Medicare Part B
Step Therapy Program
for Providers

Questions about step therapy?

HealthSpring℠ has the answers.

What is step therapy?

Step therapy is a required process that applies to certain Part B prescription drugs.

How does step therapy work?

Step therapy requires members to first try a preferred medication over nonpreferred medications that treat the same condition.

What if the preferred medication is ineffective?

If the preferred medication is proven ineffective or causes negative side effects, then a nonpreferred medication may be covered.

What if the preferred drug has been tried in the past?

If the preferred medication was tried in the past 365 days, a nonpreferred medication may be covered. If the preferred medication hasn't been tried in the past 365 days, step therapy is required.

How do I find out what drugs require Part B step therapy?

The step therapy chart applies to all HealthSpring Medicare Advantage markets.

HealthSpring℠

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Step therapy drug class	Preferred* medications	Nonpreferred medications
Antiemetic - serotonin receptor antagonists (injectable) for oncology	• Granisetron • Ondansetron • Palonosetron	• Posfrea • Sustol
Antiemetic - substance p/ neurokinin-1 receptor antagonists (injectable) for oncology	Emend	• Akynzeo • Cinvanti • Focinvez
Bevacizumab Oncology	• Alymsys • Mvasi • Zirabev	• Avastin • Avzivi • Jobevne • Vegzelma
Botulinum toxins	• Botox • Daxxify • Dysport • Xeomin	Myobloc
Colony-stimulating factors Long acting	• Fulphila • Neulasta • Udenyca	• Fylnetra • Nyvepria • Rolvedon • Ryzneuta • Stimufend • Ziextenzo
Colony-stimulating factors Short acting	• Nivestym • Zarxio	• Granix • Neupogen • Nypozi • Releuko
Denosumab Prolia	• Bildyos • Jubbonti	• Bosaya • Conexxence • Enoby • Ospomyv • Osvyrti • Prolia • Stoboclo
Denosumab Xgeva	• Bilprevda • Wyost	• Aukelso • Bomyntra • Jubereq • Osenvelt • Xbryk • Xgeva • Xtrenbo
Eculizumab	• Epysqli	• Bkemv • Soliris
Immune globulins IV	• Flebogamma DIF • Gammagard Liquid • Gammagard Liquid ERC • Gammagard S/D • Gammaked • Gammaplex • Gamunex-C • Octagam • Privigen	• Alyglo • Asceniv • Bivigam • Panzyga • Qivigy • Yimmugo
Immune globulins SC	• Cutaquig • Gammagard Liquid • Gammagard Liquid ERC • Gammaked • Gamunex-C • Hizentra • Xembify	• Cuvitru • HyQvia

*Preferred medications may require prior authorization.

Step therapy drug class	Preferred* medications	Nonpreferred medications
Immunomodulators	• Avsola • Inflectra • Renflexis	Remicade, infliximab (authorized generic)
Intravenous iron	Venofer	• Feraheme • Injectafer • Monoferric
Ophthalmic disorders Intravitreal vascular endothelial growth factor (VEGF) inhibitors	Avastin	• Beovu • Byooviz • Cimerli • Eylea • Eylea HD • Lucentis • Pavblu • Vabysmo
Paclitaxel	Paclitaxel	• Abraxane • Paclitaxel protein-bound
Rituximab	• Riabni • Ruxience • Truxima	• Rituxan hycela • Rituxan IV
Somatostatin analogs Long acting	• Lanreotide (J1930 & J1932) • Somatuline depot (J1930)	Sandostatin LAR
Systemic lupus erythematosus SLE; lupus	Benlysta IV	Saphnelo
Testosterone Injectable	• Delatestryl (testosterone enanthate) • Depo-testosterone (testosterone cypionate)	• Aveed • Azmiro • Testopel • Xyosted
Tocilizumab	• Tyenne	• Actemra • Avtozma • Tofidence
Trastuzumab	• Kanjinti • Ogivri • Trazimera	• Herceptin hylecta • Herceptin IV • Hercessi • Herzuma • Ontruzant
Ustekinumab	• Selarsdi IV • Ustekinumab-aekn IV	• Imuldosa IV • Otulfi IV • Pyzchiva IV • Starjemza IV • Stelara IV • Steqeyma IV • Ustekinumab IV • Ustekinumab-ttwe IV • Wezlana IV • Yesintek IV
Viscosupplements	• Monovisc • Orthovisc • Synvisc • Synvisc one	• Durolane • Euflexxa • Gel-One • Gelsyn-3 • GenVisc 850 • Hyalgan • Hymovis • Sodium hyaluronate 1% • Supartz FX • Synojoynt • Triluron • TriVisc • Visco-3

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Step therapy drug class	Preferred* medications	Nonpreferred medications
Calcitonin gene-related peptide inhibitors**	Preferred Part D medications (reference Part D Drug List and Part D utilization management [UM] requirements)	Vyepti
Proprotein convertase subtilisin/kexin type 9 (PSCK9) inhibitors**	Preferred Part D medications (reference Part D Drug List and Part D UM requirements)	Leqvio

*Preferred medications may require prior authorization.
**Applies to MAPD plans only.

Coverage criteria

Antiemetic - Serotonin receptor antagonists (injectable) for oncology

Preferred* medications	Nonpreferred medications
• Granisetron • Ondansetron • Palonosetron	• Posfrea • Sustol

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Sustol or Posfrea may be covered for the prevention of chemotherapy-induced nausea and vomiting when the criteria listed below are satisfied:

- History of use (brand or generic) of one injectable preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

Antiemetic – Substance P/neurokinin-1 receptor antagonists (injectable) for oncology

Preferred* medication	Nonpreferred medications
Emend	• Akynzeo • Cinvanti • Focinvez

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Akynzeo, Cinvanti or Focinvez may be covered for the prevention of chemotherapy-induced nausea and vomiting when the criteria listed below are satisfied:

- History of use of intravenous preferred medication (brand or generic), **or**
- Continuation of prior therapy or use within the past 365 days

Bevacizumab (oncology)

Preferred* medications	Nonpreferred medications
• Alymsys • Mvasi • Zirabev	• Avastin • Avzivi • Jobevne • Vegzelma

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Avastin, Avzivi, Jobevne or Vegzelma may be covered for oncology indications when the criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Botulinum toxins

Preferred* medications	Nonpreferred medication
• Botox • Daxxify • Dysport • Xeomin	Myobloc

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, NGS J6, NGS JK

Myobloc may be covered when the criteria listed below are satisfied:

- Myobloc is being prescribed to treat one of the following conditions:
  - Chronic sialorrhea, **or**
  - Urinary incontinence associated with a neurological condition, **or**
  - Primary axillary hyperhidrosis, **or**
- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL

Myobloc may be covered when the criteria listed below are satisfied:

- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM

Myobloc may be covered when the criteria listed below are satisfied:

- Myobloc is being prescribed to treat one of the following conditions:
  - Overactive bladder with symptoms of urge urinary incontinence, urgency and frequency, **or**
  - Urinary incontinence associated with a neurological condition, **or**
  - Primary axillary hyperhidrosis, **or**

- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: WPS J5, WPS J8

Myobloc may be covered when the criteria listed below are satisfied:

- Myobloc is being prescribed to treat one of the following conditions:
  - Palmar hyperhidrosis, **or**
  - Primary axillary hyperhidrosis, **or**
- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

Colony-stimulating factors, long acting

Preferred* medications	Nonpreferred medications	
• Fulphila • Neulasta/Neulasta Onpro • Udenyca/Autoinjector/Onbody	• Fylnetra • Nyvepria • Rolvedon	• Ryzneuta • Stimufend • Ziextenzo

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Fylnetra, Nyvepria, Stimufend or Ziextenzo may be covered when the criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Rolvedon or Ryzneuta may be covered when criteria listed below are satisfied:

- History of use of one pegfilgrastim medication, **or**
- Continuation of prior therapy or use within the past 365 days

Colony-stimulating factors, short acting

Preferred* medications	Nonpreferred medications	
• Nivestym • Zarxio	• Granix • Neupogen	• Nypozi • Releuko

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

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

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Denosumb, Prolia

Preferred* medications	Nonpreferred medications
• Bildyos • Jubbonti	• Bosaya • Conexxence • Enoby • Ospomyv • Osvyrti • Prolia • Stoboclo

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Bosaya, Conexxence, Enoby, Ospomyv, Osvyrti, Prolia or Stoboclo may be covered when the criteria listed below are satisfied:

- History of use of the preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**

Continuation of prior therapy or use within the past 365 days.

