

Questions about step therapy?

**HealthSpringSM 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.



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 • Vegzelma • Jobevne
Botulinum toxins	• Botox • Daxxify • Dysport • Xeomin	Myobloc
Colony-stimulating factors, Short acting	• Nivestym • Zarxio	• Granix • Neupogen • Nypozi • Releuko
Colony-stimulating factors, Long acting	• Fulphila • Neulasta • Udenyca	• Fylnetra • Nyvepria • Rolvedon • Ryzneuta • Stimufend • Ziextenzo
Eculizumab	• Epysqli	• Bkembv • Soliris
Immune globulins IV	• Flebogamma DIF • Gammagard Liquid • Gammagard S/D • Gammaked • Gammaplex • Gamunex-C • Octagam • Privigen	• Alyglo • Asceniv • Bivigam • Panzyga • Yimmugo
Immune globulins SC	• Cutaquig • Gammagard liquid • Gammaked • Gamunex-C • Hizentra • Xembify	• Cuvitru • HyQvia
Immunomodulators	• Avsola • Inflectra • Renflexis	Remicade, infliximab (authorized generic)
Intravenous iron	Venofer	• Feraheme • Injectafer • Monoferric

*Preferred medications may require prior authorization.

Step therapy drug class	Preferred* medications	Nonpreferred medications
Ophthalmic disorders Intravitreal vascular endothelial growth factor (VEGF) inhibitors	Avastin	• Beovu • Eylea HD • Byooviz • Lucentis • Cimerli • Pavblu • Eylea • 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 (PCK9) 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 • Focinvez • Cinvanti

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
• Aylmsys • 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, 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

Colony-stimulating factors, long acting

Preferred* medications	Nonpreferred medications
• Neulasta/Neulasta Onpro • Fulphila • Udenyca/Autoinjector/Onbody	• Nyvepria • Fylnetra • 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

Eculizumab

Preferred* medications	Nonpreferred medications
• Epysqli	• Bkerv • 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.

Bkerv 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 S/D • Gammaked • Gammaplex • Gamunex-C • Octagam • Privigen	• Alyglo • Asceniv • Bivigam • Panzyga • 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 [cicatrical 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 [cicatrical 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 or Yimmugo may be covered when the criteria listed below are satisfied:

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

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

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

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

- Bivigam, Panzyga 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 [cicatrical pemphigoid] and epidermolysis bullosa acquisita), **or**
 - Severe vasculitic syndromes, systemic (polyarteritis nodosa), 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 [cicatrical pemphigoid] and epidermolysis bullosa acquisita), **or**
 - Severe vasculitic syndromes, systemic (polyarteritis nodosa), 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 or Yimmugo may be covered when the criteria listed below are satisfied:

- Bivigam, Panzyga 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 nodosa), 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 • 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 • Monoferic • Injectafer

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 Monoferic 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 • Eylea HD • Byooviz • Lucentis • Cimerli • Pavblu • Eylea • 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 erythematosus (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 - Synojynt - 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, Synojynt, 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

HCPSC 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

HCPSC code	Description
Preferred	
J1453	Injection, fosaprepitant, 1 mg
Nonpreferred	
J0185	Injection, aprepitant, 1 mg

HCPCS code	Description
J1434	Injection, focinvez, 1mg
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg

Bevacizumab (for 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
	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, short acting

HCPCS code	Description
Preferred	
Q5101	Injection, filgrastim-sndz, biosimilar (Zarxio), 1 mcg
Q5110	Injection, filgrastim-aafi, biosimilar (Nivestym), 1 mcg

HCPSC code	Description
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

Colony-stimulating factors, long acting

HCPSC 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 (Flyneta), 0.5 mg

Eculizumab

HCPSC 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

HCPSC code	Description
Preferred	
J1572	Injection, immune globulin (Flebogamma), 500 mg
J1569	Injection, immune globulin (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
Nonpreferred	
J1599	Injection, immune globulin, (liquid), 500 mg
J1554	Injection, immune globulin (Asceniv), 500 mg
J1556	Injection, immune globulin (Bivigam), 500 mg
J1576	Injection, immune globulin (Panzyga), 500 mg
C9399/J3490/J3590	Injection, immune globulin (Yimmugo)

