STEP THERAPY CRITERIA FOR MEDICARE PART B DRUGS

This list is current as of 4/1/2024 and pertains to the following Independent Health Medicare Advantage Plans for 2024:

Independent Health's Encompass 65® Basic (HMO)
Independent Health's Encompass 65® Core (HMO)
Independent Health's Encompass 65® Edge (HMO)
Independent Health's Encompass 65® Element (HMO)
Independent Health's Medicare Passport® Advantage (PPO)
Independent Health's Medicare Passport® Prime (PPO)
Independent Health's Medicare Family Choice® (HMO I-SNP)
Independent Health's Assure Advantage® (HMO C-SNP)
Independent Health's Medicare Advantage Employer Group Waiver Plans (EGWP)

In some cases, we require that you first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug X and Drug Y both treat your medical condition, we may not cover Drug Y unless you try Drug X first. If Drug X does not work for you, we will then cover Drug Y.

The therapy outlined in this document may also involve a combination of Part B and Part D drugs. For example, we may not cover a Part B drug unless you try a Part D drug first. Or, we may not cover a Part D drug unless you try a Part B drug first. This is dependent on the therapy described to treat your medical condition. This document contains the Step Therapy protocols for Medicare Part B drugs that are associated with the Independent Health Medicare Advantage Plans mentioned above.

If you have any questions, please contact our Medicare Member Services Department at 1-800-665-1502 or, for TTY users 711, October 1st – March 31st: Monday through Sunday from 8 a.m. to 8 p.m., April 1st – September 30th: Monday through Friday from 8 a.m. to 8 p.m.

The formulary may change at any time. You will receive notice when necessary.

Amvuttra

Products Affected

• AMVUTTRA SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS

Criteria	For approval, the patient must have tried and failed to have an adequate response to either Onpattro or Tegsedi. This specific requirement applies
	to new starts only.

Aphexda

Products Affected

• APHEXDA SOLUTION RECONSTITUTED 62 MG SUBCUTANEOUS

only.		For approval, the patient must have tried and failed to have an adequate response to plerixafor. This specific requirement applies to new starts only.
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Apretude

Products Affected

• APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR

For approval, patient must have tried and had an intolerance to or has a
contraindication to emtricitabine/tenofovir disoproxil fumarate.

Asceniv

Products Affected

 ASCENIV SOLUTION 5 GM/50ML INTRAVENOUS

Criteria	For approval, patient must have tried and failed to have a response to
	another intravenous immunoglobulin (IVIG) product.

Bendamustine

Products Affected

- TREANDA SOLUTION RECONSTITUTED 100
 MG INTRAVENOUS
- TREANDA SOLUTION RECONSTITUTED 25 MG INTRAVENOUS

Criteria	For approval of Treanda, the patient must have tried and failed to have an adequate response to Belrapzo or Bendeka. This specific requirement applies to new starts only.
	applies to hew starts only.

Beovu

Products Affected

- BEOVU SOLUTION 6 MG/0.05ML INTRAVITREAL
- BEOVU SOLUTION PREFILLED SYRINGE 6 MG/0.05ML INTRAVITREAL

Criteria	For approval for a diagnosis of neovascular (wet) age-related macular degeneration or diabetic macular edema, the patient must have tried and failed to have an adequate response to bevacizumab (Avastin). This specific requirement applies to new starts only.
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Bevacizumab

Products Affected

- ALYMSYS SOLUTION 100 MG/4ML INTRAVENOUS
- ALYMSYS SOLUTION 400 MG/16ML INTRAVENOUS
- AVASTIN SOLUTION 100 MG/4ML INTRAVENOUS
- AVASTIN SOLUTION 400 MG/16ML INTRAVENOUS

- MVASI SOLUTION 100 MG/4ML INTRAVENOUS
- MVASI SOLUTION 400 MG/16ML INTRAVENOUS
- VEGZELMA SOLUTION 100 MG/4ML INTRAVENOUS
- VEGZELMA SOLUTION 400 MG/16ML INTRAVENOUS

Details

Criteria For approval of Alymsys, Avastin, Mvasi, or Vegzelma for oncology (cancer) indications, the patient must have tried and failed to have an adequate response to Zirabev. This specific requirement applies to new starts only. This requirement does not apply to patients using Avastin for ophthalmic (eye) indications or for any indication not shared by Zirabev and Avastin or another bevacizumab biosimilar agent.

Botulinum toxins

Products Affected

- DYSPORT SOLUTION RECONSTITUTED 300 UNIT INTRAMUSCULAR
- DYSPORT SOLUTION RECONSTITUTED 500 UNIT INTRAMUSCULAR
- MYOBLOC SOLUTION 10000 UNIT/2ML

INTRAMUSCULAR

- MYOBLOC SOLUTION 2500 UNIT/0.5ML INTRAMUSCULAR
- MYOBLOC SOLUTION 5000 UNIT/ML INTRAMUSCULAR

Criteria	For approval, the patient must have tried and failed to have an adequate response to Botox and Xeomin. This specific requirement applies to new starts only.

Enjaymo

Products Affected

• ENJAYMO SOLUTION 1100 MG/22ML INTRAVENOUS

Criteria	For approval, the patient must have tried and failed to have an adequate response to Ruxience (or another rituximab product) or any other B-cell targeting therapy. This specific requirement applies to new starts only.