Denosumb, Xgeva

Preferred* medications	Nonpreferred medications
• Bilprevda • Wyost	• Aukelso • Bomyntra • Jubereq • Osenvelt • Xbryk • Xgeva • Xtrenbo

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Aukelso, Bomyntra, Jubereq, Osenvelt, Xbryk, Xgeva or Xtrenbo may be covered when the criteria listed below are satisfied:

- History of use of the preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**

Continuation of prior therapy or use within the past 365 days.

Eculizumab

Preferred* medications	Nonpreferred medications
• Epysqli	• Bkemv • Soliris

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Bkemv or Soliris may be covered when the criteria listed below are satisfied:

- History of use of the preferred medication, **and**

- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days.

Immune globulins, IV

Preferred* medications		Nonpreferred medications	
• Flebogamma DIF • Gammagard Liquid • Gammagard Liquid ERC • Gammagard S/D	• Gammaked • Gammaplex • Gamunex-C • Octagam • Privigen	• Alyglo • Asceniv • Bivigam	• Panzyga • Qivigy • Yimmugo

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15. Additional MAC regions are listed below.

Alyglo may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:
  - Immune thrombocytopenia (ITP), **or**
  - Human immunodeficiency virus (HIV) infected infants and children to prevent recurrent infections, **or**
  - Guillain-Barré syndrome, **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP) or polyradiculoneuropathy, **or**
  - Multifocal motor neuropathy (MMN), **or**
  - Dermatomyositis or polymyositis, **or**
  - Myasthenia gravis, **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Autoimmune hemolytic anemia, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Asceniv may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
  - Immune thrombocytopenia (ITP), **or**
  - Human immunodeficiency virus (HIV) infected infants and children to prevent recurrent infections, **or**
  - Guillain-Barré syndrome, **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP) or polyradiculoneuropathy, **or**
  - Multifocal motor neuropathy (MMN), **or**
  - Dermatomyositis or polymyositis, **or**

  - Myasthenia gravis, **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Autoimmune hemolytic anemia, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Bivigam, Panzyga, Qivigy or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga, Qivigy or Yimmugo is being prescribed to treat one of the following conditions:
  - Immune thrombocytopenia (ITP), **or**
  - Human immunodeficiency virus (HIV) infected infants and children to prevent recurrent infections, **or**
  - Guillain-Barré syndrome, **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP) or polyradiculoneuropathy, **or**
  - Multifocal motor neuropathy (MMN), **or**
  - Dermatomyositis or polymyositis, **or**
  - Myasthenia gravis, **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Autoimmune hemolytic anemia, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: FCSO JN, Novitas JH, Novitas JL. Additional MAC regions are listed below.

Alyglo may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Autoimmune hemolytic anemia, **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Neuromyelitis optica (Devic's syndrome), **or**
  - Treatment of autoimmune encephalitis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Inclusion body myositis, **or**
  - Immune-mediated necrotizing myopathy, **or**
  - Overlap syndrome with myositis (including anti-synthetase syndrome), **or**
  - Systemic lupus erythematosus, **or**
  - Thyroid eye disease (Graves' disease), **or**
  - Immune thrombocytopenia (ITP), **or**
  - Multiple sclerosis (MS), acute severe exacerbation, or relapses, **or**
  - Myasthenia gravis, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Asceniv may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Autoimmune hemolytic anemia, **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Neuromyelitis optica (Devic's syndrome), **or**
  - Treatment of autoimmune encephalitis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Inclusion body myositis, **or**
  - Immune-mediated necrotizing myopathy, **or**
  - Overlap syndrome with myositis (including anti-synthetase syndrome), **or**
  - Systemic lupus erythematosus, **or**
  - Thyroid eye disease (Graves' disease), **or**
  - Immune thrombocytopenia (ITP), **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Myasthenia gravis, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Bivigam, Panzyga, Qivigy or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga, Qivigy or Yimmugo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Autoimmune hemolytic anemia, **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Neuromyelitis optica (Devic's syndrome), **or**
  - Treatment of autoimmune encephalitis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Inclusion body myositis, **or**
  - Immune-mediated necrotizing myopathy, **or**
  - Overlap syndrome with myositis (Including anti-synthetase syndrome), **or**
  - Systemic lupus erythematosus, **or**
  - Thyroid eye disease (Graves' disease), **or**
  - Immune thrombocytopenia (ITP), **or**
  - Multiple sclerosis (MS), acute severe exacerbation, or relapses, **or**
  - Myasthenia gravis, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions are listed below.

Alyglo may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**

- Alyglo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
  - Autoimmune retinopathy, **or**
  - Systemic lupus erythematosus, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Immune-mediated necrotizing myopathy, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Asceniv may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
  - Autoimmune retinopathy, **or**
  - Systemic lupus erythematosus, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Immune-mediated necrotizing myopathy, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Bivigam, Panzyga, Qivigy or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga, Qivigy or Yimmugo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid], and epidermolysis bullosa acquisita), **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
  - Autoimmune retinopathy, **or**
  - Systemic lupus erythematosus, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Immune-mediated necrotizing Myopathy, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: Noridian JE, Noridian JF. Additional MAC regions are listed below.

Alyglo may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**

  - Immune thrombocytopenia (ITP), **or**
  - Dermatomyositis or polymyositis, **or**
  - Guillain-Barré syndrome, **or**
  - Myasthenia gravis, **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP) or polyradiculoneuropathy, **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Multifocal motor neuropathy (MMN), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Asceniv may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Immune thrombocytopenia (ITP), **or**
  - Dermatomyositis or polymyositis, **or**
  - Guillain-Barré syndrome, **or**
  - Myasthenia gravis, **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP) or polyradiculoneuropathy, **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Multifocal motor neuropathy (MMN), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Bivigam, Panzyga, Qivigy or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga, Qivigy or Yimmugo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Immune thrombocytopenia (ITP), **or**
  - Dermatomyositis or polymyositis, **or**
  - Guillain-Barré syndrome, **or**
  - Myasthenia gravis, **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP) or polyradiculoneuropathy, **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Multifocal motor neuropathy (MMN), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions are listed below.

