituximab	Riabni, Ruxience, Truxima	Rituxan, Rituxan Hycela
Systemic Lupus Erythematosus Agents	Benlysta	Saphnelo
Testosterone Cypionate	Generic Testosterone Cypionate (HCPCS code J1071)	Azmiro
Tocilizumab	Avtozma, Tofidence, Tyenne	Actemra
Trastuzumab	Kanjinti, Ogivri, Trazimera	Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Ontruzant

Classes of Medical Benefit Injectables	Indication(s)	Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
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	Loqtorzi	Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, Tevimbra
	Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive ≥ 50%	Keytruda, Keytruda Qlex, Libtayo, Tecentriq, Tecentriq Hybreza	Opdivo plus Yervoy
	Squamous Cell Skin Cancer	Libtayo	Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, Unloxcyt
Bispecific T-Cell Engaging (BiTE) Antibody	Multiple Myeloma	Tecvayli	Elrexfio

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

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

Non-Preferred Product Step Therapy Criteria

Akynzeo, Cinvanti, Focinvez, Navitrox, 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, Exdensur, Fasenra, Nucala)

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

Non-Preferred Product Step Therapy Criteria

Cinqair or Exdensur, 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.

ATTR-Mediated Amyloidosis With Cardiomyopathy (Amvuttra, Attruby, Vyndamax) – Non-Employer Group MAPD Plans Only

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Attruby, Vyndamax	Amvuttra

Non-Preferred Product Step Therapy Criteria

Amvuttra, when used for the treatment of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis without evidence of polyneuropathy, may be covered when any of the criteria listed below are satisfied:

- History of use of Attruby or Vyndamax with progressive worsening or an event resulting in hospitalization related to ATTR-mediated amyloidosis with cardiomyopathy; **or**
- History of intolerance or adverse event(s) to Attruby or Vyndamax; **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)
Mvasi, Vegzelma, Zirabev	Alymsys, Avastin, Avzivi, Jobevne

Non-Preferred Product Step Therapy Criteria

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

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

Bone Density Agents – Oncology (Aukelso, Bildyos, Bilprevda, Bomynta, Boncresa, Bosaya, Connexence, Enoby, Jubbonti, Jubereq, Osenvelt, Ospomyv, Osvyrti, Oziltus, Ponlimsi, Prolia, Stoboclo, Wyost, Xbryk, Xgeva, Xtrenbo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bidyos, Bilprevda, Jubereq, Osenvelt, Osvyrti, Prolia, Stoboclo, Xgeva	Aukelso, Bomynta, Boncresa, Bosaya, Connexence, Enoby, Jubbonti, Ospomyv, Oziltus, Ponlimsi, Wyost, Xbryk, Xtrenbo

Aukelso, Bomynta, Oziltus, Wyost, Xbryk, and Xtrenbo Non-Preferred Product Step Therapy Criteria

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

Boncresta, Bosaya, Conexence, Enoby, Jubbonti, Ospomyv, and Ponlimsi Non-Preferred Product Step Therapy

Boncresta, Bosaya, Conexence, Enoby, Jubbonti, Ospomyv, or Ponlimsi may be covered when any of the criteria listed below are satisfied:⁹

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

Bone Density Agents – Osteoporosis (Bieldys, Boncresta, Bosaya, Conexence, Enoby, Evenity, Jubbonti, Ospomyv, Osvyrti, Ponlimsi, Prolia, Stoboclo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bieldys, Osvyrti, Prolia, Stoboclo	Boncresta, Bosaya, Conexence, Enoby, Evenity, Jubbonti, Ospomyv, Ponlimsi

Non-Preferred Product Step Therapy Criteria

Boncresta, Bosaya, Conexence, Enoby, Evenity, Jubbonti, Ospomyv, or Ponlimsi may be covered when any of the criteria listed below are satisfied:

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

Bortezomib (Bortezomib, Boruzu, Velcade)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Generic Bortezomib, Velcade (HCPCS codes J9041, J9049, and J9051)	Boruzu

Non-Preferred Product Step Therapy Criteria

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

- History of use of generic Bortezomib/Velcade (HCPCS codes J9041, J9049, and J9051) resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to generic Bortezomib/Velcade (HCPCS codes J9041, J9049, and J9051); **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.

