

Medicare Part B Drug Step Therapy Program

Refer to the **Medicare: Part B step therapy prior authorization** requirements notice in the [October 2022 Network Bulletin](#) for further information.

Updated: Feb. 1, 2023

Applicable Codes

Effective for dates of service starting **Jan. 1, 2023**, prior authorization is required for medications included in the Medicare Part B Step Therapy Program. You'll find the latest information in the [Medicare Part B Step Therapy Programs Policy](#).

Preferred medications marked with an * do **not** require prior authorization

Drug or medical device	HCPCS code	Status
Antiemetics for oncology		
Emend (fosaprepitant)	J1453	Preferred
*Kytril (granisetron)	J1626	Preferred
*Zofran (ondansetron)	J2405	Preferred
*Aloxi (palonosetron)	J2469	Preferred
*Ondansetron, oral	Q0162	Preferred
*Granisetron, oral	Q0166	Preferred
Cinvanti (aprepitant)	J0185	Non-Preferred
Akynzeo (fosnetupitant and palonosetron)	J1454	Non-Preferred
Sustol (granisetron, extended-release)	J1627	Non-Preferred
Bevacizumab (oncology use)		
Mvasi (bevacizumab-awwb)	Q5107	Preferred
Zirabev (bevacizumab-bvzr)	Q5118	Preferred
Allymsys (bevacizumab-maly)	J9999/C9142	Non-Preferred
Avastin (bevacizumab)	J9035	Non-Preferred
Bone Density Agents – oncology and osteoporosis		
*Alendronate, Risedronate	N/A	Preferred (Part D benefit)
*Ibandronate	J1740	Preferred
*Pamidronate	J2430	Preferred
*Zoledronic Acid	J3489	Preferred
Prolia (denosumab)	J0897	Non-Preferred
Xgeva (denosumab)	J0897	Non-Preferred
Evenity (romosozumab-aqqg)	J3111	Non-Preferred

Colony Stimulating Factors – long acting*Preferred products for non-oncology uses do not require prior authorization*

Neulasta (pegfilgrastim)	J2506	Preferred
Ziextenzo (pegfilgrastim-bmez)	Q5120	Preferred
Fylnetra (pegfilgrastim-pbbk)	J3590/C9399	Non-Preferred
Fulphila (pegfilgrastim-jmdb)	Q5108	Non-Preferred
Rolvedon (eflapegrastim-xnst)	J3490/J3590/C9399	Non-Preferred
Stimufend (pegfilgrastim-fpgk)	J3490/J3590/C9399	Non-Preferred
Udenyca (pegfilgrastim-cbqv)	Q5111	Non-Preferred
Nyvepria (pegfilgrastim-apgf)	Q5122	Non-Preferred

Colony Stimulating Factors – short acting*Preferred products for non-oncology uses do not require prior authorization*

Zarxio (filgrastim-sndz)	Q5101	Preferred
Neupogen (filgrastim)	J1442	Non-Preferred
Granix (tbo-filgrastim)	J1447	Non-Preferred
Nivestym (filgrastim-aafi)	Q5110	Non-Preferred
Releuko (filgrastim-ayow)	Q5125	Non-Preferred

Erythropoiesis-Stimulating agents

*Retacrit (epoetin alfa-epbx)	Q5106	Preferred
Epogen/Procrit (epoetin alfa)	J0885	Non-Preferred

Gemcitabine

Gemcitabine	J9201	Preferred
Infugem (gemcitabine)	J9198	Non-Preferred

Gonadotropin Releasing Hormone Analogs for oncology

Leuprolide acetate, per 7.5mg	J9217	Preferred
Leuprolide acetate, per 3.75mg	J1950	Non-Preferred

Gout agents

*Allopurinol tablet	N/A	Preferred (Part D benefit)
*Febuxostat tablet	N/A	Preferred (Part D benefit)
Krystexxa (pegloticase)	J2507	Non-Preferred

Hyaluronic Acids

*Durolane	J7318	Preferred
*Synvisc or Synvisc-One	J7325	Preferred
*Gelsyn-3	J7328	Preferred
GenVisc 850	J7320	Non-Preferred
Hyalgan, Supartz, Supartz FX, Visco-3	J7321	Non-Preferred
Hymovis	J7322	Non-Preferred
Euflexxa	J7323	Non-Preferred
Orthovisc	J7324	Non-Preferred
Gel-One	J7326	Non-Preferred
Monovisc	J7327	Non-Preferred
Trivisc	J7329	Non-Preferred
Synjoynt	J7331	Non-Preferred
Triluron	J7332	Non-Preferred