Alyglo may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**

- Alyglo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Myasthenia gravis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Pure red cell aplasia (PRCA), immunologic subtype, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Asceniv may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Myasthenia gravis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Pure red cell aplasia (PRCA), immunologic subtype, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Bivigam, Panzyga, Qivigy or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga, Qivigy or Yimmugo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Myasthenia gravis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Multiple sclerosis (MS), acute severe exacerbation or relapses, **or**
  - Pure red cell aplasia (PRCA), immunologic subtype, **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: WPS J5, WPS J8

Alyglo may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor Xia is needed based on a comorbidity of the patient, per prescriber, **or**

- Alyglo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Severe vasculitic syndromes, systemic (polyarteritis nodusa), Churg-Strauss vasculitis and livedoid vasculitis (atrophie blanche), **or**
  - Pyoderma gangrenosum, **or**
  - Immune-mediated neutropenia, **or**
  - Stevens-Johnson syndrome and/or toxic epidermal necrolysis, **or**
  - Systemic lupus erythematosus, **or**
  - Autoimmune hemolytic anemia, **or**
  - Thrombocytopenia, feto-neonatal alloimmune, **or**
  - Myasthenia gravis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Pure red cell aplasia (PRCA), immunologic subtype, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Asceniv may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Severe vasculitic syndromes, systemic (polyarteritis nodusa), Churg-Strauss vasculitis and livedoid vasculitis (atrophie blanche), **or**
  - Pyoderma gangrenosum, **or**
  - Immune-mediated neutropenia, **or**
  - Stevens-Johnson syndrome and/or toxic epidermal necrolysis, **or**
  - Systemic lupus erythematosus, **or**
  - Autoimmune hemolytic anemia, **or**
  - Thrombocytopenia, feto-neonatal alloimmune, **or**
  - Myasthenia gravis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Pure red cell aplasia (PRCA), immunologic subtype, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam, Panzyga, Qivigy or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga, Qivigy or Yimmugo is being prescribed to treat one of the following conditions:
  - Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid [cicatricial pemphigoid] and epidermolysis bullosa acquisita), **or**
  - Severe vasculitic syndromes, systemic (polyarteritis nodusa), Churg-Strauss vasculitis and livedoid vasculitis (atrophie blanche), **or**
  - Pyoderma gangrenosum, **or**

  - Immune-mediated neutropenia, **or**
  - Stevens-Johnson syndrome and/or toxic epidermal necrolysis, **or**
  - Systemic lupus erythematosus, **or**
  - Autoimmune hemolytic anemia, **or**
  - Thrombocytopenia, feto-neonatal alloimmune, **or**
  - Myasthenia gravis, **or**
  - Dermatomyositis or polymyositis, **or**
  - Immune thrombocytopenia (ITP), **or**
  - Stiff-person syndrome (Moersch-Woltman syndrome), **or**
  - Lambert-Eaton myasthenic syndrome (LEMS), **or**
  - Pure red cell aplasia (PRCA), immunologic subtype, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Immune globulins, SC

Preferred* medications		Nonpreferred medications
• Cutaquig • Gammagard Liquid • Gammagard Liquid ERC	• Gammaked • Gamunex-C • Hizentra • Xembify	• Cuvitru • HyQvia

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Cuvitru may be covered when the criteria listed below are satisfied:

- Patient with hyperprolinemia, the patient has tried Xembify, **or**
- Patient with a hypersensitivity to polysorbate 80, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

HyQvia may be covered when the criteria listed below are satisfied:

- Patient is being treated for chronic inflammatory demyelinating polyneuropathy, the patient has tried Hizentra, **or**
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days

Immunomodulators

Preferred* medications	Nonpreferred medication
• Avsola • Inflectra • Renflexis	Remicade, including infliximab (authorized generic)

Nonpreferred medication step therapy criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions listed below.

Remicade, including infliximab (authorized generic), may be covered when the criteria listed below are satisfied:

- Infliximab is being prescribed to treat one of the following conditions:
  - Behcet's disease
  - Sarcoidosis
  - Microscopic colitis, refractory, **or**

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions listed below.

Remicade, including infliximab (authorized generic), may be covered when criteria listed below are satisfied:

- Infliximab is being prescribed to treat one of the following conditions:
  - Crohn's disease
  - Plaque psoriasis
  - Ulcerative colitis
  - Behcet's disease
  - Hidradenitis suppurativa
  - Sarcoidosis
  - Spondyloarthritis (SpA), other subtypes, **or**
- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL, WPS J5, WPS J8

Remicade, including infliximab (authorized generic), may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Intravenous iron

Preferred* medication	Nonpreferred medications
Venofer	• Feraheme • Injectafer • Monoferric

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Feraheme or Monoferric may be covered when the criteria listed below are satisfied:

- For iron deficiency anemia in a patient with chronic kidney disease who is on dialysis, **or**
- For other conditions:
  - History of use of the preferred medication, **or**
  - Patient does not have chronic kidney disease, **or**
  - Continuation of prior therapy or use within the past 365 days

Injectafer may be covered when the criteria listed below are satisfied.

- Used for iron deficiency anemia in a patient with chronic kidney disease who is on dialysis, **or**
- For other conditions:
  - History of use of the preferred medication, **or**

– Patient is <2 years of age, **or**
– Patient does not have chronic kidney disease, **or**
– Continuation of prior therapy or use within the past 365 days

Ophthalmic disorders, intravitreal vascular endothelial growth factor (VEGF) inhibitors

Preferred* medication	Nonpreferred medications	
Avastin	• Beovu • Byooviz • Cimerli • Eylea	• Eylea HD • Lucentis • Pavblu • Vabysmo

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Beovu may be covered when the criteria listed below are satisfied:

- History of use of the preferred ophthalmic medication, and inadequate efficacy or intolerability was demonstrated, **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- Continuation of prior therapy or use within the past 365 days

Eylea, Eylea HD or Pavblu may be covered when criteria listed below are satisfied:

- History of use of the preferred ophthalmic medication, and inadequate efficacy or intolerability was demonstrated, **or**
- Has diabetic macular edema and a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) of 20/50 or worse (< 69 ETDRS letters) according to the prescriber, **or**
- Has diabetic macular edema with significant retinal thickening according to the prescriber, **or**
- Has diabetic retinopathy (without diabetic macular edema), **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- Continuation of prior therapy or use within the past 365 days

Byooviz, Cimerli or Lucentis may be covered when criteria listed below are satisfied:

- History of use of the preferred ophthalmic medication, and inadequate efficacy or intolerability was demonstrated, **or**
- Has diabetic retinopathy (without diabetic macular edema), **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- Continuation of prior therapy or use within the past 365 days

Vabysmo may be covered when the criteria listed below are satisfied::

- History of use of the preferred ophthalmic medication, and inadequate efficacy or intolerability was demonstrated, **or**
- Has diabetic macular edema and a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) of 20/50 or worse (69 ETDRS letters) according to the prescriber, **or**

- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion, **or**
- Continuation of prior therapy or use within the past 365 days

Paclitaxel

Preferred* medication	Nonpreferred medications
Paclitaxel	• Abraxane • Paclitaxel protein-bound

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Abraxane or paclitaxel protein-bound may be covered when the criteria listed below are satisfied:

- For non-small cell lung cancer:
  - Hypersensitivity reaction to Paclitaxel intravenous infusion or Docetaxel intravenous infusion, **or**
  - Contraindication to the standard premedications, **or**
  - Usage as subsequent therapy with advanced or metastatic disease, **or**
  - Continuation of prior therapy or use within the past 365 days
- For breast cancer, cervical cancer, endometrial cancer, melanoma, ovarian cancer:
  - Hypersensitivity reaction to Paclitaxel intravenous infusion or Docetaxel intravenous infusion, **or**
  - Contraindication to the standard premedications, **or**
  - Continuation of prior therapy or use within the past 365 days

Rituximab

Preferred* medications	Nonpreferred medications
• Riabni • Ruxience • Truxima	• Rituxan Hycela • Rituxan IV

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15. Additional MAC regions listed below.

