Policy Number	**RX502.061**
Policy Effective Date	**01/01/2026**

Oncology Medications

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Related Policies (if applicable)
None

Disclaimer

Medical policies are a set of written guidelines that support current standards of practice. They are based on current generally accepted standards of and developed by nonprofit professional association(s) for the relevant clinical specialty, third-party entities that develop treatment criteria, or other federal or state governmental agencies. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and generally accepted standards of medical care. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Medical Benefit Therapeutic Alternatives

Certain prescription drugs administered by a health care provider in a clinical or professional setting have therapeutic equivalents or alternatives. Benefits may be limited to certain therapeutic equivalents or alternatives unless a coverage exception is granted. Members and their providers may visit the plan website for more information or may call the number on the member's ID card for further assistance.

Legislative Mandates

EXCEPTION: For members residing in the state of Louisiana, R.S. 22:999 prohibits excluding coverage for a drug prescribed for the treatment of cancer even where the FDA has not approved the product for that indication so long as that drug is recognized for treatment of the covered indication in a standard reference compendium or in substantially accepted peer reviewed medical literature. Coverage requirement also includes all medically necessary services related to the administration of the product. Coverage is not required where use of the product for the prescribed indication is contraindicated. "Medical literature" means scientific studies published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Action, 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended. "Standard reference compendia" means authoritative compendia as identified by the secretary of the United States Department of Health and Human Services.

EXCEPTION: For members residing in the state of Louisiana, R.S. 22:1054.1 requires coverage for a minimum initial treatment period of not less than three months for medically necessary drugs prescribed for the treatment of metastatic or unresectable tumors or other advanced cancers even where the drug is not FDA approved to treat the specific tumor type or a cancer of the location of the body afflicted so long as the drug is FDA approved for the treatment of cancer with the specific genetic mutation. Continued coverage of the prescribed drug shall be provided after the initial treatment period if the treating physician certifies the prescribed drug is medically necessary for the treatment of the patient's cancer based on documented improvement of the patient. Coverage may be denied only if an alternative treatment has proven to be more effective in published randomized clinical trials and is not contraindicated in the patient.

EXCEPTION: New Mexico: For plans delivered, or issued for delivery or renewal on or after January 1, 2025, NMSA 1978 §59A-22B-8 (SB 135) prohibits step therapy requirements before authorizing coverage for medication approved by the U.S. Food and Drug Administration (FDA) that is prescribed for the treatment of an autoimmune disorder, cancer, or a substance use disorder, pursuant to a medical necessity determination, except in cases in which a biosimilar, interchangeable biologic or generic version is available. Any approved step therapy exception may be continued for no less than the duration of the therapeutic effect of the drug. This does not prevent a requirement of a member trying biosimilars, interchangeable biologics or generics of a prescription drug before providing coverage for the equivalent brand name prescription drug. This applies to the following: fully insured group business; Individual and Family Market plans, both on- and off-exchange; the State's Medicaid Plan; and the mandatory coverage for IBAC plans (i.e., State of New Mexico, Public Schools Insurance Authority, Albuquerque Public Schools and the New Mexico Retiree Health Care Authority).

EXCEPTION: For members residing in the state of Ohio, § 3923.60 requires any group or individual policy (Small, Mid-Market, Large Groups, Municipalities/Counties/Schools, State Employees, Fully-Insured, PPO, HMO, POS, EPO) that covers prescription drugs to provide for the coverage of any drug approved by the U. S. Food and Drug Administration (FDA) when it is prescribed for a use recognized as safe and effective for the treatment of a given indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature even if the FDA has not approved the drug for that indication. Medical literature support is only satisfied when safety and efficacy has been confirmed in two articles from major peer-reviewed professional medical journals that present data supporting the proposed off-label use or uses as generally safe and effective. Examples of accepted journals include, but are not limited to, Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), and Lancet. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. Evidence limited to case studies or case series is not sufficient to meet the standard of this criterion. Coverage is never required where the FDA has recognized a use to be contraindicated and coverage is not required for non-formulary drugs.

