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

Details

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.

4/1/2024

Aphexda

Products Affected

- APHEXDA SOLUTION RECONSTITUTED 62 MG SUBCUTANEOUS

Details

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

4/1/2024

Apretude

Products Affected

- APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR

Details

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

4/1/2024

Asceniv

Products Affected

- ASCENIV SOLUTION 5 GM/50ML
  INTRAVENOUS

Details

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

4/1/2024

Bendamustine

Products Affected

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

Details

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.

4/1/2024

Beovu

Products Affected

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

Details

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.

4/1/2024

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.

4/1/2024

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

Details

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.

4/1/2024

Enjaymo

Products Affected

- ENJAYMO SOLUTION 1100 MG/22ML INTRAVENOUS

Details

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.

4/1/2024

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

Details

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.

4/1/2024

Evkeeza

Products Affected

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

Details

Criteria	For approval of Evkeeza, the patient must have tried and failed to have an adequate response to or have a contraindication to both a maximally-tolerated dose of a statin drug and a PCSK9 inhibitor. This specific requirement applies to new starts only.

4/1/2024

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

Details

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.

4/1/2024

Feiba

Products Affected

- FEIBA SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS
- FEIBA SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS
- FEIBA SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS

Details

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.

4/1/2024

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*

Details

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.

4/1/2024

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

Details

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).

4/1/2024

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

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

Details

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.

4/1/2024

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

Details

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.

4/1/2024

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*

Details

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.

4/1/2024

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

Details

Criteria	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.

4/1/2024

Lyfgenia

Products Affected

- LYFGENIA SUSPENSION INTRAVENOUS

Details

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

4/1/2024

Opdualag

Products Affected

- OPDUALAG SOLUTION 240-80 MG/20ML
  INTRAVENOUS

Details

Criteria	For approval, the patient must have tried and failed to have an adequate response to Opdivo plus Yervoy or has a contraindication to the use of Yervoy. This specific requirement applies to new starts only.

4/1/2024

Paclitaxel

Products Affected

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

Details

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.

4/1/2024

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.

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.

4/1/2024

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.

4/1/2024

Soliris

Products Affected

- SOLIRIS SOLUTION 300 MG/30ML
  INTRAVENOUS

Details

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.

4/1/2024

Spinraza

Products Affected

- SPINRAZA SOLUTION 12 MG/5ML INTRATHECAL

Details

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.

4/1/2024

Tezspire

Products Affected

- TEZSPIRE SOLUTION PREFILLED SYRINGE 210 MG/1.91ML SUBCUTANEOUS

Details

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.

4/1/2024

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

Details

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.

4/1/2024

Ultomiris

Products Affected

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

Details

Criteria	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.

4/1/2024

Uplizna

Products Affected

- UPLIZNA SOLUTION 100 MG/10ML INTRAVENOUS

Details

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.

4/1/2024

Vabysmo

Products Affected

- VABYSMO SOLUTION 6 MG/0.05ML INTRAVITREAL

Details

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.

4/1/2024

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 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 plans.

4/1/2024

Vyepti

Products Affected

- VYEPTI SOLUTION 100 MG/ML INTRAVENOUS

Details

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.

4/1/2024

Vyvgart

Products Affected

- VYVGART SOLUTION 400 MG/20ML
  INTRAVENOUS

Details

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.

4/1/2024

Zilretta

Products Affected

- ZILRETTA SUSPENSION RECONSTITUTED ER 32 MG INTRA-ARTICULAR

Details

Criteria	For approval, the patient must have tried and failed to have an adequate response to at least one other injectable corticosteroid. This specific requirement applies to new starts only.

4/1/2024

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