Rituxan IV may be covered when the criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy within the past 365 days, **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
  - Graft-versus-host disease (GVHD), **or**
  - Immune thrombocytopenia (ITP), **or**
  - Multiple sclerosis (MS), **or**
  - Neuromyelitis optica (NMO) spectrum disorder, **or**
  - Systemic lupus erythematous (SLE; lupus), **or**
  - Thrombotic thrombocytopenic purpura (acquired), **or**
  - Evans syndrome, **or**
  - Bullous pemphigoid, **or**
  - Immunotherapy-related encephalitis, **or**

  - Immune-mediated myopathy/idiopathic inflammatory myopathy, **or**
  - Immunoglobulin G4-related disease (IgG4-RD), **or**
  - Myasthenia gravis, **or**
  - Minimal change disease, **or**
  - Antibody-mediated rejection (AMR)

Rituxan Hycela may be covered when the criteria listed below are satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication, **or**
- Inability to obtain or maintain intravenous access, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions listed below.

Rituxan intravenous may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy within the past 365 days, **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
  - Immune thrombocytopenia (ITP), **or**
  - Multiple sclerosis (MS), **or**
  - Antibody-mediated rejection (AMR), **or**
  - Immune-mediated myopathy/idiopathic inflammatory myopathy, **or**
  - Hemophilia (acquired), **or**
  - Thrombotic thrombocytopenic purpura (acquired), **or**
  - Immunoglobulin G4-related disease (IgG4-RD), **or**
  - Minimal change disease, **or**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP), **or**
  - Sjogren's Syndrome, **or**
  - Systemic Sclerosis, **or**
  - Susac Syndrome

Rituxan Hycela may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication, **or**
- Inability to obtain or maintain intravenous access, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions listed below.

Rituxan intravenous may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy within the past 365 days, **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
  - Rheumatoid arthritis (RA), **or**
  - Graft-versus-host disease (GVHD), **or**
  - Multiple sclerosis (MS), **or**
  - Autoimmune hemolytic anemia, **or**

– Multifocal motor neuropathy (MMN), **or**
– Polymyositis, **or**
– Autologous stem cell rescue for progressive or relapsed disease (given before the stem cell rescue)

Rituxan Hycela may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication, **or**
- Inability to obtain or maintain intravenous access, **or**
- Continuation of prior therapy or use within the past 365 days

Nonpreferred medication step therapy criteria

Applicable MAC regions: FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL, WPS J5, WPS J8

Rituxan intravenous may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Rituxan Hycela may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication, **or**
- Inability to obtain or maintain intravenous access, **or**
- Continuation of prior therapy or use within the past 365 days

Somatostatin analogs, long acting

Preferred* medications	Nonpreferred medications
• Lanreotide (J1930 & J1932) • Somatuline Depot (J1930)	Sandostatin LAR

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Sandostatin LAR may be covered when the criteria listed below are satisfied:

For acromegaly:

- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

For neuroendocrine tumors (NETs) of the gastrointestinal tract, lung, thymus (carcinoid tumors) and pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas):

- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

For pheochromocytoma and paraganglioma:

- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

For small bowel bleeds/angiodysplasia related bleeding:

- History of use of the preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days.

Systemic lupus erythematosus (SLE; lupus) drugs

Preferred* medication	Nonpreferred medication
Benlysta IV	Saphnelo

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

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

- History of Benlysta use, **or**
- History of depression or suicidality, according to prescriber, **or**
- Continuation of prior therapy or use within the past 365 days

Testosterone, injectable

Preferred* medications	Nonpreferred medications	
• Delatestryl (testosterone enanthate) • Depo-Testosterone (testosterone cypionate)	• Aveed • Azmiro	• Testopel • Xyosted

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Aveed, Azmiro, Testopel or Xyosted may be covered when the criteria listed below are satisfied:

- History of use of one preferred medication, **or**
- Continuation of prior therapy or use within the past 365 days

Tocilizumab

Preferred* medication	Nonpreferred medications	
• Tyenne	• Actemra • Avtozma	• Tofidence

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Actemra, Avtozma, or Tofidence may be covered when the criteria listed below are satisfied:

- History of use of the preferred medication, **and**
- Inability to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Trastuzumab

Preferred* medications	Nonpreferred medications	
• Kanjinti • Ogivri • Trazimera	• Herceptin Hylecta • Herceptin IV • Hercessi	• Herzuma • Ontruzant

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

Herceptin intravenous, Hercessi, Herzuma or Ontruzant may be covered when the criteria listed below are satisfied:

- History of use of one preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s), which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Herceptin Hylecta may be covered when criteria listed below are satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication, **or**
- Inability to obtain or maintain intravenous access, **or**
- Continuation of prior therapy or use within the past 365 days

Ustekinumab

Preferred* medications	Nonpreferred medications	
• Selarsdi IV • Ustekinumab-aekn IV	• Imuldosa IV • Otulfi IV • Pyzchiva IV • Starjemza IV • Stelara IV	• Steqeyma IV • Ustekinumab IV • Ustekinumab-ttwe IV • Wezlana IV • Yesintek IV

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Imuldosa IV, Otulfi IV, Pyzchiva IV, Starjemza IV, Stelara IV, Steqeyma IV, Ustekinumab IV, Ustekinumab-ttwe IV, Wezlana IV, or Yesintek IV may be covered when the criteria listed below are satisfied.

- History of use of preferred medication, **and**
- Inability to continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction, **or**
- Continuation of prior therapy or use within the past 365 days

Viscosupplements

Preferred* medications	Nonpreferred medications
• Monovisc • Orthovisc • Synvisc • Synvisc One	• Durolane • Euflexxa • Gel-One • Gelsyn-3 • GenVisc 850 • Hyalgan • Hymovis • Sodium Hyaluronate 1% • Supartz FX • Synojoynt • Triluron • TriVisc • Visco-3

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL. Does not apply to all other MAC regions not listed.

Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Sodium Hyaluronate 1%, Supartz FX, Synojoynt, Triluron, TriVisc or Visco-3 may be covered when the criteria listed below are satisfied:

- History of two different preferred medication therapy courses, **or**
- Continuation of prior therapy or use within the past 365 days

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Calcitonin gene-related peptide inhibitors**

Preferred* medication	Nonpreferred medication
Preferred Part D medication (reference Part D Drug List and Part D UM requirements)	Vyepti

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

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

- History of use of one preferred Part D subcutaneous calcitonin gene-related peptide inhibitor for migraine prophylaxis, **or**
- Continuation of prior therapy or use within the past 365 days

Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors**

Preferred* medication	Nonpreferred medication
Preferred Part D medication (reference Part D Drug List and Part D UM requirements)	Leqvio

Nonpreferred medication step therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8

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

- History of use of one preferred Part D proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor, **and**
- Inadequate efficacy or significant intolerance, according to prescriber, **or**
- Continuation of prior therapy or use within the past 365 days

Applicable codes

Antiemetic - Serotonin receptor antagonists (injectable) for oncology

HCPCS code	Description
Preferred	
J1626	Injection, granisetron hydrochloride, 100 mcg
J2405	Injection, ondansetron hydrochloride, per 1 mg
J2469	Injection, palonosetron HCl, 25 mcg
Nonpreferred	
J1627	Injection, granisetron, extended-release, 0.1 mg
J2468	Injection, palonosetron (posfrea), 25mcg

Antiemetic - Substance P/neurokinin-1 receptor antagonists (injectable) for oncology

HCPCS code	Description
Preferred	
J1453	Injection, fosaprepitant, 1 mg
Nonpreferred	
J0185	Injection, aprepitant, 1 mg
J1434	Injection, focinvez, 1mg
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg

Bevacizumab - Oncology

HCPCS code	Description
Preferred	
Q5107	Injection, bevacizumab-awwb, biosimilar (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar (Zirabev), 10 mg
Q5126	Injection, bevacizumab-maly, biosimilar (Alymsys), 10 mg
Nonpreferred	
J9035	Injection, bevacizumab, 10 mg
Q5129	Injection, bevacizumab-adcd, biosimilar (Vegzelma), 10 mg
	Injection, bevacizumab-tnjn, biosimilar (Avzivi), 10 mg
Q5160	Injection, bevacizumab-ngwd (Jobevne), biosimilar, 10 mg

Botulinum toxins

HCPCS code	Description
Preferred	
J0585	Injection, onabotulinumtoxinA, 1 unit
J0589	Injection, daxibotulinumtoxinA-lanm, 1 unit
J0586	Injection, abobotulinumtoxinA, 5 units
J0588	Injection, incobotulinumtoxinA, 1 unit
Nonpreferred	
J0587	Injection, rimabotulinumtoxinB, 100 units

Colony-stimulating factors, long acting

HCPCS code	Description
Preferred	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg
Q5108	Injection, pegfilgrastim-jmdb, biosimilar (Fulphila), 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv, biosimilar (Udenyca), 0.5 mg
Nonpreferred	
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J9361	Injection, efbemalenograstim alfa-vuxw (Ryzneuta), 0.5 mg
Q5120	Injection, pegfilgrastim-bmez, biosimilar (Ziextenzo), 0.5 mg
Q5122	Injection, pegfilgrastim-apgf, biosimilar (Nyvepria), 0.5 mg
Q5127	Injection, pegfilgrastim-fpgk, biosimilar (Stimufend), 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk, biosimilar (Fylnetra), 0.5 mg

Colony-stimulating factors, short acting

HCPCS code	Description
Preferred	
Q5101	Injection, filgrastim-sndz, biosimilar (Zarxio), 1 mcg
Q5110	Injection, filgrastim-aafi, biosimilar (Nivestym), 1 mcg
Nonpreferred	
J1442	Injection, filgrastim (G-CSF) (Neupogen), excludes biosimilars, 1 mcg
J1447	Injection, tbo-filgrastim (Granix), 1 mcg
Q5125	Injection, filgrastim-ayow, biosimilar (Releuko), 1 mcg
Q5148	Injection, filgrastim-txid, biosimilar (Nypozi), 1 mcg

Denosumab, Prolia

HCPCS code	Description
Preferred	
J3490/J3590	Injection, denosumab-nxxp, biosimilar (Bildyos)
Q5136	Injection, denosumab-bbdz, biosimilar (Jubbonti), 1 mg
Nonpreferred	
J3490/J3590	Injection, denosumab-kyqq, biosimilar (Bosaya)
Q5158	Injection, denosumab-bnht, biosimilar (Conexxence), 1 mg
J3490/J3590	Injection, denosumab-qbde, biosimilar (Enoby)
Q5159	Injection, denosumab-dssb, biosimilar (Ospomyv), 1 mg
J3490/J3590	Injection, denosumab-desu, biosimilar (Osvyrti)
J0897	Injection, denosumab 1 mg
Q5157	Injection, denosumab-bmwo, biosimilar (Stoboclo), 1 mg

Denosumab, Xgeva

HCPCS code	Description
Preferred	
J3490/J35900	denosumab-nxxp, biosimilar (Bilprevda)
Q5136	denosumab-bbdz, biosimilar (Wyost), 1 mg
Nonpreferred	
J3490/J3590	Injection, denosumab-kyqq, biosimilar (Aukelso)
Q5158	Injection, denosumab-bnht, biosimilar (Bomyntra), 1 mg
J3490/J3590	Injection, denosumab-qbde, biosimilar (Xtrenbo)
Q5159	Injection, denosumab-dssb, biosimilar (Xbryk), 1 mg
J3490/J3590	Injection, denosumab-desu, biosimilar (Jubereq)
J0897	Injection, denosumab 1 mg
Q5157	Injection, denosumab-bmwo, biosimilar (Osenvelt), 1 mg

Eculizumab

HCPCS code	Description
Preferred	
Q5151	Injection, eculizumab-aagh (epysqli), 2 mg
Nonpreferred	
J1299	Injection, eculizumab, 2mg
Q5152	Injection, eculizumab-aeeb (bkemv), 2 mg

Immune globulins, IV

HCPCS code	Description
Preferred	
J1572	Injection, immune globulin (Flebogamma), 500 mg
J1569	Injection, immune glogulin (Gammagard liquid), 500 mg
J1566	Injection, immune globulin (powder), 500 mg
J1561	Injection, immune globulin (Gamunex-C/Gammaked), 500 mg
J1557	Injection, immune globulin (Gammaplex), 500 mg
J1568	Injection, immune globulin (Octagam), 500 mg
J1459	Injection, immune globulin (Privigen), 500 mg
J1599/J3490/ J3590/C9399	Injection, immune globulin (Gammagard Liquid ERC)
Nonpreferred	
J1552	Injection, immune globulin, Alyglo, 500 mg
J1554	Injection, immune globulin (Asceniv), 500 mg
J1556	Injection, immune globulin (Bivigam), 500 mg
J1576	Injection, immune globulin (Panzyga), 500 mg
J1599/J3490/ J3590/C9399	Injection, immune globulin (Yimmugo)
J1599/J3490/ J3590/C9399	Injection, immune globulin (Qivigy)

Immune globulins, SC

HCPCS code	Description
Preferred	
J1551	Injection, immune globulin (Cutaquig), 100 mg
J1569	Injection, immune globulin (Gammagard liquid), 500 mg
J1561	Injection, immune globulin (Gamunex-C/Gammaked), 500 mg
J1559	Injection, immune globulin (Hizentra), 100 mg
J1558	Injection, immune globulin (Xembify), 100 mg
J1599/J3490/ J3590/C9399	Injection, immune globulin (Gammagard Liquid ERC)
Nonpreferred	
J1555	Injection, immune globulin (Cuvitru), 100 mg
J1575	Injection, immune globulin (Hyqvia), 100 mg

Immunomodulators

HCPCS 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), 10 mg
Nonpreferred	
J1745	Injection, infliximab, excludes biosimilar, 10 mg

Intravenous iron

HCPCS code	Description
Preferred	
J1756	Injection, iron sucrose, 1 mg
Nonpreferred	
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg
Q0138	Injection, ferumoxytol, 1 mg (for treatment of iron deficiency anemia)

Ophthalmic disorders, intravitreal vascular endothelial growth factor (VEGF) inhibitors

HCPCS code	Description
Preferred	
C9257	Injection, bevacizumab (Avastin), 0.25 mg
J7999	Compounded drug, not otherwise classified
J9035	Injection, bevacizumab (Avastin), 10 mg
Nonpreferred	
J0178	Injection, aflibercept, 1 mg
J0179	Injection, brolucizumab-dbll, 1 mg
J0177	Injection, aflibercept hd, 1 mg
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
Q5147	Injection, afilbercept-ayyh, (Pavblu), 1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar (Byooviz), 0.1 mg
Q5128	Injection, ranibizumab-eqrn, biosimilar (Cimerli), 0.1 mg

Paclitaxel medications

HCPCS code	Description
Preferred	
J9267	Injection, paclitaxel, 1 mg
Nonpreferred	
J9264	Injection, paclitaxel protein-bound particles, 1 mg

Rituximab

HCPCS 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
Nonpreferred	
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg

Somatostatin analogs, long acting

HCPCS code	Description
Preferred	
J1930	Injection, lanreotide, 1 mg
J1932	Injection, lanreotide, (Cipla), 1 mg
Nonpreferred	
J2353	Injection, octreotide depot, 1 mg

Systemic lupus erythematosus (SLE; lupus) drugs

HCPCS code	Description
Preferred	
J0490	Injection, belimumab, 10 mg
Nonpreferred	
J0491	Injection, anifrolumab-fnia, 1 mg

Testosterone, injectable

HCPCS code	Description
Preferred	
J1071	Injection, testosterone cypionate, 1 mg
J3121	Injection, testosterone enanthate, 1 mg
Nonpreferred	
J1072	Injection, testosterone cypionate (Azmiro), 1 mg
J3145	Injection, testosterone undecanoate, 1 mg
J1073	Unclassified drugs, Testopel
J3490	Unclassified drugs, Xyosted

Tocilizumab

HCPCS code	Description
Preferred	
Q5135	Injection, Tyenne, 1 mg
Nonpreferred	
J3262	Injection, Tocilizumab injection (Actemra), 1 mg
Q5133	Injection, Tofidence, 1 mg
Q5156	Injection, Avtozma, 1 mg

Trastuzumab

HCPCS 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
Nonpreferred	
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, biosimilar (Hercessi), 10 mg

Ustekinumab

HCPCS code	Description
Preferred	
Q9998	Injection, ustekinumab-aekn, 1mg
Nonpreferred	
J3358	Injection ustekinumab, IV 1 mg
Q5098	Injection, ustekinumab -srlf, 1 mg
Q5099	Injection, ustekinumab-stba, 1 mg
Q5100	Injection, ustekinumab-kfce, 1 mg
Q5138	Injection, wezlana, iv 1mg
Q9997	Injection, ustekinumab-ttwe, iv 1 mg
Q9999	Injection, ustekinumab- aauz, 1 mg
	Injection, ustekinumab-hmny, 1mg

Viscosupplements

HCPCS code	Description
Preferred	
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
Nonpreferred	
J7318	Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
J7320	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg
J7329	Hyaluronan or derivative, TriVisc, for intra-articular injection, 1 mg
J7331	Hyaluronan or derivative, Synojoynt, for intra-articular injection, 1 mg
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Calcitonin gene-related peptide inhibitors**

HCPCS code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Nonpreferred	
J3032	Injection, eptinezumab-jjmr, 1 mg

Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors**

HCPCS code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Nonpreferred	
J1306	Injection, inclisiran, 1 mg

Provider next steps

For medical non-oncology indications, or for non-EviCore by Evernorth®-delegated oncology reviews:

Providers can:

- Access the prior authorization list at **healthspring.com/providers/clinical-review**.
- Access Part B forms at **healthspring.com/providers/forms**.
- Request prior authorization or step therapy review by:
  - Logging in to the Availity Essentials portal (**Availity.com**), **or**
  - Faxing requests to **877-730-3858**.

Providers requiring help and members starting a request may contact the Prior Authorization team at **888-454-0013**.

For medical oncology indications, or EviCore-delegated reviews:

Providers may request prior authorization or step therapy review by:

- Accessing the prior authorization list at **EviCore.com/Resources**.
- Submitting a request via the Providers' Hub at **EviCore.com**, or calling **866-686-4452** (encouraged for urgent treatment requests).

For the Part D Drug List and Part D Utilization Management Requirements:

View the Part D Complete Medicare Drug List Formulary at healthspring.com/providers/resources.

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1. Centers for Medicare & Medicaid Services, National Government Services, Inc, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) applicable coverage policies. Available at https://www.cms.gov/medicare-coverage-database/search.aspx.
2. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®). Available at www.nccn.org.

Antiemetic - Serotonin receptor antagonists (injectable) for oncology

1. Palonosetron intravenous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; December 2020.
2. Ondansetron intramuscular injection or intravenous infusion [prescribing information]. Lake Zurich, IL: Fresenius Kabi; November 2023.
3. Granisetron intravenous infusion [prescribing information]. Rockford, IL: Fresenius Kabi; November 2022.
4. Sustol® extended-release subcutaneous injection [prescribing information]. Redwood City, CA: Heron; September 2024.
5. Posfrea® intravenous infusion [prescribing information]. Parsippany, NJ: Avyxa Pharma; July 2024
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Antiemetic – Substance P/neurokinin-1 receptor antagonists (injectable) for oncology

1. Cinvanti™ intravenous infusion [prescribing information]. San Diego, CA: Heron; March 2024.
2. Emend® intravenous infusion [prescribing information]. Whitehouse Station, NJ: Merck; May 2022.
3. Akynzeo® intravenous infusion [prescribing information]. Iselin, NJ: Helsinn; December 2023.
4. Focinvez® intravenous infusion [prescribing information] Plainsboro, Nj; Amneal; March 2024.

Bevacizumab (for oncology)

1. Avastin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; September 2022.
2. Mvasi® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; February 2023.
3. Zirabev™ intravenous infusion [prescribing information]. New York, NY: Pfizer; August 2024.
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5. Vegzelma™ intravenous infusion [prescribing information]. Incheon, Republic of Korea: Celltrion; September 2022.
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Botulinum toxins

1. Botox® injection [prescribing information]. Madison, NJ: Allergan; November 2023.
2. Charles AC, Digre KB, Goadsby PJ, Robbins MS, Hershey A; American Headache Society. Calcitonin gene-related peptide-targeting therapies are a first-line option for the prevention of migraine: An American Headache Society position statement update. Headache. 2024;64(4):333-341.
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30. Xeomin® injection [prescribing information]. Raleigh, NC and Franksville, WI: Merz; July 2024.
31. Daxxify® injection [prescribing information]. Newark, CA: Revance; January 2024.
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Colony-stimulating factors, long acting

1. Neulasta® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; October 2024.
2. Fulphila® subcutaneous injection [prescribing information]. Rockford, IL: Mylan; December 2023.
3. Udenyca™ subcutaneous injection [prescribing information]. Redwood City, CA: Coherus; August 2024.
4. Ziextenzo™ subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; Decemeber 2022.
5. Nyvepria™ subcutaneous injection [prescribing information]. New York, NY: Pfizer; June 2023.

6. Fylnetra® subcutaneous injection [prescribing information]. Bridgewater, NJ: Amneal; May 2022.
7. Stimufend® subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; October 2023.
8. Rolvedon™ subcutaneous injection [prescribing information]. Irvine, CA: Spectrum; November 2023.
9. Ryzneuta® subcutaneous injection [prescribing information]. Singapore: Evive; March 2024.
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Colony-stimulating factors, short acting

1. Neupogen® intravenous or subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; April 2023.
2. Zarxio™ intravenous or subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; October 2024.
3. Nivestym™ intravenous or subcutaneous injection [prescribing information]. Lake Forest, IL: Hospira/Pfizer; February 2024.
4. Releuko® subcutaneous or intravenous injection [prescribing information]. Bridgewater, NJ: Amneal; August 2023.
5. Granix® subcutaneous injection [prescribing information]. North Wales, PA: Teva; November 2023.
6. Nypozi™ subcutaneous or intravenous injection [prescribing information]. San Diego, CA: Tanvex, June 2024.
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Denosumab, Prolia