EXCEPTION: For members residing in the state of Arkansas, § 23-79-147 relating to cancer drug step therapy, requires any policy that covers prescription drugs and which provides coverage for the treatment of metastatic cancer to not limit or exclude coverage under the health benefit plan for a drug approved by the United States Food and Drug Administration that is on the prescription drug formulary of the insurance policy by mandating that a covered person with metastatic cancer undergo step therapy unless the preferred drug is consistent with best practices and have an approved indication for the treatment of metastatic cancer or associated conditions by US FDA or the National Comprehensive Cancer Network Drugs and Biologics Compendium or based on evidence-based, peer-reviewed, recognized medical literature. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For members residing in the state of Arkansas, § 23-79-147 relating to off-label prescription drug coverage, requires any plan that covers prescription drugs to provide for the coverage of any anticancer chemotherapeutic regimen (“drug”) approved by the U.S. Food and Drug Administration (FDA) when that drug has been recognized as safe and effective for treatment of that specific type of cancer in standard reference compendia, (the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network Drugs and Biologics Compendium, The Elsevier Gold Standard's Clinical Pharmacology), or has been recognized as safe and effective for treatment of that specific type of cancer in two [2] articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature, or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services.

This coverage must include medically necessary services associated with the administration of the drug, provided that such services are covered by the insurance policy. However, coverage is never required where the FDA has recognized a use to be contraindicated. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For members in Insured plans residing in the state of Indiana: § 27 8 20 et seq. requires coverage of any anticancer chemotherapeutic regimen ("drug") approved by the U.S. Food and Drug Administration (FDA) when it is prescribed for a use recognized for a given indication in at least one standard medical reference compendia or when such drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain even if the FDA has not approved the drug for that indication. Standard reference compendia are defined as the US Pharmacopeia, the American Medical Association Drug Evaluations, and the American Hospital Formulary Service Drug Information. However, coverage is never required where the FDA has recognized a use to be contraindicated. This applies to Fully Insured Small Group, Mid-Market, Large Group HMO, EPO, PPO, POS, and Student.

Coverage

NOTE 1: See the Appendix for exception criteria for medications in this class. The Appendix is not applicable to plans regulated by the Illinois Department of Insurance or Medicare or Medicaid plans.

Oncology medications **may be considered medically necessary** when either of the following criteria is met:

- The drug is approved and being administered in accordance with the U.S. Food and Drug Administration (FDA) labeling for an oncologic indication; or
- The drug has a category 1, 2A or 2B recommendation by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®), or its derivative information product, the NCCN Drugs & Biologics Compendium (NCCN Compendium®). (www.nccn.org)

The following table contains a list of some, but not all, oncologic medications applicable to this policy. This list is **not all-inclusive**.

Table 1. Oncology Medications and Codes

Oncology Medications		
Code	**Generic**	**Brand**
0537T, 0538T, 0539T, 0540T, Q2055	Idecabtagene vicleucel	Abecma®
J9264	Paclitaxel Protein-Bound Particles	Abraxane®
J3262	Tocilizumab	Actemra®
J9042	Brentuximab vedotin	Adcetris®
J9029	Nadofaragene firadenovec-vncg	Adstiladrin®
C9142, Q5126	Bevacizumab-maly	Alymsys®
C9399, J3490, J3590, J9999	Lifileucel	Amtagvi™
C9169, J3490, J3590, J9028, J9999	Nogapendekin alfa inbakicept-pmln	Anktiva®
J0881	Darbepoetin alfa	Aranesp®
J9302	Ofatumumab	Arzerra®
J9118	Calaspargase pegol-mknl	Asparlas™
C9301, C9399, J3490, J3590, J9999	Obecabtagene autoleucel	Aucatzyl®
J9035	Bevacizumab	Avastin™
C9399, J3490, J3590, J9999	Bevacizumab-tnjn	Avzivi®
J9023	Avelumab	Bavencio®
J9032	Belinostat	Beleodaq®
J9229	Inotuzamab ozogamicin	Besponsa™
C9399, J3490, J3590, J9999	Zenocutuzumab-zbco	Bizengri®
J9039	Blinatumomab	Blincyto™
0537T, 0538T, 0539T, 0540T, Q2054	Lisocabtagene maraleucel	Breyanzi®
J9064	Cabazitaxel (Sandoz)	Cabazitaxel (Sandoz)
0537T, 0538T, 0539T, 0540T, C9098, Q2056	Ciltacabtagene autoleucel	Carvykti™
J9286	Glofitamab-gxbm	Columvi™
J1448	Trilaciclib	Cosela™
J9308	Ramucirumab	Cyramza®
J9348	Naxitamab-gqgk	Danyelza®
J9145	Daratumumab	Darzalex®