Immune globulins, SC

HCPSC 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
Nonpreferred	
J1555	Injection, immune globulin (Cuvitru), 100 mg
J1575	Injection, immune globulin (Hyqvia), 100 mg

Immunomodulators

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

Intravenous iron

HCPSC 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

HCPSC 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, brotacizumab-dbl, 1 mg
J0177	Injection, aflibercept hd, 1 mg
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
Q5147	Injection, aflibercept-ayyh, (Pavblu), 1 mg

HCPCS code	Description
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	
J9259	Injection, paclitaxel protein-bound particles (American Regent) not therapeutically equivalent to J9264, 1 mg
J9264	Injection, paclitaxel protein-bound particles, 1 mg

Rituximab

HCPCS code	Description
Preferred	
Q5115	Injection, rituximab-abbs, biosimilar (Truxima), 10 mg
Q5119	Injection, rituximab-pwvr, 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	

HCPCS code	Description
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
J3490	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

HCPSC code	Description
Q5133	Injection, Tofidence, 1 mg
Q5156	Injection, Avtozma, 1 mg

Trastuzumab

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

HCPSC code	Description
Preferred	
Q9998	Injection, ustekinumab-aekn, 1 mg
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 1 mg
Q9997	Injection, ustekinumab-ttwe, iv 1 mg
Q9999	Injection, ustekinumab- aaaz, 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, Synjoynt, 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.
- Access quick Part B reference guides and forms at HealthSpring.com/Providers.
- 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.

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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
6. Hesketh PJ, Kris MG, Basch E, et al. Antiemetics: American Society of Clinical Oncology Clinical Practice Guideline Update. J Clin Oncol. 2020 Aug 20; 38(24):2782-2797.
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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.
4. Alymsys® intravenous infusion [prescribing information]. Bridgewater, NJ: Amneal; April 2022.
5. Vegzelma™ intravenous infusion [prescribing information]. Incheon, Republic of Korea: Celltrion; September 2022.
6. Avzivi™ intravenous infusion [prescribing information]. Guangzhou, Guangdong Province, China: Bio-Thera Solutions; October 2024.
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13. Grill J, Massimino M, Boufett E, et al. Phase II, open-label, randomized, multicenter trial (HERBY) of bevacizumab in pediatric patients with newly diagnosed high-grade glioma. J Clin Oncol. 2018;36:951-958.
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Botulinum toxins

1. Botox® injection [prescribing information]. Madison, NJ: Allergan; November 2023.
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36. Daxxify® injection [prescribing information]. Newark, CA: Revance; January 2024.

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; April 2020.
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Colony-stimulating factors, long acting

1. Neulasta® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; March 2021.
2. Fulphila® subcutaneous injection [prescribing information]. Rockford, IL: Mylan; July 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; September 2022.
8. Rolvedon™ subcutaneous injection [prescribing information]. Irvine, CA: Spectrum; June 2023.
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Ecilizumab

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Immune globulins, SC

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Immunomodulators

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Intravenous iron

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

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2. Eylea® intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; December 2023.
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; October 2023.
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Paclitaxel

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Rituximab

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2. Ruxience [prescribing information]. New York, NY: Pfizer; October 2023.
3. Truxima [prescribing information]. North Wales, PA: Teva/Celltrion; July 2024.
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Somatostatin analogs, long acting

1. Somatuline® Depot injection [prescribing information]. Basking Ridge, NJ: Ipsen; July 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 2023.
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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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Testosterone, injectable

1. Depo®-Testosterone [prescribing information]. New York, NY: Pfizer; September 2018.
2. Testosterone enanthate injection [prescribing information]. Berkeley Heights, NJ: Hikma; January 2021.
3. Testopel® [prescribing information]. Malvern, PA: Endo; March 2024.
4. Aveed™ [prescribing information]. Malvern, PA: Endo; August 2021.
5. Xyosted [prescribing information]. Ewing, NJ: Antares; August 2023.
6. Azmiro™ [prescribing information]. Woburn, MA: Azurity; May 2024.
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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.