1. Prolia® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; May 2025.
2. Conexxence® subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; March 2025.
3. Jubbonti® subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; October 2024.
4. Stoboclo® subcutaneous injection [prescribing information]. Jersey City, NJ: Celltrion; February 2025.
5. Bildyos® subcutaneous injection [prescribing information]. Jersey City, NJ: Shanghai Henlius Biotech/Organon; August 2025.
6. Ospomyv™ subcutaneous injection [prescribing information]. Incheon, Republic of Korea: Samsung Bioepis; February 2025.
7. Osvyrti® subcutaneous injection [prescribing information]. Raleigh, NC: Accord; October 2025.
8. Bosaya™ subcutaneous injection [prescribing information]. Cambridge, MA. Biocon: September 2025.
9. Enoby™ subcutaneous injection [prescribing information]. Cherry Hill, NJ. Hikma: September 2025.
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Denosumab, Xgeva

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2. Bomyntra® subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; March 2025.
3. Osenvelt® subcutaneous injection [prescribing information]. Jersey City, NJ: Celltrion; February 2025.
4. Wyost® subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; March 2024.
5. Xbryk™ subcutaneous injection [prescribing information]. Incheon, Republic of Korea: Samsung Bioepis; February 2025.
6. Aukelso™ subcutaneous injection [prescribing information]. Cambridge, MA. Biocon: September 2025.
7. Jubereq® subcutaneous injection [prescribing information]. Raleigh, NC: Accord; October 2025
8. Xtrenbo™ subcutaneous injection [prescribing information]. Cherry Hill, NJ. Hikma: September 2025.
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Eculizumab

1. Soliris® intravenous infusion [prescribing information]. Boston, MA: Alexion; March 2025.
2. Bkemv™ intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; October 2024.
3. Epysqli® intravenous infusion [prescribing information]. Yeonsu-gu, Incheon, Republic of Korea; April 2025.

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Immune globulins, IV

1. Bivigam® 10% intravenous solution [prescribing information]. Boca Raton, FL: ADMA Biologics; April 2025.
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3. Flebogamma® 5% DIF intravenous solution [prescribing information]. Los Angeles, CA: Grifols; August 2024.
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5. Gammagard® Liquid 10% solution [prescribing information]. Cambridge, MA: Takeda; September 2024.
6. Gammagard® S/D IgA < 1 mcg/mL in a 5% intravenous solution [prescribing information]. Cambridge, MA: Takeda; February 2025.
7. Gammaked™ 10% solution [prescribing information]. Fort Lee, NJ: Kedrion; January 2020.
8. Gammaplex® 5% intravenous solution [prescribing information]. Fort Lee, NJ: Kedrion (Bio Products Laboratory); July 2025.
9. Gamunex®-C 10% solution [prescribing information]. Research Triangle Park, NJ: Grifols; January 2020.
10. Octagam® 5% intravenous solution [prescribing information]. Paramus, NJ: Octapharma; April 2022.
11. Octagam® 10% intravenous solution [prescribing information]. Paramus, NJ: Octapharma; April 2022.
12. Privigen® 10% intravenous solution [prescribing information]. Kankakee, IL: CSL Behring; May 2025.
13. McLean HQ, Fiebelkorn AP, Temte JL, Wallace GS; Centers for Disease Control and Prevention. Prevention of measles, rubella, congenital rubella syndrome, and mumps, 2013: summary recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep. 2013;62:1-34.
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15. Panzyga 10% intravenous solution [prescribing information]. New York; NY: Pfizer; April 2025.
16. Asceniv 10% intravenous solution [prescribing information]. Boca Raton, FL. ADMA Biologics; April 2025.
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81. Qivigy 10% intravenous solution [prescribing information]. Fort Lee, NJ: Kedrion; September 2025.

Immune globulins, SC

1. Gammagard® Liquid 10% [prescribing information]. Lexington, MA: Takeda; January 2024.
2. Gammaked™ 10% solution [prescribing information]. Fort Lee, NJ: Kedrion; January 2020.
3. Gamunex®-C 10% solution [prescribing information]. Research Triangle Park, NC: Grifols; July 2024.
4. Hizentra® 20% subcutaneous solution [prescribing information]. Kankakee, IL: CSL Behring; April 2023.
5. HyQvia® 10% subcutaneous solution with recombinant human hyaluronidase [prescribing information]. Lexington, MA: Takeda; July 2025.
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Immunomodulators

1. Infliximab intravenous infusion [prescribing information]. Horsham, PA: Janssen; October 2021.
2. Inflectra® intravenous infusion [prescribing information]. Yeonsu-gu, Incheon, Republic of Korea: Celltrion/Pfizer; September 2025.
3. Renflexis® intravenous infusion [prescribing information]. Jersey City, NJ: Samsung Bioepis/Organon; October 2025.
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27. Avsola® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; August 2025.

Intravenous iron

1. Injectafer® intravenous infusion or injection [prescribing information]. Shirley, NY: American Regent; May 2023.
2. Venofer® intravenous infusion or injection [prescribing information]. Shirley, NY: American Regent; July 2022.
3. Feraheme® intravenous infusion [prescribing information]. Waltham, MA: AMAG Pharmaceuticals; June 2022.
4. Monoferric® intravenous infusion [prescribing information]. Morristown, NJ: Pharmacosmos Therapeutics; September 2024.
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Ophthalmic disorders, intravitreal vascular endothelial growth factor (VEGF) inhibitors

1. Beovu® intravitreal injection [prescribing information]. Hanover, NJ: Novartis; July 2024.
2. Eylea® intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; October 2024.
3. Lucentis® intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; February 2024.
4. Byooviz™ intravitreal injection [prescribing information]. Cambridge, MA: Biogen; October 2023.
5. Vabysmo™ intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; July 2024.
6. Cimerli™ intravitreal injection [prescribing information]. Redwood City, CA: Coherus; May 2024.
7. Eylea™ HD intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; October 2024.
8. Pavblu™ intravitreal injection [prescribing information]. Thousand Oaks, CA: Amgen; August 2024.
9. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-related macular degeneration. San Francisco, CA: American Academy of Ophthalmology; 2019. https://www.aao.org/preferred-practice-pattern/age-related-macular-degeneration-ppp. Accessed on August 1, 2024.

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Paclitaxel

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2. Abraxane® intravenous infusion [prescribing information]. Summit, NJ: Celgene; August 2020.
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Rituximab

1. Rituxan [prescribing information]. South San Francisco, CA: Genentech; December 2021.
2. Ruxience [prescribing information]. New York, NY: Pfizer; October 2023.
3. Truxima [prescribing information]. North Wales, PA: Teva/Celltrion; July 2024.
4. Rituxan Hycela™ injection for SC use [prescribing information]. South San Francisco, CA: Biogen and Genentech/Roche; June 2021.
5. Riabni [prescribing information]. Thousand Oaks, CA: Amgen; February 2023.
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Somatostatin analogs, long acting

1. Somatuline® Depot injection [prescribing information]. Basking Ridge, NJ: Ipsen; October 2024.
2. Lanreotide subcutaneous injection [prescribing information]. Warren, NJ: Cipla; September 2024.
3. Sandostatin® LAR Depot intramuscular injection [prescribing information]. East Hanover, NJ: Novartis; July 2024.
4. Strosberg JR, Halfdanarson TR, Bellizi AR, et al. The North American Neuroendocrine Tumor Society consensus guidelines for surveillance and medical management of midgut neuroendocrine Tumors. Pancreas. 2017;46(6):707-714.
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Systemic lupus erythematosus (SLE; lupus) drugs

1. Benlysta® injection [prescribing information]. Rockville, MD: Human Genome Sciences/GlaxoSmithKline; May 2024.
2. Saphnelo® injection [prescribing information]. Wilmington, DE: AstraZeneca; September 2022.
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4. Kidney Disease: Improving Global Outcomes (KDIGO) Lupus Nephritis Work Group. KDIGO 2024 Clinical Practice Guideline for the management of LUPUS NEPHRITIS. Kidney Int. 2024;105(1S):S1-S69.
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Testosterone, injectable