Erythropoietins

Products Affected

- EPOGEN SOLUTION 10000 UNIT/ML INJECTION
- EPOGEN SOLUTION 2000 UNIT/ML INJECTION
- EPOGEN SOLUTION 20000 UNIT/ML INJECTION
- EPOGEN SOLUTION 3000 UNIT/ML INJECTION
- EPOGEN SOLUTION 4000 UNIT/ML INJECTION
- PROCRIT SOLUTION 10000 UNIT/ML

INJECTION

- PROCRIT SOLUTION 2000 UNIT/ML INJECTION
- PROCRIT SOLUTION 20000 UNIT/ML INJECTION
- PROCRIT SOLUTION 3000 UNIT/ML INJECTION
- PROCRIT SOLUTION 4000 UNIT/ML INJECTION
- PROCRIT SOLUTION 40000 UNIT/ML INJECTION

Criteria	For approval, the patient must have tried and failed to have an adequate
	response to Retacrit. This specific requirement applies to new starts only.

Evkeeza

Products Affected

- EVKEEZA SOLUTION 1200 MG/8ML INTRAVENOUS
- EVKEEZA SOLUTION 345 MG/2.3ML INTRAVENOUS

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Eylea

Products Affected

- EYLEA HD SOLUTION 8 MG/0.07ML INTRAVITREAL
- EYLEA SOLUTION 2 MG/0.05ML

INTRAVITREAL

• EYLEA SOLUTION PREFILLED SYRINGE 2 MG/0.05ML INTRAVITREAL

Criteria	For approval for a diagnosis of neovascular (wet) age-related macular degeneration, diabetic macular edema, or diabetic retinopathy in patients with diabetic macular edema, the patient must have tried and failed to have an adequate response to bevacizumab (Avastin). This specific requirement applies to new starts only.

Feiba

Products Affected

- FEIBA SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS
- FEIBA SOLUTION RECONSTITUTED 2500

UNIT INTRAVENOUS

 FEIBA SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS

Criteria	For approval of Feiba, the patient must have tried and failed to have an adequate response to Hemlibra. This specific requirement applies to new starts only. This requirement does not apply to treatment of hemophilia B.

Filgrastim

Products Affected

- GRANIX SOLUTION 300 MCG/ML SUBCUTANEOUS
- GRANIX SOLUTION 480 MCG/1.6ML SUBCUTANEOUS
- GRANIX SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML SUBCUTANEOUS
- GRANIX SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML SUBCUTANEOUS
- NEUPOGEN SOLUTION 300 MCG/ML INJECTION
- NEUPOGEN SOLUTION 480 MCG/1.6ML INJECTION
- NEUPOGEN SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION
- NEUPOGEN SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML INJECTION

- NIVESTYM SOLUTION 300 MCG/ML INJECTION
- NIVESTYM SOLUTION 480 MCG/1.6ML INJECTION
- NIVESTYM SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION
- NIVESTYM SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML INJECTION
- RELEUKO SOLUTION 300 MCG/ML INJECTION
- releuko solution 480 mcg/1.6ml injection
- releuko solution prefilled syringe 300 mcg/0.5ml subcutaneous
- releuko solution prefilled syringe 480 mcg/0.8ml subcutaneous

Criteria	For approval of Neupogen for any indication other than Hematopoietic Syndrome of Acute Radiation Syndrome, Granix, Nivestym, or Releuko, the patient must have tried and failed to have an adequate response to Zarxio. This specific requirement applies to new starts only.
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Growth hormone

Products Affected

- GENOTROPIN CARTRIDGE 12 MG SUBCUTANEOUS
- GENOTROPIN CARTRIDGE 5 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.2 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.4 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.6 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.8 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 1 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.2 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.4 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.6 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.8 MG SUBCUTANEOUS
- GENOTROPIN MINIQUICK PREFILLED SYRINGE 2 MG SUBCUTANEOUS
- HUMATROPE CARTRIDGE 12 MG INJECTION
- HUMATROPE CARTRIDGE 24 MG INJECTION
- HUMATROPE CARTRIDGE 6 MG INJECTION

- NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS
- NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS
- NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 30 MG/3ML SUBCUTANEOUS
- NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS
- NUTROPIN AQ NUSPIN 10 SOLUTION PEN-INJECTOR 10 MG/2ML SUBCUTANEOUS
- NUTROPIN AQ NUSPIN 20 SOLUTION PEN-INJECTOR 20 MG/2ML SUBCUTANEOUS
- NUTROPIN AQ NUSPIN 5 SOLUTION PEN-INJECTOR 5 MG/2ML SUBCUTANEOUS
- OMNITROPE SOLUTION CARTRIDGE 10 MG/1.5ML SUBCUTANEOUS
- OMNITROPE SOLUTION CARTRIDGE 5 MG/1.5ML SUBCUTANEOUS
- OMNITROPE SOLUTION RECONSTITUTED 5.8 MG SUBCUTANEOUS
- SAIZEN SOLUTION RECONSTITUTED 5 MG INJECTION
- SAIZEN SOLUTION RECONSTITUTED 8.8 MG INJECTION
- SAIZENPREP SOLUTION RECONSTITUTED 8.8 MG INJECTION

Details

Criteria	For Commercial and Essential plans, the patient must have tried and failed to have an adequate response to Genotropin.
	For Medicaid plans, the patient must have tried and failed to have an adequate response to Norditropin.