Carboplatin (Carboplatin, Kyxata)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Generic Carboplatin (HCPCS code J9045)	Kyxata

Non-Preferred Product Step Therapy Criteria

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

- History of use of generic Carboplatin (HCPCS code J9045) resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to generic Carboplatin (HCPCS code J9045); **or**
- Continuation of prior therapy within the past 365 days.

Colony Stimulating Factors

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

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

Non-Preferred Product Step Therapy Criteria

Filkri, 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 (Armlupeg, Ennumo, Fulphila, Fylnetra, Neulasta, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca, Ziextenzo)

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

Non-Preferred Product Step Therapy Criteria

Armlupeg, Ennumo, 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.

Cyclophosphamide (Cyclophosphamide, Frindovyx)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Generic Cyclophosphamide (HCPCS codes J9071, J9073, and J9075)	Frindovyx, Generic Cyclophosphamide (HCPCS codes J9074 and J9076)

Non-Preferred Product Step Therapy Criteria

Frindovyx or Generic Cyclophosphamide (HCPCS codes J9074 and J9076) may be covered when any of the criteria listed below are satisfied:

- History of use of generic Cyclophosphamide (HCPCS codes J9071, J9073, and J9075) resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to generic Cyclophosphamide (HCPCS codes J9071, J9073, and J9075); **or**
- Continuation of prior therapy within the past 365 days.

Docetaxel (Beizray, Docetaxel, Docivyx)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Generic Docetaxel (HCPCS code J9171)	Beizray, Docivyx

Non-Preferred Product Step Therapy Criteria

Beizray or Docivyx may be covered when any of the criteria listed below are satisfied:

- History of use of generic Docetaxel (HCPCS code J9171) resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Docetaxel (HCPCS code J9171); **or**
- Continuation of prior therapy within the past 365 days.

Gemcitabine (Avgemsi, Gemcitabine)

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

Non-Preferred Product Step Therapy Criteria

Avgemsi 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, Hymovis One, 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, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz Fx, Synjoynt, Triluron, TriVisc, Visco-3

Non-Preferred Product Step Therapy Criteria

Euflexxa, Gel-One, Genvisc 850, Hyalgan, Hymovis, Hymovis One, 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, Qivigy, 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, Octagam, Privigen, Xembify	Alyglo, Asceniv, Cutaquig, HyQvia, Panzyga, Qivigy, Yimmugo

Non-Preferred Product Step Therapy Criteria

Alyglo, Asceniv, Cutaquig, HyQvia, Panzyga, Qivigy, 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:
 - Bkemv
 - Epysqli
 - Soliris
 - Ultomiris
 - Vyvgart
 - Vyvgart Hytrulo**or**
- History of intolerance or adverse event(s) to **two** of the following:
 - Bkemv
 - Epysqli
 - Soliris
 - Ultomiris
 - Vyvgart
 - Vyvgart Hytrulo**or**
- 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:
 - Entyvio
 - Steqeyma
 - Yesintek**or**
- History of intolerance or adverse event(s) to two of the following:
 - Entyvio
 - Steqeyma
 - Yesintek**or**
- 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 (ferric carboxymaltose), 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 (ferric carboxymaltose), Monoferic

Non-Preferred Product Step Therapy Criteria

Injectafer (ferric carboxymaltose) 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 doses (given no less frequently than every 6 weeks) of repackaged Avastin (bevacizumab), resulting in minimal clinical response to therapy; **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 doses (given no less frequently than every 6 weeks) of repackaged Avastin (bevacizumab), resulting in minimal clinical response to therapy; **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, Vykoura)

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

Non-Preferred Product Step Therapy Criteria

Fusilev, Khapzory, Levoleucovorin, or Vykoura 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.

Testosterone Cypionate (Azmiro, Testosterone Cypionate)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Generic Testosterone Cypionate (HCPCS code J1071)	Azmiro

Non-Preferred Product Step Therapy Criteria

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

- History of use of generic Testosterone Cypionate (HCPCS code J1071) resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to generic Testosterone Cypionate (HCPCS code J1071); **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)
Avtozma, Tofidence, Tyenne	Actemra

Non-Preferred Product Step Therapy Criteria

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

- History of use of Avtozma, Tofidence or Tyenne resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance or adverse event(s) to Avtozma, 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, Keytruda Qlex, Opdivo, Opdivo Qvantig, Tevimbra

Non-Preferred Product Step Therapy Criteria

Keytruda, Keytruda Qlex, 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, Keytruda Qlex, 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, Keytruda Qlex, 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, Keytruda Qlex, Libtayo, Tecentriq, or Tecentriq Hybreza; **or**
- Continuation of prior therapy within the past 365 days.