12. Starjemza™ intravenous infusion, subcutaneous injection [prescribing information]. Berkeley Heights, NJ: Hikma; May 2025.
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Viscosupplements

1. Durolane® intraarticular injection [prescribing information]. Durham, NC: Bioventus; not dated.
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]. Durham, NC: Bioventus; not dated.
17. SynJoyn™ injection [prescribing information]. Naples, FL: Arthrex; 2022.
18. Kolasinski SH, Neogi T, Hochberg MC, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the management of osteoarthritis of the hand, hip, and knee. *Arthritis Care Res*. 2019;72(2):149-162.
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32. Tikiz C, Unlu Z, Sener A, et al. Comparison of the efficacy of lower and higher molecular weight viscosupplementation in the treatment of hip osteoarthritis. *Clin Rheumatol*. 2005;24:244-250.
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Calcitonin gene-related peptide inhibitors**

1. Vyepti® intravenous infusion [prescribing information]. Bothell, WA: Lundbeck; October 2022.
2. Aimovig® injection for subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen; May 2023.
3. Ajovy® injection for subcutaneous use [prescribing information]. North Wales, PA: Teva; October 2022.
4. Emgality® injection for subcutaneous use [prescribing information]. Indianapolis, IN: Lilly; May 2022
5. Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders: 3rd edition. *Cephalalgia*. 2018;38:1-211.
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13. Qulipta® tablets [prescribing information]. Madison, NJ: AbbVie; April 2023.
14. Nurtec® ODT [prescribing information]. New Haven, CT: Biohaven; April 2022.

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; September 2021.
3. Leqvio® subcutaneous injection [prescribing information]. East Hanover, NJ: Novartis; July 2023.
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13. Razavi AC, Agatston AS, Shaw LJ, et al. Evolving role of calcium density in coronary artery calcium scoring and atherosclerotic cardiovascular disease risk. *JACC Cardiovas Imaging*. 2022;15:1648-1662.
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Revision history

Date	Summary of changes
10/24/2025	Coverage criteria Antiemetic – Serotonin receptor antagonists (injectable) for oncology - Added Posfrea as nonpreferred medication. Antiemetic – Substance P/neurokinin-1 receptor antagonists (injectable) for oncology - Added Focinvez as nonpreferred medication. Bevacizumab (for oncology) - Added Jobevne as nonpreferred medication. Eculizumab - New step therapy class and criteria added. Long-acting colony-stimulating factors - Moved Nyvepria to a nonpreferred medication. - Moved Fulphila to a preferred medication. Intravenous iron - Added criteria for Feraheme and Monoferic - Patient does not have chronic kidney disease - Added criteria for Injectafer - Patient is less than 2 years of age - Patient does not have chronic kidney disease Rituximab - Added criteria for NGS MAC region - Susac syndrome Somatostatin analogs - Added criteria for small bowel bleeds/angiodyspasia related bleeding Tocilizumab - Added criteria - Inability to continue to use the preferred medication due to formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. - Added Avtozma as nonpreferred medication. Ustekinumab - New step therapy class and criteria added. Antiemetic – Serotonin receptor antagonists (injectable) for oncology - J2468 <i>Nonpreferred</i> Antiemetic – Substance P/neurokinin-1 receptor antagonists (injectable) for oncology - J1434 <i>Nonpreferred</i> Bevacizumab (for oncology) - Jobevne <i>Nonpreferred</i> Eculizumab - Q5151 <i>Preferred</i> - J1299 <i>Nonpreferred</i> - Q5152 <i>Nonpreferred</i>

Date	Summary of changes
	Coverage criteria (continued) Long-acting colony-stimulating factors • Q5108 <i>Preferred</i> • Q5122 <i>Nonpreferred</i> Tocilizumab • Q5156 <i>Nonpreferred</i> Ustekinumab • Q9998 <i>Preferred</i> • J3358 <i>Nonpreferred</i> • Q5098 <i>Nonpreferred</i> • Q5099 <i>Nonpreferred</i> • Q5100 <i>Nonpreferred</i> • Q5138 <i>Nonpreferred</i> • Q9997 <i>Nonpreferred</i> • Q9999 <i>Nonpreferred</i> • Starjemza <i>Nonpreferred</i>