J9144	Daratumumab and hyaluronidase-fihj	Darzalex Faspro™
C9399, J3490, J3590, J9999	Datopotamab deruxtecan-dlnk	Datroway®
Q2050	Doxorubicin liposomal	Doxil®
J9063	Mirvetuximab soratansine-gynx	Elahere™
J9269	Tagraxofusp-erzs	Elzonris®
J1323	Elranatamab-bcmm	Elrexfio™
J9176	Elotuzumab	Empliciti™
C9399, J3490, J3590, J9999	Telisotuzumab vedotin-tllv	Emrelis™
J9358	Fam-trastuzumab deruxtecan-nxki	Enhertu®
J9321	Epcoritamab-bysp	Epikinly™
J0885	Epoetin alfa	Epogen®
J9055	Cetuximab	Erbitux®
J9019	Asparaginase Erwinia chrysanthemi	Erwinaze®
J9155	Degarelix Acetate	Firmagon®
Q5108	Pegfilgrastim-jmdb	Fulphila®
J0641	Levoleucovorin calcium	Fusilev®
J9331	Sirolimus albumin bound nanoparticles	Fyarro™
Q5130	Pegfilgrastim-pbbk	Fylnetra®
J9301	Obinutuzumab	Gazyva™
J1447	Tbo-filgrastim	Granix®
J9179	Eribulin	Halaven®
J9355	Trastuzumab	Herceptin®
J9356	Trastuzumab and Hyaluronidase-oysk	Herceptin Hycleta™
C9399, J3490, J3590, J9999, Q5146	Trastuzumab-strf	Hercessi™
Q5113	Trastuzumab-pkrb	Herzuma®
C9170, J3490, J3590, J9026, J9999	Tarlatamab-dlle	Imdelltra™
J9173	Durvalumab	Imfinzi™
J9347	Tremelimumab-actl	Imjudo®
J9325	Talimogene Laherparepvect	Imlygic®

J9207	Ixabepilone	Ixempra®
J9281	Mitomycin	Jelmyto™
J9272	Dostarlimab-gxly	Jemperli
J9043	Cabazitaxel	Jevtana®
C9399, J3490, J3590, J9999	Bevacizumab-nwgd	Jobevne™
J9354	Ado-trastuzumab emtansine	Kadcyla™
Q5117	Trastuzumab-anns	Kanjinti™
J9271	Pembrolizumab	Keytruda®
J0642	Levoleucovorin	Khapzory™
J9274	Tebentafusp-tebn	Kimmtrak®
0537T; 0538T; 0539T; 0540T; Q2042	Tisagenlecleucel	Kymriah®
J9047	Carfilzomib	Kyprolis™
J2820	Sargramostim	Leukine®
J9119	Cemiplimab-rwlc	Libtayo®
J3263	Toripalimab-tpzi	Loqtorzi™
J9350	Mosunetuzumab-axgb	Lunsumio™
J1950; J1954; J9217; J9218; J9219	Leuprolide acetate	Lupron® Lutrate®
C9399, J3490, J3590, J9999	Denileukin diftitox-cxdl	Lymphir™
C9399, J3490, J3590, J9999	Linvoseltamab-gcpt	Lynozyfic™
J9353	Margetuximab-cmkb	Margenza™
J9349	Tafasitamab-cxix	Monjuvi®
J2562	Plerixafor	Mozobil™
Q5107	Bevacizumab-awwb	Mvasi™
J9203	Gemtuzumab Ozogamicin	Mylotarg™
J2506	Pegfilgrastim	Neulasta®
J2506, 96377	Pegfilgrastim	Neulasta® Onpro®
J1442	Filgrastim	Neupogen®
Q5110	Filgrastim-aafi	Nivestym™
Q5148	Filgrastim-txid	Nypozi®
Q5122	Pegfilgrastim-apgf	Nyvepria™
Q5114	Trastuzumab-dkst	Ogivri®
J9266	Pegaspargase	Oncaspar®
J9205	Irinotecan Liposome	Onivyde®
Q5112	Trastuzumab-dttb	Ontruzant®
J9299	Nivolumab	Opdivo®

C9399, J3490, J3590, J9999	Nivolumab hyaluronidase-nvhy	Opdivo Qvantig™
J9298	Relatlimab and nivolumab	Opdualag™
J0129	Abatacept	Orencia®
J9177	Enfortumab vedotin-ejfv	Padcev®
J9306	Pertuzumab	Perjeta™
J9316	Pertuzumab, trastuzumab, and hyaluronidase-zzxf	Phesgo™
J9309	Polatuzumab vedotin-piiq	Polivy™
J9295	Necitumumab	Portrazza ™
J9204	Mogamulizumab-kpkc	Poteligeo
J0885	Epoetin alfa	Procrit®
Q2043	Sipuleucel-T	Provenge®
J0896	Luspatercept-aamt	Reblozyl
Q5125	Filgrastim-ayow	Releuko®
Q5106	Epoetin alfa, biosimilar	Retacrit™
Q5123	Rituximab-arrx	Riabni™
J9312	Rituximab	Rituxan®
J9311	Rituximab and hyaluronidase human	Rituxan Hycela®
J1449	Eflapegrastim-xnst	Rolvedon®
Q5119	Rituximab-pvvr	Ruxience®
J9061	Amivantamab-vmjw	Rybrevant®
J9021	Asparaginase erwinia chrysanthemi (recombinant)-rywn	Rylaze™
C9399, J0870, J3490, J3590, J9999	Imetelstat	Rytelo®
J9361	Efbemalenograstim alfa-vuxw	Ryzneuta®
J2353	Octreotide	Sandostatin® LAR
J9227	Isatuximab-irfc	Sarclisa®
J1930	Lanreotide	Somatuline® Depot
Q5127	Pegfilgrastim-fpgk	Stimufend®
J1627	Granisetron	Sustol®
J2860	Siltuximab	Sylvant®
J3055	Talquetamab-tgvs	Talvey™