Squamous Cell Skin Cancer

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Libtayo	Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, Unloxcyt

Non-Preferred Product Step Therapy Criteria

Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, or Unloxcyt, when prescribed for squamous cell skin cancer, may be covered when any of the criteria listed below are satisfied:

- History of use of Libtayo resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Libtayo; **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	Elrexfio

Non-Preferred Product Step Therapy Criteria

Elrexfio, 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, Aloxi [palonosetron], Cinvanti, Emend [fosaprepitant], Focinvez, Granisetron, Navitrox, Ondansetron, Posfrea, Sustol)

HCPSC Code	Description
Preferred	
J1453	Injection, fosaprepitant, 1 mg
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
Non-Preferred	
C9399	Unclassified drugs or biologicals
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
J3490	Unclassified drugs

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

HCPSC Code	Description
Preferred	
J0517	Injection, benralizumab, 1 mg
J2182	Injection, mepolizumab, 1 mg
Non-Preferred	
J2361	Injection, depemokimab-ulaa, 1mg
J2786	Injection, reslizumab, 1 mg

ATTR-Mediated Amyloidosis With Cardiomyopathy (Amvuttra, Atttruby, Vyndamax)

HCPSC Code	Description
Preferred	
N/A	N/A

HCPSC Code	Description
Non-Preferred	
J0225	Injection, vutrisiran, 1 mg

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

HCPSC Code	Description
Preferred	
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg
Non-Preferred	
J9035	Injection, bevacizumab, 10 mg
J9999	Not otherwise classified, antineoplastic drugs
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Q5160	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg

Bone Density Agents – Oncology and Osteoporosis (Aukelso, Bildyos, Bilprevda, Bomynta, Boncresa, Bosaya, Connexence, Enoby, Evenity, Jubbonti, Jubereq, Osenvelt, Ospomyv, Osvyrti, Oziltus, Ponlimsi, Prolia, Stoboclo, Wyost, Xbryk, Xgeva Xtrenbo)

HCPSC Code	Description
Preferred	
J0897	Injection, denosumab, 1 mg
Q5157	Injection, denosumab-bmwo (Stoboclo/Osenvelt), biosimilar, 1 mg
Q5162	Injection, denosumab-nxxp (bilydos/bilprevda), biosimilar, 1 mg
Q5166	Injection, denosumab-desu (osvyrti/jubereq), biosimilar, 1 mg
Non-Preferred	
J3111	Injection, romosozumab-aqqg, 1 mg
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg
Q5158	Injection, denosumab-bnht (bomynta/connexence), biosimilar, 1 mg
Q5159	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg
Q5161	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg
Q5165	Injection, denosumab-mobz (oziltus), biosimilar, 1 mg
Q5167	Injection, denosumab-qbde (enoby/xtrenbo), biosimilar, 1mg
Q5171	Injection, denosumab-mobz (boncresa), biosimilar, 1 mg
Q5173	Injection, denosumab-adet (ponlimsi), biosimilar, 1mg

Bortezomib (Bortezomib, Boruzu, Velcade)

HCPSC Code	Description
Preferred	
J9041	Injection, bortezomib, 0.1 mg
J9049	Injection, bortezomib (hospira), not therapeutically equivalent to j9041, 0.1 mg
J9051	Injection, bortezomib (maia), not therapeutically equivalent to j9041, 0.1 mg
Non-Preferred	
J9054	Injection, bortezomib (boruzu), 0.1 mg

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

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

Carboplatin (Carboplatin, Kyxata)

HCPSC Code	Description
Preferred	
J9045	Injection, carboplatin, 50 mg
Non-Preferred	
J9278	Injection, carboplatin (avyxa), 1 mg

Colony Stimulating Factors

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

HCPSC Code	Description
Preferred	
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio) 1 microgram
Non-Preferred	
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
Q5172	Injection, filgrastim-laha (filkri), biosimilar, 1 microgram