4/1/2024

Ilumya

Products Affected

• ILUMYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS

Criteria	For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to at least the formulary-preferred IL-17 inhibitor (Cosentyx) and one other on-formulary biologic agent for the treatment of psoriasis (Cimzia, Enbrel, Humira, Otezla, Skyrizi, Stelara, Tremfya).
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Infliximab

Products Affected

- AVSOLA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS
- INFLECTRA SOLUTION RECONSTITUTED 100

MG INTRAVENOUS

 RENFLEXIS SOLUTION RECONSTITUTED 100 MG INTRAVENOUS

Details

Criteria	For approval of Avsola, Inflectra, or Renflexis, the patient must have tried and failed to have an adequate response to generic infliximab or Remicade. This specific requirement applies to new starts only. This requirement does not apply to patients using Avsola, Inflectra, Renflexis, or another infliximab biosimilar agent for any indication not shared with generic infliximab or Remicade.

4/1/2024

Invega Hafyera

Products Affected

- SYRINGE 1092 MG/3.5ML INTRAMUSCULAR
- INVEGA HAFYERA SUSPENSION PREFILLED INVEGA HAFYERA SUSPENSION PREFILLED SYRINGE 1560 MG/5ML INTRAMUSCULAR

Criteria	For approval, documentation of at least 4 months' treatment with 1-month paliperidone palmitate extended-release injectable suspension or at least one 3-month injection of 3-month paliperidone palmitate extended-release injectable suspension. This specific requirement applies to new starts only.
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Invega Trinza

Products Affected

- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML INTRAMUSCULAR
- INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML INTRAMUSCULAR

Criteria	For approval, documentation of at least 4 months' treatment with 1-month paliperidone palmitate extended-release injectable suspension. This specific requirement applies to new starts only.

Leucovorins

Products Affected

- FUSILEV SOLUTION RECONSTITUTED 50 MG INTRAVENOUS
- KHAPZORY SOLUTION RECONSTITUTED 175 MG INTRAVENOUS
- KHAPZORY SOLUTION RECONSTITUTED 300 MG INTRAVENOUS
- levoleucovorin calcium pf solution 175 mg/17.5ml intravenous
- levoleucovorin calcium pf solution 250 mg/25ml intravenous
- levoleucovorin calcium solution reconstituted 50 mg intravenous

Criteria	For approval, the patient must have tried and failed to have an adequate response to generic leucovorin. This specific requirement applies to new starts only.

Long-acting hemophilia factors

Products Affected

- adynovate solution reconstituted 1000 unit intravenous
- adynovate solution reconstituted 1500 unit intravenous
- adynovate solution reconstituted 2000 unit intravenous
- adynovate solution reconstituted 250 unit intravenous
- adynovate solution reconstituted 3000 unit intravenous
- adynovate solution reconstituted 500 unit intravenous
- adynovate solution reconstituted 750 unit intravenous
- ELOCTATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 2000

- **UNIT INTRAVENOUS**
- ELOCTATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 6000 UNIT INTRAVENOUS
- ESPEROCT SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS
- ESPEROCT SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS
- ESPEROCT SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS
- ESPEROCT SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS
- ESPEROCT SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS

		For approval of Adynovate, Eloctate, or Esperoct, the patient must have tried and failed to have an adequate response to Jivi. This specific requirement applies to new starts only.
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Lyfgenia

Products Affected

• LYFGENIA SUSPENSION INTRAVENOUS

Criteria	For approval, the patient must have a contraindication to Casgevy or
	other clinical reason why Casgevy cannot be used.

Opdualag

Products Affected

 OPDUALAG SOLUTION 240-80 MG/20ML INTRAVENOUS

response to Opdivo plus Yervoy or has a contraindication to the use of Yervoy. This specific requirement applies to new starts only.
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Paclitaxel

Products Affected

- ABRAXANE SUSPENSION RECONSTITUTED 100 MG INTRAVENOUS
- paclitaxel protein-bound part suspension reconstituted 100 mg intravenous

Criteria	For approval of Abraxane for any indication other than pancreatic cancer or small bowel carcinoma, the patient must have tried and failed to have an adequate response to generic paclitaxel. This specific requirement applies to new starts only.
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Pegfilgrastim

Products Affected

- FULPHILA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- FYLNETRA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- NYVEPRIA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- ROLVEDON SOLUTION PREFILLED SYRINGE 13.2 MG/0.6ML SUBCUTANEOUS
- STIMUFEND SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- ZIEXTENZO SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS

Details

Criteria	For approval of Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend, or Ziextenzo, the patient must have tried and failed to have an adequate response to both Udenyca and Neulasta. This specific requirement applies to new starts only.
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4/1/2024

