STEP THERAPY CRITERIA FOR MEDICARE PART B DRUGS

This list is current as of 10/1/2024 and pertains to the following Independent Health Medicare Advantage Plans for 2025:

Independent Health's Encompass 65® Basic (HMO)
Independent Health's Encompass 65® Core (HMO)
Independent Health's Encompass 65® Direct (HMO)
Independent Health's Medicare Passport® Access (PPO)
Independent Health's Medicare Passport® Connect (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.
	to new starts only.

Anktiva

Products Affected

 ANKTIVA SOLUTION 400 MCG/0.4ML INTRAVESICAL

Criteria For approval, the patient must have tried and failed to response to Adstiladrin. This specific requirement apponly.	•
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Aphexda

Products Affected

• APHEXDA SOLUTION RECONSTITUTED 62 MG SUBCUTANEOUS

Criteria For approval, the patient must have tried and failed to have an adequence response to plerixafor. This specific requirement applies to new start 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.
 contrainalcation to emitricitabilite, teriorovii disoproxii 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. This specific
	requirement applies to new starts only and does not apply to patients using Asceniv for any indication not shared with preferred IVIG products.

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 han adequate response to Belrapzo or Bendeka. This specific requires applies to new starts only and does not apply to patients using Treafor any indication not shared with preferred agents.	ment
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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 and does not apply to patients using Beovu for any off-label indication not shared with bevacizumab.

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

Details

Criteria

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

Botulinum toxins

Products Affected

- DAXXIFY SOLUTION RECONSTITUTED 100 UNIT INTRAMUSCULAR
- 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.
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Briumvi

Products Affected

• BRIUMVI SOLUTION 150 MG/6ML INTRAVENOUS

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

Camcevi

Products Affected

• CAMCEVI PREFILLED SYRINGE 42 MG SUBCUTANEOUS

Criteria For approval, the patient must have tried and failed to have an a response to either Eligard or Lupron. This specific requirement a new starts only.	•
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Enjaymo

Products Affected

• ENJAYMO SOLUTION 1100 MG/22ML INTRAVENOUS

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

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 and does not apply to patients using Epogen or Procrit for any indication not shared with Retacrit.

10/1/2024

Evkeeza

Products Affected

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

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

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.	Criteria	patients with diabetic macular edema, the patient must have tried and failed to have an adequate response to bevacizumab (Avastin). This
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10/1/2024

Feiba

Products Affected

- FEIBA SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS
- FEIBA SOLUTION RECONSTITUTED 2500 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.
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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 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 and does not apply to patients using a non-preferred agent for any indication not shared with Zarxio.

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.

10/1/2024

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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Imjudo

Products Affected

- IMJUDO SOLUTION 25 MG/1.25ML INTRAVENOUS
- IMJUDO SOLUTION 300 MG/15ML INTRAVENOUS

Criteria	For approval for hepatocellular carcinoma, the patient must have tried and failed to have an adequate response to or had an intolerance or contraindication to Avastin or Avastin-containing regimens. For approval for non-small cell lung cancer, the patient must have tried and failed to have an adequate response to or had an intolerance or contraindication to regimens containing Keytruda or Tecentriq.
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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.

10/1/2024

Invega Hafyera

Products Affected

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

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.

10/1/2024

Leucovorins

Products Affected

- KHAPZORY SOLUTION RECONSTITUTED 175 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

	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 and does not apply to patients using levoleucovorin for any indication not shared with leucovorin.
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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 requirement applies to new starts only.	
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10/1/2024

Opdualag

Products Affected

 OPDUALAG SOLUTION 240-80 MG/20ML INTRAVENOUS

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.

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 and does not apply to patients using Abraxane for any indication not shared with generic paclitaxel.
	for any indication not shared with generic paclitaxel.

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 and does not apply to patients using a non-preferred pegfilgrastim product for any indication not shared with a preferred pegfilgrastim product.

Pemetrexed

Products Affected

- PEMFEXY SOLUTION 500 MG/20ML INTRAVENOUS
- PEMRYDI RTU SOLUTION 100 MG/10ML
- **INTRAVENOUS**
- PEMRYDI RTU SOLUTION 500 MG/50ML INTRAVENOUS

Details

For approval of Pemrydi RTU (J9324) and Pemfexy (J9304), the patient must have tried and failed to have an adequate response to one of the following drugs: pemetrexed (J9294, J9296, J9297, J9314, J9322, J9323) unless contraindicated or not tolerated. This specific requirement applies to new starts only.
to new starts only.