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

HCPSC Code	Description
Preferred	
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
Non-Preferred	
C9399	Unclassified drugs or biologicals
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J3490	Unclassified drugs
J3590	Unclassified biologics
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

HCPSC Code	Description
Non-Preferred	
Q5169	Injection, pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg

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

HCPSC Code	Description
Preferred	
J1299	Injection, eculizumab, 2 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg
Non-Preferred	
J1307	Injection, crovalimab-akkz, 10 mg

Cyclophosphamide (Cyclophosphamide, Frindovyx)

HCPSC Code	Description
Preferred	
J9071	Injection, cyclophosphamide, (auromedics), 5 mg
J9073	Injection, cyclophosphamide (dr. reddy's), 5 mg
J9075	Injection, cyclophosphamide, not otherwise specified, 5mg
Non-Preferred	
J9072	Injection, cyclophosphamide (frindovyx), 5 mg
J9074	Injection, cyclophosphamide (sandoz), 5 mg
J9076	Injection, cyclophosphamide (baxter), 5 mg

Docetaxel (Beizray, Docetaxel, Docivyx)

HCPSC Code	Description
Preferred	
J9171	Injection, docetaxel, 1 mg
Non-Preferred	
J9172	Injection, docetaxel (docivyx), 1 mg
J9174	Injection, docetaxel (beizray), 1 mg

Gemcitabine (Avgemsi, Gemcitabine)

HCPSC Code	Description
Preferred	
J9196	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg
J9201	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg
Non-Preferred	
J9184	Injection, gemcitabine hydrochloride (avyxa), 200 mg

Gonadotropin Releasing Hormone Analogs for Oncology

HCPSC Code	Description
Preferred	
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg

HCP/PCS Code	Description
Non-Preferred	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg

Gout Agents (Krystexxa)

HCP/PCS Code	Description
Preferred	
N/A	N/A
Non-Preferred	
J2507	Injection, pegloticase, 1 mg

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

HCP/PCS Code	Description
Preferred	
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
Non-Preferred	
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 or Hymovis One, 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, Qivigy, Xembify, Yimmugo)

CPT/HCP/PCS Code	Description
Preferred	
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

CPT/HCPCS Code	Description
Preferred	
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (gammagard liquid/gammagard liquid erc), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, nonlyophilized (e.g., liquid), 500 mg
Non-Preferred	
J1551	Injection, immune globulin (cutaquig), 100 mg
J1552	Injection, immune globulin (alyglo), 100 mg
J1553	Injection, immune globulin (yimmugo), 100 mg
J1554	Injection, immune globulin (Asceniv), 500 mg
J1575	Injection, immune globulin/hyaluronidase, (Hyqvia), 100 mg immune globulin
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1577	Injection, immune globulin (qivigy), 100mg
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)

HCPCS Code	Description
Preferred	
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
Non-Preferred	
J9256	Injection, nipocalimab-aahu, 3 mg
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
Preferred	
J3380	Injection, vedolizumab, intravenous, 1 mg
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg
Non-Preferred	
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
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg
Q5164	Injection, ustekinumab-hmny (starjemza), biosimilar, 1mg
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg

HCPSC Code	Description
Non-Preferred	
Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg
Q9999	Injection, ustekinumab-aaaz (otulfi), biosimilar, 1 mg

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

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

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

HCPSC Code	Description
Preferred	
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)
Non-Preferred	
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)

HCPSC Code	Description
Preferred	
C9257	Injection, bevacizumab (Avastin), 0.25mg
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
Non-Preferred	
J0179	Injection, brolucizumab-dbl, 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

Diagnosis Code	Description
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)

HCPSC Code	Description
Preferred	
J9206	Injection, irinotecan, 20 mg
Non-Preferred	
J9205	Injection, irinotecan liposome, 1 mg

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

HCPSC Code	Description
Preferred	
J0643	Injection, leucovorin calcium, not otherwise specified, 1 mg
Non-Preferred	
J0641	Injection, levoleucovorin, not otherwise specified, 0.5 mg
J0642	Injection, levoleucovorin (Khapzory), 0.5 mg
J0644	Injection, leucovorin calcium (avyxa), 1mg

Lipid Modifying Agents (Leqvio)

HCPSC Code	Description
Preferred	
N/A	N/A
Non-Preferred	
J1306	Injection, inclisiran, 1 mg