Ranibizumab

Products Affected

- BYOOVIZ SOLUTION 0.5 MG/0.05ML INTRAVITREAL
- CIMERLI SOLUTION 0.3 MG/0.05ML INTRAVITREAL
- CIMERLI SOLUTION 0.5 MG/0.05ML INTRAVITREAL
- LUCENTIS SOLUTION 0.3 MG/0.05ML INTRAVITREAL
- LUCENTIS SOLUTION PREFILLED SYRINGE 0.3 MG/0.05ML INTRAVITREAL
- LUCENTIS SOLUTION PREFILLED SYRINGE 0.5 MG/0.05ML INTRAVITREAL
- SUSVIMO (IMPLANT 1ST FILL) SOLUTION 10 MG/0.1ML INTRAVITREAL
- SUSVIMO (IMPLANT REFILL) SOLUTION 10 MG/0.1ML INTRAVITREAL

Details

Criteria

For approval of Cimerli for shared indications, the patient must have tried and failed to have an adequate response to both (Step 1) bevacizumab (Avastin) and (Step 2) either aflibercept (Eylea/Eylea HD), brolucizumab (Beovu), or faricimab (Vabysmo). For approval of Byooviz, Lucentis, or Susvimo for shared indications, the patient must have tried and failed to have an adequate response to Steps 1 and 2 and Cimerli. This specific requirement applies to new starts only.

Rituximab

Products Affected

- RIABNI SOLUTION 100 MG/10ML INTRAVENOUS
- RIABNI SOLUTION 500 MG/50ML INTRAVENOUS
- RITUXAN HYCELA SOLUTION 1400-23400 MG -UT/11.7ML SUBCUTANEOUS
- RITUXAN HYCELA SOLUTION 1600-26800 MG -UT/13.4ML SUBCUTANEOUS
- RITUXAN SOLUTION 100 MG/10ML INTRAVENOUS
- RITUXAN SOLUTION 500 MG/50ML INTRAVENOUS
- TRUXIMA SOLUTION 100 MG/10ML INTRAVENOUS
- TRUXIMA SOLUTION 500 MG/50ML INTRAVENOUS

Details

Criteria

For approval of Rituxan for all indications except pemphigus vulgaris (PV), Riabni, Rituxan Hycela, or Truxima, the patient must have tried and failed to have an adequate response to Ruxience. This specific requirement applies to new starts only. This requirement does not apply to patients using Riabni, Rituxan, Rituxan Hycela, or Truxima for any indication not shared by Ruxience or another rituximab biosimilar agent.

Soliris

Products Affected

• SOLIRIS SOLUTION 300 MG/30ML INTRAVENOUS

Criteria	For a diagnosis of neuromyelitis optica spectrum disorder (NMOSD), the patient must have tried and failed to have an adequate response to or had an intolerance to or contraindication to Enspryng and either Uplizna or rituximab. For a diagnosis of generalized myasthenia gravis, the
	patient must have tried and failed to have an adequate response to or had an intolerance to or contraindication to Vyvgart. These requirements apply to new starts only.

Spinraza

Products Affected

• SPINRAZA SOLUTION 12 MG/5ML INTRATHECAL

Criteria	For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to or contraindication to Evrysdi. This specific requirement applies to new starts only.

Tezspire

Products Affected

• TEZSPIRE SOLUTION PREFILLED SYRINGE 210 MG/1.91ML SUBCUTANEOUS

Criteria	For approval, the patient must have (1) tried and failed, was intolerant to, or had a contraindication to dupilumab plus one other biologic for severe asthma, including either an IL-5 antagonist, an IL-5 receptor antagonist, or omalizumab or (2) an eosinophil count below that required to use these other medications. This specific requirement applies to new starts only.
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Trastuzumab

Products Affected

- HERCEPTIN HYLECTA SOLUTION 600-10000 MG-UNT/5ML SUBCUTANEOUS
- HERCEPTIN SOLUTION RECONSTITUTED 150 MG INTRAVENOUS
- HERZUMA SOLUTION RECONSTITUTED 150 MG INTRAVENOUS
- HERZUMA SOLUTION RECONSTITUTED 420 MG INTRAVENOUS
- KANJINTI SOLUTION RECONSTITUTED 150 MG INTRAVENOUS

- KANJINTI SOLUTION RECONSTITUTED 420 MG INTRAVENOUS
- OGIVRI SOLUTION RECONSTITUTED 150 MG INTRAVENOUS
- OGIVRI SOLUTION RECONSTITUTED 420 MG INTRAVENOUS
- ONTRUZANT SOLUTION RECONSTITUTED 150 MG INTRAVENOUS
- ONTRUZANT SOLUTION RECONSTITUTED 420 MG INTRAVENOUS

Criteria	For approval of Herceptin, Herceptin Hylecta, Herzuma, Kanjinti, Ogivri, or Ontruzant, the patient must have tried and failed to have an adequate response to Trazimera. This specific requirement applies to new starts only. This requirement does not apply to patients using a trastuzumab
	biosimilar agent for any indication not shared by Trazimera.

Ultomiris

Products Affected

- ULTOMIRIS SOLUTION 1100 MG/11ML INTRAVENOUS
- ULTOMIRIS SOLUTION 300 MG/3ML INTRAVENOUS

t	For a diagnosis of generalized myasthenia gravis, the patient must have tried and failed to have an adequate response to or had an intolerance to or contraindication to Vyvgart. These requirements apply to new starts only.
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Uplizna

Products Affected

• UPLIZNA SOLUTION 100 MG/10ML INTRAVENOUS

Criteria	For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to or contraindication to Enspryng. This specific requirement applies to new starts only.
	The opening requirement approach to their starts only.