0537T; 0538T; 0539T; 0540T; Q2053	Brexucabtagene autoleucel	Tecartus™
Q2057, C9399, J3490, J3590, J9999	Afamitresgene autoleucel	Tecelra®
J9022	Atezolizumab	Tecentriq™
C9399, J9204, J3490, J3590, J9999	Atezolizumab and hyaluronidase-tqjs	Tecentriq Hybreza™
J9380	Teclistamab-cqyv	Tecvayli®
J9258	Paclitaxel protein-bound particles (Teva)	Paclitaxel protein-bound particles (Teva)
C9399, J9329	Tislelizumab-jsgr	Tevimbra®
J9273	Tisotumab vedotin-tftv	Tivdak®
Q5116	Trastuzumab-qyyp	Trazimera™
J3315	Triptorelin Pamoate	Trelstar®
J9317	Sacituzumab govitecan-hziy	Trodelvy™
Q5115	Rituximab-abbs	Truxima®
Q5111	Pegfilgrastim-cbqv	Udenyca®
Q5111, 96377	Pegfilgrastim-cbqv	Udenyca® Onbody™
C9399, J3490, J3590, J9999	Dinutuximab	Unituxin®
C9399, J3490, J3590, J9999	Cosibelimab-ipdl	Unloxcyt™
J9225	Histrelin Acetate	Vantas®
J9303	Panitumumab	Vecitibix®
Q5129	Bevacizumab-adcd	Vegzelma®
C9303, C9399, J3490, J3590, J9999	Zolbetuximab-clzb	Vyloy®
J9153	Daunorubicin and cytarabine	Vyxeos®
J9228	Ipilimumab	Yervoy™
0537T; 0538T; 0539T; 0540T; Q2041	Axicabtagene ciloleucel	Yescarta®
J9352	Trabectedin	Yondelis®
Q5101	Filgrastim-sndz	Zarxio®
J9223	Lurbinectedin	Zepzelca™
Q5120	Pegfilgrastim-bmez	Ziextenzo™
C9302, C9399, J3490, J3590, J9999	Zanidatamab-hrii	Ziihera®
Q5118	Bevacizumab-bvzr	Zirabev®

J9202	Goseralin Acetate	Zoladex®
C9399, J3490, J3590, J9999	Mitomycin	Zusduri™
J9359	Loncastuximab tesirine-lpyl	Zynlonta®
J9350	Retifanlimab-dlwr	Zynyz™
C9399, J3490, J3590, J9999	Unspecified oncology product	N/A
C9399, J3490, J3590, J9999	Penpulimab-kcqx	N/A

NOTE 1: Some drugs may have non-oncologic indications. When they are used for such indications refer to HCSC medical policy, and/or FDA prescribing information for guidance.

Policy Guidelines

None.

Description

In the United States, the Food and Drug Administration (FDA) oversees the drug/biologic evaluation process and grants approval for marketing of new drug products. (1) Pharmaceutical companies seeking FDA approval to sell a drug in the U.S. must evaluate the drug in various ways. This includes laboratory and animal testing, and finally, testing in humans to determine if the drug/biologic is safe and effective when used to treat or diagnose a disease.

When testing has been completed, the pharmaceutical company will submit a New Drug Application (NDA) or Biologic Licensing Application (BLA) to the FDA to request consideration for marketing the drug in the U.S. The NDA/BLA includes all the animal and human testing data and analysis of data as well as information about the drug's behavior in the participant's body, and how the drug will be manufactured. A review team of physicians, chemists, statisticians, microbiologists, pharmacologists, and other experts evaluates the studies the sponsor submitted showing the drug is safe and effective for its proposed use. The FDA may call on an advisory committee of outside experts to review the NDA/BLA and make their recommendations. Traditional approval requires that clinical benefit be shown before approval can be granted. Once the FDA has provided approval, the pharmaceutical company can begin marketing the drug for that specific approved indication.