10/1/2024

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.

Rebyota

Products Affected

• REBYOTA SUSPENSION 150 ML RECTAL

For approval, the patient must have had prior therapy with bezlotoxumab or has a contraindication to its use.
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Rituximab

Products Affected

- 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), Rituxan Hycela or Truxima, the patient must have tried and failed to have an adequate response to Ruxience or Riabni. This specific requirement applies to new starts only. This requirement does not apply to patients using a rituximab agent for any indication not shared by Ruxience or Riabni.

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.
	Telephone 1 1 1 1 1 1 1 1 1

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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Tocilizumab

Products Affected

- ACTEMRA SOLUTION 200 MG/10ML INTRAVENOUS
- ACTEMRA SOLUTION 400 MG/20ML INTRAVENOUS
- ACTEMRA SOLUTION 80 MG/4ML INTRAVENOUS
- TOFIDENCE SOLUTION 200 MG/10ML INTRAVENOUS
- TOFIDENCE SOLUTION 400 MG/20ML INTRAVENOUS
- TOFIDENCE SOLUTION 80 MG/4ML INTRAVENOUS

Details

Criteria For approval of Actemra or Tofidence, the patient must have tried and failed to have an adequate response to Tyenne. This specific requirement applies to new starts only. This requirement does not apply to patients using Actemra, Tofidence, or another tocilizumab biosimilar agent for any indication not shared with Tyenne.

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

Ultomiris

Products Affected

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

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.
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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 and does not apply
	to patients using Uplizna for any indication not shared with Enspryng.

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 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

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. This specific requirement applies to new starts only and does not apply to patients using a non-preferred viscosupplement for any indication not shared with Euflexxa or Synvisc-One.

10/1/2024

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 HYTRULO SOLUTION 180-2000 MG-UNIT/ML SUBCUTANEOUS
- VYVGART SOLUTION 400 MG/20ML INTRAVENOUS

Criteria For approval, the patient must have failed to respond to therapy with a 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.	Criteria	ing drug groups: acetylcholinesterase inhibitors, roidal immunosuppressive therapies (e.g., prine, mycophenolate, cyclosporine). This specific
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Zilretta

Products Affected

 ZILRETTA SUSPENSION RECONSTITUTED ER 32 MG INTRA-ARTICULAR

	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.
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INDEX