Vabysmo

Products Affected

 VABYSMO SOLUTION 6 MG/0.05ML INTRAVITREAL

Criteria	For approval for a diagnosis of neovascular (wet) age-related macular degeneration or diabetic macular edema, the patient must have tried and failed to have an adequate response to bevacizumab (Avastin). This specific requirement applies to new starts only.

Viscosupplements

Products Affected

- DUROLANE PREFILLED SYRINGE 60 MG/3ML INTRA-ARTICULAR
- GEL-ONE PREFILLED SYRINGE 30 MG/3ML INTRA-ARTICULAR
- GELSYN-3 SOLUTION PREFILLED SYRINGE 16.8 MG/2ML INTRA-ARTICULAR
- GENVISC 850 SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR
- HYALGAN SOLUTION 20 MG/2ML INTRA-ARTICULAR
- HYALGAN SOLUTION PREFILLED SYRINGE 20 MG/2ML INTRA-ARTICULAR
- HYMOVIS SOLUTION PREFILLED SYRINGE 24 MG/3ML INTRA-ARTICULAR
- MONOVISC SOLUTION PREFILLED SYRINGE

plans.

- 88 MG/4ML INTRA-ARTICULAR
- ORTHOVISC SOLUTION PREFILLED SYRINGE 30 MG/2ML INTRA-ARTICULAR
- SUPARTZ FX SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR
- SYNOJOYNT SOLUTION PREFILLED SYRINGE 20 MG/2ML INTRA-ARTICULAR
- SYNVISC SOLUTION PREFILLED SYRINGE 16 MG/2ML INTRA-ARTICULAR
- TRILURON SOLUTION PREFILLED SYRINGE 20 MG/2ML INTRA-ARTICULAR
- TRIVISC SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR
- VISCO-3 SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR

Details

Criteria For approval of viscosupplements other than Euflexxa or Synvisc-One, the patient must have tried and failed to have an adequate response to or had an intolerance to both preferred agents (Euflexxa, Synvisc-One). All viscosupplements require medical prior authorization. Because all viscosupplements are considered medical devices and not drugs by the FDA, they can only be billed through Medicare Part B. Viscosupplements are not covered on Commercial and State health

4/1/2024

Vyepti

Products Affected

• VYEPTI SOLUTION 100 MG/ML INTRAVENOUS

Criteria	For approval of Vyepti, the patient must have tried and failed to have an adequate response to any two oral agents used to prevent/reduce frequency of migraines and have had prior use of one injectable CGRP antagonist/receptor antagonist. This specific requirement applies to new starts only.
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Vyvgart

Products Affected

 VYVGART SOLUTION 400 MG/20ML INTRAVENOUS

Criteria	For approval, the patient must have failed to respond to therapy with at least two of the following drug groups: acetylcholinesterase inhibitors, corticosteroids, nonsteroidal immunosuppressive therapies (e.g., methotrexate, azathioprine, mycophenolate, cyclosporine). This specific requirement applies to new starts only.
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Zilretta

Products Affected

 ZILRETTA SUSPENSION RECONSTITUTED ER 32 MG INTRA-ARTICULAR

INDEX

ABRAXANE SUSPENSION RECONSTITUTED	CIMERLI SOLUTION 0.5 MG/0.05ML
100 MG INTRAVENOUS24	INTRAVITREAL26
adynovate solution reconstituted 1000 unit	DUROLANE PREFILLED SYRINGE 60
intravenous21	MG/3ML INTRA-ARTICULAR35
adynovate solution reconstituted 1500 unit	DYSPORT SOLUTION RECONSTITUTED 300
intravenous21	UNIT INTRAMUSCULAR8
adynovate solution reconstituted 2000 unit	DYSPORT SOLUTION RECONSTITUTED 500
intravenous21	UNIT INTRAMUSCULAR8
adynovate solution reconstituted 250 unit	ELOCTATE SOLUTION RECONSTITUTED
intravenous21	1000 UNIT INTRAVENOUS21
adynovate solution reconstituted 3000 unit	ELOCTATE SOLUTION RECONSTITUTED
intravenous21	2000 UNIT INTRAVENOUS21
adynovate solution reconstituted 500 unit	ELOCTATE SOLUTION RECONSTITUTED 250
intravenous21	UNIT INTRAVENOUS21
adynovate solution reconstituted 750 unit	ELOCTATE SOLUTION RECONSTITUTED
intravenous21	4000 UNIT INTRAVENOUS21
ALYMSYS SOLUTION 100 MG/4ML	ELOCTATE SOLUTION RECONSTITUTED
INTRAVENOUS7	6000 UNIT INTRAVENOUS21
ALYMSYS SOLUTION 400 MG/16ML	ENJAYMO SOLUTION 1100 MG/22ML
INTRAVENOUS7	INTRAVENOUS9
AMVUTTRA SOLUTION PREFILLED SYRINGE	EPOGEN SOLUTION 10000 UNIT/ML
25 MG/0.5ML SUBCUTANEOUS 1	INJECTION10
APHEXDA SOLUTION RECONSTITUTED 62	EPOGEN SOLUTION 2000 UNIT/ML
MG SUBCUTANEOUS2	INJECTION10
APRETUDE SUSPENSION EXTENDED	EPOGEN SOLUTION 20000 UNIT/ML
RELEASE 600 MG/3ML INTRAMUSCULAR 3	INJECTION10
ASCENIV SOLUTION 5 GM/50ML	EPOGEN SOLUTION 3000 UNIT/ML
INTRAVENOUS4	INJECTION10
AVASTIN SOLUTION 100 MG/4ML	EPOGEN SOLUTION 4000 UNIT/ML
INTRAVENOUS7	INJECTION10
AVASTIN SOLUTION 400 MG/16ML	ESPEROCT SOLUTION RECONSTITUTED
INTRAVENOUS7	1000 UNIT INTRAVENOUS21
AVSOLA SOLUTION RECONSTITUTED 100	ESPEROCT SOLUTION RECONSTITUTED
MG INTRAVENOUS17	1500 UNIT INTRAVENOUS21
BEOVU SOLUTION 6 MG/0.05ML	ESPEROCT SOLUTION RECONSTITUTED
INTRAVITREAL6	2000 UNIT INTRAVENOUS21
BEOVU SOLUTION PREFILLED SYRINGE 6	ESPEROCT SOLUTION RECONSTITUTED
MG/0.05ML INTRAVITREAL6	3000 UNIT INTRAVENOUS21
BYOOVIZ SOLUTION 0.5 MG/0.05ML	ESPEROCT SOLUTION RECONSTITUTED 500
INTRAVITREAL	UNIT INTRAVENOUS21
CIMERLI SOLUTION 0.3 MG/0.05ML	EVKEEZA SOLUTION 1200 MG/8ML
INTRAVITREAL	INTRAVENOUS11