1. Depo®-Testosterone [prescribing information]. New York, NY: Pfizer; June 2024.
2. Testosterone enanthate injection [prescribing information]. Berkeley Heights, NJ: Hikma; January 2021.
3. Testopel® [prescribing information]. Malvern, PA: Endo; July 2025.
4. Aveed™ [prescribing information]. Malvern, PA: Endo; July 2025.
5. Xyosted [prescribing information]. Ewing, NJ: Antares; July 2025.
6. Azmiro™ [prescribing information]. Woburn, MA: Azurity; July 2025.
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Tocilizumab
1. Actemra® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; September 2024.
2. Tofidence™ intravenous infusion [prescribing information]. Cambridge, MA: Biogen; July 2024.
3. Tyenne® intravenous infusion [prescribing information]. Lake Zurich, IL: Fresenius Kabi; March 2024.
4. Avtozma® intravenous infusion [prescribing information]. Jersey City, NJ: Celltrion; February 2025.
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Trastuzumab
1. Herceptin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; February 2021.
2. Herzuma® intravenous infusion [prescribing information]. North Wales, PA: Teva; May 2019.
3. Kanjinti® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; October 2022.
4. Ogivri® intravenous infusion [prescribing information]. Steinhausen, Switzerland: Mylan; July 2023.
5. Trazimera™ intravenous infusion [prescribing information]. New York, NY: Pfizer; November 2020.
6. Herceptin Hylecta™ subcutaneous injection [prescribing information]. South San Francisco, CA: Genentech; June 2024.
7. Ontruzant® intravenous infusion [prescribing information]. Whitehouse Station, NJ: Merck; March 2020.
8. Hercessi™ intravenous infusion [prescribing information]. Raleigh, NC: Accord BioPharma; September 2024.

Ustekinumab
1. Stelara® intravenous infusion, subcutaneous injection [prescribing information]. Horsham, PA: Janssen Biotech; March 2024.
2. Ustekinumab intravenous infusion, subcutaneous injection [prescribing information]. Horsham, PA: Janssen Biotech; April 2025.
3. Wezlana® intravenous infusion, subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; October 2023.
4. Otulfi® intravenous infusion, subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius; December 2024.
5. Pyzchiva® intravenous infusion, subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; June 2024.
6. Selarsdi® intravenous infusion, subcutaneous injection [prescribing information]. Parsippany, NJ: Teva; October 2024.
7. Steqeyma® intravenous infusion, subcutaneous injection [prescribing information]. Incheon, Republic of Korea: Celltrion; December 2024.
8. Yesintek® intravenous infusion, subcutaneous injection [prescribing information]. Cambridge, MA: Biocon; December 2024.
9. Imuldosa® intravenous infusion, subcutaneous injection [prescribing information]. Raleigh, NC: Accord; October 2025.
10. Ustekinumab-ttwe intravenous infusion, subcutaneous injection [prescribing information]. Grand Cayman, Cayman Islands: Quallent; March 2025.
11. Ustekinumab-aekn intravenous infusion, subcutaneous injection [prescribing information]. Parsippany, NJ: Teva; October 2024.
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Viscosupplements

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2. Euflexxa® intraarticular injection [prescribing information]. Parsippany, NJ: Ferring; July 2016.
3. Gel-One® intraarticular injection [prescribing information]. Warsaw, IN: Zimmer; May 2011.
4. Gelsyn-3® intraarticular injection [prescribing information]. Durham, NC: Bioventus; 2016.
5. GenVisc® 850 intraarticular injection [prescribing information]. Doylestown, PA: OrthogenRx; not dated.
6. Hyalgan® intraarticular injection [prescribing information]. Parsippany, NJ: Fidia Pharma; May 2014.
7. Hymovis® intraarticular injection [prescribing information]. Parsippany, NJ: Fidia Pharma; October 2015.
8. Monovisc® intraarticular injection [prescribing information]. Bedford, MA: DePuy Synthes; not dated.
9. Orthovisc® intraarticular injection [prescribing information]. Raynham, MA: DePuy Synthes; September 2014.
10. Sodium hyaluronate 1% intraarticular injection [prescribing information]. North Wales, PA: Teva; March 2019.
11. Supartz® FX™ intraarticular injection [prescribing information]. Durham, NC: Bioventus; April 2015.
12. Synvisc® intraarticular injection [prescribing information]. Ridgefield, NJ: Genzyme; September 2014.
13. Synvisc-One® intraarticular injection [prescribing information]. Ridgefield, NJ: Genzyme; September 2014.
14. Triluron intraarticular injection [prescribing information]. Florham Park, NJ: Fidia Pharma; March 2019.
15. Trivisc intraarticular injection [prescribing information]. Doylestown, PA: OrthogenRx; not dated.
16. Visco-3 intraarticular injection [prescribing information]. Durhan, NC: Bioventus; not dated.
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Calcitonin gene-related peptide inhibitors**

1. Vyepti® intravenous infusion [prescribing information]. Bothell, WA: Lundbeck; March 2025.
2. Aimovig® injection for subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen; March 2025.
3. Ajovy® injection for subcutaneous use [prescribing information]. North Wales, PA: Teva; March 2025.
4. Emgality® injection for subcutaneous use [prescribing information]. Indianapolis, IN: Lilly; March 2025.
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13. Qulipta® tablets [prescribing information]. Madison, NJ: AbbVie; March 2025.
14. Nurtec® ODT [prescribing information]. New Haven, CT: Biohaven; March 2025.

Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors**

1. Praluent® subcutaneous injection [prescribing information]. Tarrytown, NY: Regeneron; March 2024.
2. Repatha® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; November 2024.
3. Leqvio® subcutaneous injection [prescribing information]. East Hanover, NJ: Novartis; July 2025.
4. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2022 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. J Am Coll Cardiol. 2022;80(14):1366-1418.
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16. Patel SB, Wyne KL, Afreen S, et al. American Association of Clinical Endocrinology clinical practice guideline on pharmacologic management of adults with dyslipidemia. Endocrine Pract. 2025;31:236-262.

Date	Summary of changes
01/07/2026	**Coverage criteria** **Denosumab - Prolia** • New step therapy class and criteria added. **Denosumab - Xgeva** • New step therapy class and criteria added. **Immune Globulins - IV** • Added Gammagard Liquid ERC as preferred medication. • Added Qivigy as nonpreferred medication. **Immune Globulin - SC** • Added Gammagard Liquid ERC as preferred medication. **Applicable Codes** **Denosumab - Prolia** • Bildyos *Preferred* • Q5136 *Preferred* • Bosaya *Nonpreferred* • Q5158 *Nonpreferred* • Enoby *Nonpreferred* • Q5159 *Nonpreferred* • Osvyrti *Nonpreferred* • J0897 *Nonpreferred* • Q5157 *Nonpreferred* **Denosumab – Prolia** • Bilprevda *Preferred* • Q5136 *Preferred* • Aukelso *Nonpreferred* • Q5158 *Nonpreferred* • Xtrenbo *Nonpreferred* • Q5159 *Nonpreferred* • Jubereq *Nonpreferred* • J0897 *Nonpreferred* • Q5157 *Nonpreferred* **Immune Globulins – IV** • Gammagard Liquid ERC *Preferred* • Qivigy *Nonpreferred* **Immune Globulin – SC** • Gammagard Liquid ERC *Preferred*

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