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

HCPSC Code	Description
Preferred	
N/A	N/A

HCPSC Code	Description
Non-Preferred	
J3032	Injection, eptinezumab-jjmr, 1 mg

Multiple Sclerosis Agents (Briumvi, Ocrevus, Ocrevus Zunovo)

HCPSC Code	Description
Preferred	
J2350	Injection, ocrelizumab, 1 mg
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq
Non-Preferred	
J2329	Injection, ublituximab-xiyy, 1mg

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

HCPSC Code	Description
Preferred	
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
Non-Preferred	
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)

HCPSC Code	Description
Preferred	
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg
Non-Preferred	
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg

Systemic Lupus Erythematosus Agents (Benlysta, Saphnelo)

HCPSC Code	Description
Preferred	
J0490	Injection, belimumab, 10 mg
Non-Preferred	
J0491	Injection, anifrolumab-fnia, 1 mg

Testosterone Cypionate (Azmiro, Testosterone Cypionate)

HCPSC Code	Description
Preferred	
J1071	Injection, testosterone cypionate, 1 mg
Non-Preferred	
J1072	Injection, testosterone cypionate (azmiro), 1 mg

Tocilizumab (Actemra, Avtozma, Tofidence, Tyenne)

HCPSC Code	Description
Preferred	
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg
Q5156	Injection, tocilizumab-anoh (Avtozma), biosimilar, 1 mg
Non-Preferred	
J3262	Injection, tocilizumab, 1 mg

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

HCPSC Code	Description
Preferred	
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg
Non-Preferred	
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)

HCPSC Code	Description
Preferred	
J3263	Injection, toripalimab-tpzi, 1 mg
Non-Preferred	
J9271	Injection, pembrolizumab, 1 mg
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
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
Preferred	
J9022	Injection, atezolizumab, 10 mg
J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs
J9119	Injection, cemiplimab-rwlc, 1 mg
J9271	Injection, pembrolizumab, 1 mg
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
Non-Preferred	
J9228	Injection, ipilimumab, 1 mg

HCPSC Code	Description
Non-Preferred	
J9299	Injection, nivolumab, 1 mg

Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) (Squamous Cell Skin Cancer)

HCPSC Code	Description
Preferred	
J9119	Injection, cemiplimab-rwlc, 1 mg
Non-Preferred	
J9271	Injection, pembrolizumab, 1 mg
J9275	Injection, cosibelimab-ipdl, 2 mg
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy
J9299	Injection, nivolumab, 1 mg

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

HCPSC Code	Description
Preferred	
J9380	Injection, teclistamab-cqyv, 0.5 mg
Non-Preferred	
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.

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Policy History/Revision Information

Date	Summary of Changes
01/01/2027	Application - Revised list of plans excluded from this policy: Non-Employer Group Medicare Advantage - Added the following UnitedHealthcare Dual Complete and Dual Choice plans: - Arizona: H0321-002 - Florida: H1045-073 and H1889-002 - Hawaii: H6824-003 - Idaho: H4032-003 - Michigan: H2247-006 - New Mexico: H0294-052 - Tennessee: H0251-009 - Removed the following UnitedHealthcare Dual Complete and Dual Choice plans: - Florida: H1045-063, H1045-065, and H5420-016 - Michigan: H2247-005 - New Mexico: H0294-049 - Tennessee: H0251-008 - Virginia: H2445-005 Employer Group Medicare Advantage - Added the following Group PPO plans for United Auto Workers (UAW) Trust: H1537-870 and H1537-872 Coverage Rationale - Replaced language indicating: “For the purposes of this policy, a current drug/product means the member has a <i>paid claim</i> 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” with “for the purposes of this policy, a current drug/product means the member has a <i>history of use of</i> the drug/product (e.g., <i>medical records</i>, paid claim) within the past 365 days; for example, a new UnitedHealthcare plan member with <i>medical records or</i> claim history of a particular drug/product will not be required to switch to the preferred drug/product upon enrollment” “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” with “an existing UnitedHealthcare plan member with <i>medical records or</i> paid claims for a particular drug/product will not be required to change drugs/products in the event this policy is updated” - Added list of applicable drugs/products for: Bortezomib - Generic bortezomib and Velcade (HCP codes J9041, J9049, and J9051) (preferred) - Boruzu (non-preferred)