EVKEEZA SOLUTION 345 MG/2.3ML	GENOTROPIN MINIQUICK PREFILLED
INTRAVENOUS	SYRINGE 1.8 MG SUBCUTANEOUS15
EYLEA HD SOLUTION 8 MG/0.07ML	GENOTROPIN MINIQUICK PREFILLED
INTRAVITREAL	SYRINGE 2 MG SUBCUTANEOUS15
EYLEA SOLUTION 2 MG/0.05ML	GENVISC 850 SOLUTION PREFILLED
INTRAVITREAL	SYRINGE 25 MG/2.5ML INTRA-ARTICULAR 35
EYLEA SOLUTION PREFILLED SYRINGE 2	GRANIX SOLUTION 300 MCG/ML
MG/0.05ML INTRAVITREAL12	SUBCUTANEOUS14
FEIBA SOLUTION RECONSTITUTED 1000	GRANIX SOLUTION 480 MCG/1.6ML
UNIT INTRAVENOUS	SUBCUTANEOUS14
FEIBA SOLUTION RECONSTITUTED 2500	GRANIX SOLUTION PREFILLED SYRINGE
UNIT INTRAVENOUS13	300 MCG/0.5ML SUBCUTANEOUS14
FEIBA SOLUTION RECONSTITUTED 500	GRANIX SOLUTION PREFILLED SYRINGE
UNIT INTRAVENOUS13	480 MCG/0.8ML SUBCUTANEOUS 14
FULPHILA SOLUTION PREFILLED SYRINGE 6	HERCEPTIN HYLECTA SOLUTION 600-10000
MG/0.6ML SUBCUTANEOUS25	MG-UNT/5ML SUBCUTANEOUS31
FUSILEV SOLUTION RECONSTITUTED 50	HERCEPTIN SOLUTION RECONSTITUTED
MG INTRAVENOUS20	150 MG INTRAVENOUS31
FYLNETRA SOLUTION PREFILLED SYRINGE 6	HERZUMA SOLUTION RECONSTITUTED 150
MG/0.6ML SUBCUTANEOUS25	MG INTRAVENOUS31
GEL-ONE PREFILLED SYRINGE 30 MG/3ML	HERZUMA SOLUTION RECONSTITUTED 420
INTRA-ARTICULAR35	MG INTRAVENOUS31
GELSYN-3 SOLUTION PREFILLED SYRINGE	HUMATROPE CARTRIDGE 12 MG
16.8 MG/2ML INTRA-ARTICULAR35	INJECTION15
GENOTROPIN CARTRIDGE 12 MG	HUMATROPE CARTRIDGE 24 MG
SUBCUTANEOUS15	INJECTION15
GENOTROPIN CARTRIDGE 5 MG	HUMATROPE CARTRIDGE 6 MG INJECTION. 15
SUBCUTANEOUS15	HYALGAN SOLUTION 20 MG/2ML INTRA-
GENOTROPIN MINIQUICK PREFILLED	ARTICULAR 35
SYRINGE 0.2 MG SUBCUTANEOUS15	HYALGAN SOLUTION PREFILLED SYRINGE
GENOTROPIN MINIQUICK PREFILLED	20 MG/2ML INTRA-ARTICULAR35
SYRINGE 0.4 MG SUBCUTANEOUS15	HYMOVIS SOLUTION PREFILLED SYRINGE
GENOTROPIN MINIQUICK PREFILLED	24 MG/3ML INTRA-ARTICULAR35
SYRINGE 0.6 MG SUBCUTANEOUS15	ILUMYA SOLUTION PREFILLED SYRINGE
GENOTROPIN MINIQUICK PREFILLED	100 MG/ML SUBCUTANEOUS 16
SYRINGE 0.8 MG SUBCUTANEOUS15	INFLECTRA SOLUTION RECONSTITUTED
GENOTROPIN MINIQUICK PREFILLED	100 MG INTRAVENOUS17
SYRINGE 1 MG SUBCUTANEOUS15	INVEGA HAFYERA SUSPENSION PREFILLED
GENOTROPIN MINIQUICK PREFILLED	SYRINGE 1092 MG/3.5ML
SYRINGE 1.2 MG SUBCUTANEOUS15	INTRAMUSCULAR18
GENOTROPIN MINIQUICK PREFILLED	INVEGA HAFYERA SUSPENSION PREFILLED
SYRINGE 1.4 MG SUBCUTANEOUS15	SYRINGE 1560 MG/5ML INTRAMUSCULAR 18
GENOTROPIN MINIQUICK PREFILLED	
SYRINGE 1.6 MG SUBCUTANEOUS15	