Immune Globulins		
Immune Globulin (IgIV)	90283	Preferred
Immune Globulin (SCIg)	90284	Preferred
Privigen	J1459	Preferred
Cuvitru	J1555	Preferred
Bivigam	J1556	Preferred
Gammaplex	J1557	Preferred
Xembify	J1558	Preferred
Hizentra	J1559	Preferred
Gamunex-C / Gammaked	J1561	Preferred
Carimune NF / Gammagard S/D	J1566	Preferred
Octagam	J1568	Preferred
Gammagard Liquid	J1569	Preferred
Flebogamma DIF	J1572	Preferred
HyQvia	J1575	Preferred
Cutaquig	J1551	Non-Preferred
Asceniv	J1554	Non-Preferred
Panzyga	J1599	Non-Preferred
Infliximab		
*Infectra (infliximab-dyyb)	Q5103	Preferred
*Avsola (infliximab-axxq)	Q5121	Preferred
Remicade (infliximab), Infliximab	J1745	Non-Preferred
Renflexis (infliximab-abda)	Q5104	Non-Preferred
Intravenous Iron Replacement Therapy		
*INFeD (iron dextran)	J1750	Preferred
*Venofer (iron sucrose)	J1756	Preferred
*Ferrlecit (sodium ferric gluconate complex)	J2916	Preferred
Feraheme (ferumoxytol)	Q0138	Preferred (as of 2/1/23)
Monoferric (ferric derisomaltose)	J1437	Non-Preferred
Injectafer (ferric carboxymaltose)	J1439	Non-Preferred
Leucovorin/Levoleucovorin		
Leucovorin	J0640	Preferred
Fusilev (levoleucovorin)	J0641	Non-Preferred
Khazory (levoleucovorin)	J0642	Non-Preferred
Nebulizer Solutions (dispensed at a pharmacy)		
*Perforomist (formoterol fumarate)	N/A	Preferred
Brovana (arformoterol tartrate)	N/A	Non-Preferred
Rituximab		
<i>Preferred products for non-oncology uses do not require prior authorization</i>		
Truxima (rituximab-abbs)	Q5115	Preferred
Ruxience (rituximab-pvvr)	Q5119	Preferred
Rituxan Hycela (rituximab and hyaluronidase)	J9311	Non-Preferred
Rituxan (rituximab)	J9312	Non-Preferred
Riabni (rituximab-arrx)	Q5123	Non-Preferred
Systemic Lupus Erythematosus agents		
*Benlysta (belimumab)	J0490	Preferred

Saphnelo (anifrolumab-fnia)	J0491	Non-Preferred
Trastuzumab		
Trazimera (trastuzumab-qyyp)	Q5116	Preferred
Kanjinti (trastuzumab-anns)	Q5117	Preferred
Herceptin (trastuzumab)	J9355	Non-Preferred
Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)	J9356	Non-Preferred
Ontruzant (trastuzumab-dttb)	Q5112	Non-Preferred
Herzuma (trastuzumab-pkrb)	Q5113	Non-Preferred
Ogivri (trastuzumab-dkst)	Q5114	Non-Preferred
Vascular Endothelial Growth Factor (VEGF) inhibitors for ophthalmologic use For Neovascular (Wet) Age-Related Macular Degeneration		
*Compounded Avastin (bevacizumab)	J9035/C9257	Preferred
Eylea (aflibercept)	J0178	Preferred, after Compounded Avastin
Beovu (brolucizumab-dbli)	J0179	Non-Preferred
Vabysmo (faricimab-svoa)	J2777	Non-Preferred
Lucentis (ranibizumab)	J2778	Non-Preferred
Susvimo (ranibizumab)	J2779	Non-Preferred
Cimerli (ranibizumab-eqrn)	J3590/C9399	Non-Preferred
Byooviz (ranibizumab-nuna)	Q5124	Non-Preferred
Vascular Endothelial Growth Factor (VEGF) inhibitors for ophthalmologic use For Non-Neovascular (Wet) Age-Related Macular Degeneration conditions		
Eylea (aflibercept)	J0178	Preferred
Beovu (brolucizumab-dbli)	J0179	Non-Preferred
Vabysmo (faricimab-svoa)	J2777	Non-Preferred
Lucentis (ranibizumab)	J2778	Non-Preferred
Susvimo (ranibizumab)	J2779	Non-Preferred
Cimerli (ranibizumab-eqrn)	J3590/C9399	Non-Preferred
Byooviz (ranibizumab-nuna)	Q5124	Non-Preferred

Healthcare Common Procedure Coding System (HCPCS)

* Medication does not require prior authorization