ABRAXANE SUSPENSION RECONSTITUTED	BEOVU SOLUTION 6 MG/0.05ML	
100 MG INTRAVENOUS27	INTRAVITREAL	. 7
ACTEMRA SOLUTION 200 MG/10ML	BEOVU SOLUTION PREFILLED SYRINGE 6	
INTRAVENOUS36	MG/0.05ML INTRAVITREAL	.7
ACTEMRA SOLUTION 400 MG/20ML	BRIUMVI SOLUTION 150 MG/6ML	
INTRAVENOUS36	INTRAVENOUS	10
ACTEMRA SOLUTION 80 MG/4ML	BYOOVIZ SOLUTION 0.5 MG/0.05ML	
INTRAVENOUS36	INTRAVITREAL	30
adynovate solution reconstituted 1000 unit	CAMCEVI PREFILLED SYRINGE 42 MG	
intravenous25	SUBCUTANEOUS	11
adynovate solution reconstituted 1500 unit	CIMERLI SOLUTION 0.3 MG/0.05ML	
intravenous25	INTRAVITREAL	30
adynovate solution reconstituted 2000 unit	CIMERLI SOLUTION 0.5 MG/0.05ML	
intravenous25	INTRAVITREAL	30
adynovate solution reconstituted 250 unit	DAXXIFY SOLUTION RECONSTITUTED 100	
intravenous25	UNIT INTRAMUSCULAR	. 9
adynovate solution reconstituted 3000 unit	DUROLANE PREFILLED SYRINGE 60	
intravenous25	MG/3ML INTRA-ARTICULAR	41
adynovate solution reconstituted 500 unit	DYSPORT SOLUTION RECONSTITUTED 300	
intravenous25	UNIT INTRAMUSCULAR	. 9
adynovate solution reconstituted 750 unit	DYSPORT SOLUTION RECONSTITUTED 500	
intravenous25	UNIT INTRAMUSCULAR	. 9
ALYMSYS SOLUTION 100 MG/4ML	ELOCTATE SOLUTION RECONSTITUTED	
INTRAVENOUS8	1000 UNIT INTRAVENOUS	25
ALYMSYS SOLUTION 400 MG/16ML	ELOCTATE SOLUTION RECONSTITUTED	
INTRAVENOUS8	2000 UNIT INTRAVENOUS	25
AMVUTTRA SOLUTION PREFILLED SYRINGE	ELOCTATE SOLUTION RECONSTITUTED 250	
25 MG/0.5ML SUBCUTANEOUS 1	UNIT INTRAVENOUS	25
ANKTIVA SOLUTION 400 MCG/0.4ML	ELOCTATE SOLUTION RECONSTITUTED	
INTRAVESICAL2	4000 UNIT INTRAVENOUS	25
APHEXDA SOLUTION RECONSTITUTED 62	ELOCTATE SOLUTION RECONSTITUTED	
MG SUBCUTANEOUS3	6000 UNIT INTRAVENOUS	25
APRETUDE SUSPENSION EXTENDED	ENJAYMO SOLUTION 1100 MG/22ML	
RELEASE 600 MG/3ML INTRAMUSCULAR 4	INTRAVENOUS	12
ASCENIV SOLUTION 5 GM/50ML	EPOGEN SOLUTION 10000 UNIT/ML	
INTRAVENOUS5	INJECTION	13
AVASTIN SOLUTION 100 MG/4ML	EPOGEN SOLUTION 2000 UNIT/ML	
INTRAVENOUS8	INJECTION	13
AVASTIN SOLUTION 400 MG/16ML	EPOGEN SOLUTION 20000 UNIT/ML	
INTRAVENOUS8	INJECTION	13
AVSOLA SOLUTION RECONSTITUTED 100	EPOGEN SOLUTION 3000 UNIT/ML	
MG INTRAVENOUS21	INJECTION	13