INVEGA TRINZA SUSPENSION PREFILLED	MYOBLOC SOLUTION 5000 UNIT/ML
SYRINGE 273 MG/0.88ML	INTRAMUSCULAR8
INTRAMUSCULAR19	NEUPOGEN SOLUTION 300 MCG/ML
INVEGA TRINZA SUSPENSION PREFILLED	INJECTION14
SYRINGE 410 MG/1.32ML	NEUPOGEN SOLUTION 480 MCG/1.6ML
INTRAMUSCULAR19	INJECTION14
INVEGA TRINZA SUSPENSION PREFILLED	NEUPOGEN SOLUTION PREFILLED SYRINGE
SYRINGE 546 MG/1.75ML	300 MCG/0.5ML INJECTION14
INTRAMUSCULAR19	NEUPOGEN SOLUTION PREFILLED SYRINGE
INVEGA TRINZA SUSPENSION PREFILLED	480 MCG/0.8ML INJECTION14
SYRINGE 819 MG/2.63ML	NIVESTYM SOLUTION 300 MCG/ML
INTRAMUSCULAR19	INJECTION14
KANJINTI SOLUTION RECONSTITUTED 150	NIVESTYM SOLUTION 480 MCG/1.6ML
MG INTRAVENOUS31	INJECTION14
KANJINTI SOLUTION RECONSTITUTED 420	NIVESTYM SOLUTION PREFILLED SYRINGE
MG INTRAVENOUS31	300 MCG/0.5ML INJECTION14
KHAPZORY SOLUTION RECONSTITUTED	NIVESTYM SOLUTION PREFILLED SYRINGE
175 MG INTRAVENOUS20	480 MCG/0.8ML INJECTION14
KHAPZORY SOLUTION RECONSTITUTED	NORDITROPIN FLEXPRO SOLUTION PEN-
300 MG INTRAVENOUS20	INJECTOR 10 MG/1.5ML SUBCUTANEOUS15
levoleucovorin calcium pf solution 175	NORDITROPIN FLEXPRO SOLUTION PEN-
mg/17.5ml intravenous20	INJECTOR 15 MG/1.5ML SUBCUTANEOUS15
levoleucovorin calcium pf solution 250	NORDITROPIN FLEXPRO SOLUTION PEN-
mg/25ml intravenous20	INJECTOR 30 MG/3ML SUBCUTANEOUS15
levoleucovorin calcium solution	NORDITROPIN FLEXPRO SOLUTION PEN-
reconstituted 50 mg intravenous20	INJECTOR 5 MG/1.5ML SUBCUTANEOUS15
LUCENTIS SOLUTION 0.3 MG/0.05ML	NUTROPIN AQ NUSPIN 10 SOLUTION PEN-
INTRAVITREAL26	INJECTOR 10 MG/2ML SUBCUTANEOUS15
LUCENTIS SOLUTION PREFILLED SYRINGE	NUTROPIN AQ NUSPIN 20 SOLUTION PEN-
0.3 MG/0.05ML INTRAVITREAL26	INJECTOR 20 MG/2ML SUBCUTANEOUS15
LUCENTIS SOLUTION PREFILLED SYRINGE	NUTROPIN AQ NUSPIN 5 SOLUTION PEN-
0.5 MG/0.05ML INTRAVITREAL26	INJECTOR 5 MG/2ML SUBCUTANEOUS15
LYFGENIA SUSPENSION INTRAVENOUS22	NYVEPRIA SOLUTION PREFILLED SYRINGE 6
MONOVISC SOLUTION PREFILLED SYRINGE	MG/0.6ML SUBCUTANEOUS25
88 MG/4ML INTRA-ARTICULAR35	OGIVRI SOLUTION RECONSTITUTED 150
MVASI SOLUTION 100 MG/4ML	MG INTRAVENOUS31
INTRAVENOUS7	OGIVRI SOLUTION RECONSTITUTED 420
MVASI SOLUTION 400 MG/16ML	MG INTRAVENOUS31
INTRAVENOUS7	OMNITROPE SOLUTION CARTRIDGE 10
MYOBLOC SOLUTION 10000 UNIT/2ML	MG/1.5ML SUBCUTANEOUS15
INTRAMUSCULAR8	OMNITROPE SOLUTION CARTRIDGE 5
MYOBLOC SOLUTION 2500 UNIT/0.5ML	MG/1.5ML SUBCUTANEOUS15
INTRAMUSCULAR8	OMNITROPE SOLUTION RECONSTITUTED
	5.8 MG SUBCUTANEOUS15