Off-Label Indications

Off-label or unlabeled drug use is the use of a drug/biologic approved by the FDA for other uses or in treatment regimens or patient populations that are not included in approved labeling. When a drug is used for an indication other than those specifically included in the labeling, it is referred to as an off-label use. Many off-label uses are effective, well-documented in the literature, and widely used.

Unapproved or unlabeled uses of drugs include a variety of situations ranging from completely unstudied to thoroughly investigated drug uses where the FDA has not been asked for approval, whereas approved uses of drugs have been shown to be safe and effective by the FDA after the review of adequate and controlled clinical trials that have documented their uses.

National Comprehensive Cancer Network® (NCCN®)

The National Comprehensive Cancer Network® (NCCN®) is an organization of cancer centers, developing treatment guidelines for most cancers. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) present evidence-based recommendations for the diagnosis and treatment of cancer and cancer care supportive therapies. (2) NCCN provides the following definitions for their categories of evidence and consensus:

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
- Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

A majority NCCN Panel vote of at least 85% is required for the uniform NCCN consensus defined in Categories 1 and 2A. A Panel vote of at least 50% (but less than 85%) is required for the NCCN consensus defined in Category 2B. Where there is a strong Panel disagreement regardless of the quality of evidence, NCCN requires a Panel vote of at least 25% to include and designate a recommendation as Category 3. The large majority of the recommendations within the Guidelines are Category 2A. Where not specified within the Guidelines, the default designation for the recommendation is Category 2A. (2)

The NCCN Drugs & Biologics Compendium (NCCN Compendium®) includes FDA approved indications of cancer and cancer supportive recommendations, as well as recommended non-FDA approved uses based on the recommendations contained within the NCCN Guidelines.

Rationale

The United States Food and Drug Administration (FDA) has responsibility for the review of clinical data prior to approval of a new medication. Once approved, the pharmaceutical company may market that drug based on the FDA approved indications. Oncology medications may be used for other indications not approved by the FDA, based on the National Comprehensive Cancer Network® Panel recommendations, and contained in the NCCN Guidelines® and/or the NCCN Drugs & Biologics Compendium®.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	See Table 1 in Coverage for Applicable Codes

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

1. FDA –The FDA's Drug Review Process: Ensuring Drugs are Safe and Effective. U.S. Food and Drug Administration. Available at: <https://www.fda.gov> (accessed September 24, 2025).
2. National Comprehensive Cancer Network (NCCN). Development and Update of the NCCN Guidelines®. Available at: <https://www.nccn.org> (accessed September 24, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
01/01/2026	New medical document.

Appendix

The Appendix is not applicable to plans regulated by the Illinois Department of Insurance or Medicare or Medicaid plans.

Continuation Therapy
Continuation of therapy with non-preferred agents **is considered medically necessary** for all members (including new members):

- Who are currently receiving the requested medication for an indication listed below; AND
- Who are experiencing benefit from therapy as evidenced by disease stability or disease improvement; AND
- When dosing is in accordance with an authoritative source.

Initial Therapy:
Coverage for non-preferred agents will be provided contingent to the criteria in this section. For patients initiating therapy, the following criteria would apply prior to non-preferred agent use:

- Patient has tried and failed, is intolerant to, or has a clinical contraindication to the preferred agent; AND

- Physician attests that in their clinical opinion, the same intolerance, contraindications, lack of clinical efficacy, or adverse event would not be expected to occur with non-preferred agents;

OR

- The preferred drugs are experiencing documented drug shortages or recalls from a wholesaler, manufacturer, the ASHP (American Hospital of Health-System Pharmacist) Drug Shortage web page or the US Food and Drug Administration.

State specific drug criteria may apply.

Oncology Medications:

Preferred Drugs	Non-Preferred Drugs
Mvasi Zirabev	Avastin Avzivi Alymsys Vegzelma Jobevne
Kanjinti Ogivri Trazimera	Herceptin Herceptin Hylecta Hercessi Herzuma Ontruzant
Ruxience Riabni Truxima	Rituxan Rituxan Hycela

WBC Colony Stimulating Factors:

Preferred Drugs	Non-Preferred Drugs
Nivestym Zarxio	Neupogen Granix Releuko Nypozi
Fulphila Neulasta Neulasta Onpro	Nyvepria Udenyca Udenyca Onbody Ziextenzo Stimufend Fylnetra Rolvedon Ryzneuta