Date	Summary of Changes
	Carboplatin ○ Generic carboplatin (HCPCS code J9045) (preferred) ○ Kyxata (non-preferred) Cyclophosphamide ○ Generic cyclophosphamide (HCPCS codes J9071, J9073, and J9075) (preferred) ○ Frindovyx and generic cyclophosphamide (HCPCS codes J9074 and J9076) (non-preferred) Docetaxel ○ Generic Docetaxel (HCPCS code J9171) (preferred) ○ Beizray and Docivyx (non-preferred) Testosterone Cypionate ○ Generic testosterone cypionate (HCPCS code J1071) (preferred) ○ Azmiro (non-preferred) ● Revised list of applicable drugs/products for: Antiemetics for Oncology ○ Added Navitrox (non-preferred) Bone Density Agents – Oncology ○ Added: ▪ Jubereq and Osvyrti (preferred) ▪ Aukelso, Boncresa, Bosaya, Oziltus, and Ponlimsi (non-preferred) ○ Changed Bıldıyos and Bilprevda from “non-preferred” to “preferred” ○ Changed Jubbonti and Wyost from “preferred” to “non-preferred” Bone Density Agents – Osteoporosis ○ Added: ▪ Osvyrti (preferred) ▪ Boncresa, Bosaya, and Ponlimsi (non-preferred) ○ Changed Bıldıyos from “non-preferred” to “preferred” ○ Changed Jubbonti from “preferred” to “non-preferred” Colony Stimulating Factors: Long Acting ○ Added Ennumo (non-preferred) Intravenous Iron Replacement Therapy ○ Replaced “Injectafer” with “Injectafer (<i>ferric carboxymaltose</i>)” Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) for Squamous Cell Skin Cancer ○ Added: ▪ Libtayo (preferred) ▪ Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, and Unloxcyt (non-preferred) ● Added non-preferred step therapy criteria for: ○ Aukelso ○ Azmiro ○ Beizray ○ Boncresa ○ Boruzu ○ Bosaya ○ Docivyx ○ Ennumo ○ Frindovyx ○ Generic cyclophosphamide (HCPCS codes J9074 and J9076) ○ Jubbonti ○ Keytruda (for squamous cell skin cancer) ○ Keytruda Qlex (for squamous cell skin cancer) ○ Kyxata ○ Navitrox ○ Opdivo (for squamous cell skin cancer) ○ Opdivo Qvantig (for squamous cell skin cancer) ○ Oziltus

Date	Summary of Changes
	○ Ponlinsi ○ Unloxyt (for squamous cell skin cancer) ○ Wyost ● Removed non-preferred step therapy criteria for: ○ Bilyos ○ Bilprevda Applicable Codes Antiemetics for Oncology ● Added HCPCS codes C9399 and J3490 (non-preferred) Bone Density Agents – Oncology and Osteoporosis ● Added HCPCS codes: ○ Q5166 (preferred) ○ Q5161, Q5165, Q5171, and Q5173 (non-preferred) ● Changed HCPCS code: ○ Q5136 from “preferred” to “non-preferred” ○ Q5162 from “non-preferred” to “preferred” Bortezomib ● Added HCPCS codes: ○ J9041, J9049, and J9051 (preferred) ○ J9054 (non-preferred) Carboplatin ● Added HCPCS codes: ○ J9045 (preferred) ○ J9278 (non-preferred) Colony Stimulating Factors: Long-Acting ● Added HCPCS codes C9399, J3490, and J3590 (non-preferred) Cyclophosphamide ● Added HCPCS codes: ○ J9071, J9073, and J9075 (preferred) ○ J9072, J9074, and J9076 (non-preferred) Docetaxel ● Added HCPCS codes: ○ J9171 (preferred) ○ J9172 and J9174 (non-preferred) Testosterone Cypionate ● Added HCPCS codes: ○ J1071 (preferred) ○ J1072 (non-preferred) Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) (Squamous Cell Skin Cancer) ● Added HCPCS codes: ○ J9119 (preferred) ○ J9271, J9275, J9277, and J9289 ○ J9299 (non-preferred) Supporting Information ● Updated <i>FDA</i> section to reflect the most current information ● Archived previous policy version MMP365.14

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.