ONTRUZANT SOLUTION RECONSTITUTED	ROLVEDON SOLUTION PREFILLED SYRINGE
150 MG INTRAVENOUS31	13.2 MG/0.6ML SUBCUTANEOUS25
ONTRUZANT SOLUTION RECONSTITUTED	SAIZEN SOLUTION RECONSTITUTED 5 MG
420 MG INTRAVENOUS31	INJECTION15
OPDUALAG SOLUTION 240-80 MG/20ML	SAIZEN SOLUTION RECONSTITUTED 8.8
INTRAVENOUS23	MG INJECTION15
ORTHOVISC SOLUTION PREFILLED SYRINGE	SAIZENPREP SOLUTION RECONSTITUTED
30 MG/2ML INTRA-ARTICULAR35	8.8 MG INJECTION15
paclitaxel protein-bound part suspension	SOLIRIS SOLUTION 300 MG/30ML
reconstituted 100 mg intravenous24	INTRAVENOUS28
PROCRIT SOLUTION 10000 UNIT/ML	SPINRAZA SOLUTION 12 MG/5ML
INJECTION10	INTRATHECAL29
PROCRIT SOLUTION 2000 UNIT/ML	STIMUFEND SOLUTION PREFILLED
INJECTION10	SYRINGE 6 MG/0.6ML SUBCUTANEOUS 25
PROCRIT SOLUTION 20000 UNIT/ML	SUPARTZ FX SOLUTION PREFILLED
INJECTION10	SYRINGE 25 MG/2.5ML INTRA-ARTICULAR 35
PROCRIT SOLUTION 3000 UNIT/ML	SUSVIMO (IMPLANT 1ST FILL) SOLUTION
INJECTION10	10 MG/0.1ML INTRAVITREAL26
PROCRIT SOLUTION 4000 UNIT/ML	SUSVIMO (IMPLANT REFILL) SOLUTION 10
INJECTION10	MG/0.1ML INTRAVITREAL26
PROCRIT SOLUTION 40000 UNIT/ML	SYNOJOYNT SOLUTION PREFILLED SYRINGE
INJECTION10	20 MG/2ML INTRA-ARTICULAR35
RELEUKO SOLUTION 300 MCG/ML	SYNVISC SOLUTION PREFILLED SYRINGE 16
INJECTION14	MG/2ML INTRA-ARTICULAR35
releuko solution 480 mcg/1.6ml injection14	TEZSPIRE SOLUTION PREFILLED SYRINGE
releuko solution prefilled syringe 300	210 MG/1.91ML SUBCUTANEOUS 30
mcg/0.5ml subcutaneous14	TREANDA SOLUTION RECONSTITUTED 100
releuko solution prefilled syringe 480	MG INTRAVENOUS5
mcg/0.8ml subcutaneous14	TREANDA SOLUTION RECONSTITUTED 25
RENFLEXIS SOLUTION RECONSTITUTED	MG INTRAVENOUS5
100 MG INTRAVENOUS17	TRILURON SOLUTION PREFILLED SYRINGE
RIABNI SOLUTION 100 MG/10ML	20 MG/2ML INTRA-ARTICULAR35
INTRAVENOUS27	TRIVISC SOLUTION PREFILLED SYRINGE 25
RIABNI SOLUTION 500 MG/50ML	MG/2.5ML INTRA-ARTICULAR35
INTRAVENOUS27	TRUXIMA SOLUTION 100 MG/10ML
RITUXAN HYCELA SOLUTION 1400-23400	INTRAVENOUS27
MG -UT/11.7ML SUBCUTANEOUS27	TRUXIMA SOLUTION 500 MG/50ML
RITUXAN HYCELA SOLUTION 1600-26800	INTRAVENOUS27
MG -UT/13.4ML SUBCUTANEOUS27	ULTOMIRIS SOLUTION 1100 MG/11ML
RITUXAN SOLUTION 100 MG/10ML	INTRAVENOUS32
INTRAVENOUS27	ULTOMIRIS SOLUTION 300 MG/3ML
RITUXAN SOLUTION 500 MG/50ML	INTRAVENOUS32
INTRAVENOUS27	UPLIZNA SOLUTION 100 MG/10ML
	INTRAVENOUS33

VABYSMO SOLUTION 6 MG/0.05ML	
INTRAVITREAL	34
VEGZELMA SOLUTION 100 MG/4ML	
INTRAVENOUS	7
VEGZELMA SOLUTION 400 MG/16ML	
INTRAVENOUS	7
VISCO-3 SOLUTION PREFILLED SYRINGE 25	
MG/2.5ML INTRA-ARTICULAR	35
VYEPTI SOLUTION 100 MG/ML	
INTRAVENOUS	36
VYVGART SOLUTION 400 MG/20ML	
INTRAVENOUS	37
ZIEXTENZO SOLUTION PREFILLED SYRINGE	
6 MG/0.6ML SUBCUTANEOUS	25
ZILRETTA SUSPENSION RECONSTITUTED ER	
32 MG INTRA-ARTICULAR	38