EPOGEN SOLUTION 4000 UNIT/ML	GENOTROPIN MINIQUICK PREFILLED
INJECTION13	SYRINGE 0.8 MG SUBCUTANEOUS18
ESPEROCT SOLUTION RECONSTITUTED	GENOTROPIN MINIQUICK PREFILLED
1000 UNIT INTRAVENOUS25	SYRINGE 1 MG SUBCUTANEOUS18
ESPEROCT SOLUTION RECONSTITUTED	GENOTROPIN MINIQUICK PREFILLED
1500 UNIT INTRAVENOUS25	SYRINGE 1.2 MG SUBCUTANEOUS18
ESPEROCT SOLUTION RECONSTITUTED	GENOTROPIN MINIQUICK PREFILLED
2000 UNIT INTRAVENOUS25	SYRINGE 1.4 MG SUBCUTANEOUS18
ESPEROCT SOLUTION RECONSTITUTED	GENOTROPIN MINIQUICK PREFILLED
3000 UNIT INTRAVENOUS25	SYRINGE 1.6 MG SUBCUTANEOUS18
ESPEROCT SOLUTION RECONSTITUTED 500	GENOTROPIN MINIQUICK PREFILLED
UNIT INTRAVENOUS25	SYRINGE 1.8 MG SUBCUTANEOUS18
EVKEEZA SOLUTION 1200 MG/8ML	GENOTROPIN MINIQUICK PREFILLED
INTRAVENOUS14	SYRINGE 2 MG SUBCUTANEOUS18
EVKEEZA SOLUTION 345 MG/2.3ML	GENVISC 850 SOLUTION PREFILLED
INTRAVENOUS14	SYRINGE 25 MG/2.5ML INTRA-ARTICULAR 41
EYLEA HD SOLUTION 8 MG/0.07ML	GRANIX SOLUTION 300 MCG/ML
INTRAVITREAL15	SUBCUTANEOUS17
EYLEA SOLUTION 2 MG/0.05ML	GRANIX SOLUTION 480 MCG/1.6ML
INTRAVITREAL15	SUBCUTANEOUS17
EYLEA SOLUTION PREFILLED SYRINGE 2	GRANIX SOLUTION PREFILLED SYRINGE
MG/0.05ML INTRAVITREAL15	300 MCG/0.5ML SUBCUTANEOUS17
FEIBA SOLUTION RECONSTITUTED 1000	GRANIX SOLUTION PREFILLED SYRINGE
UNIT INTRAVENOUS16	480 MCG/0.8ML SUBCUTANEOUS17
FEIBA SOLUTION RECONSTITUTED 2500	HERCEPTIN HYLECTA SOLUTION 600-10000
UNIT INTRAVENOUS16	MG-UNT/5ML SUBCUTANEOUS37
FULPHILA SOLUTION PREFILLED SYRINGE 6	HERCEPTIN SOLUTION RECONSTITUTED
MG/0.6ML SUBCUTANEOUS28	150 MG INTRAVENOUS37
FYLNETRA SOLUTION PREFILLED SYRINGE 6	HERZUMA SOLUTION RECONSTITUTED 150
MG/0.6ML SUBCUTANEOUS28	MG INTRAVENOUS37
GEL-ONE PREFILLED SYRINGE 30 MG/3ML	HERZUMA SOLUTION RECONSTITUTED 420
INTRA-ARTICULAR41	MG INTRAVENOUS37
GELSYN-3 SOLUTION PREFILLED SYRINGE	HUMATROPE CARTRIDGE 12 MG
16.8 MG/2ML INTRA-ARTICULAR41	INJECTION18
GENOTROPIN CARTRIDGE 12 MG	HUMATROPE CARTRIDGE 24 MG
SUBCUTANEOUS18	INJECTION18
GENOTROPIN CARTRIDGE 5 MG	HUMATROPE CARTRIDGE 6 MG INJECTION. 18
SUBCUTANEOUS18	HYALGAN SOLUTION 20 MG/2ML INTRA-
GENOTROPIN MINIQUICK PREFILLED	ARTICULAR41
SYRINGE 0.2 MG SUBCUTANEOUS18	HYALGAN SOLUTION PREFILLED SYRINGE
GENOTROPIN MINIQUICK PREFILLED	20 MG/2ML INTRA-ARTICULAR41
SYRINGE 0.4 MG SUBCUTANEOUS18	HYMOVIS SOLUTION PREFILLED SYRINGE
GENOTROPIN MINIQUICK PREFILLED	24 MG/3ML INTRA-ARTICULAR41
SYRINGE 0.6 MG SUBCUTANEOUS18	

ILUMYA SOLUTION PREFILLED SYRINGE	MYOBLOC SOLUTION 2500 UNIT/0.5ML
100 MG/ML SUBCUTANEOUS 19	INTRAMUSCULAR9
IMJUDO SOLUTION 25 MG/1.25ML	MYOBLOC SOLUTION 5000 UNIT/ML
INTRAVENOUS20	INTRAMUSCULAR9
IMJUDO SOLUTION 300 MG/15ML	NEUPOGEN SOLUTION 300 MCG/ML
INTRAVENOUS20	INJECTION17
INFLECTRA SOLUTION RECONSTITUTED	NEUPOGEN SOLUTION 480 MCG/1.6ML
100 MG INTRAVENOUS21	INJECTION17
INVEGA HAFYERA SUSPENSION PREFILLED	NEUPOGEN SOLUTION PREFILLED SYRINGE
SYRINGE 1092 MG/3.5ML	300 MCG/0.5ML INJECTION17
INTRAMUSCULAR22	NEUPOGEN SOLUTION PREFILLED SYRINGE
INVEGA HAFYERA SUSPENSION PREFILLED	480 MCG/0.8ML INJECTION17
SYRINGE 1560 MG/5ML INTRAMUSCULAR22	NIVESTYM SOLUTION 300 MCG/ML
INVEGA TRINZA SUSPENSION PREFILLED	INJECTION17
SYRINGE 273 MG/0.88ML	NIVESTYM SOLUTION 480 MCG/1.6ML
INTRAMUSCULAR23	INJECTION17
INVEGA TRINZA SUSPENSION PREFILLED	NIVESTYM SOLUTION PREFILLED SYRINGE
SYRINGE 410 MG/1.32ML	300 MCG/0.5ML INJECTION17
INTRAMUSCULAR23	NIVESTYM SOLUTION PREFILLED SYRINGE
INVEGA TRINZA SUSPENSION PREFILLED	480 MCG/0.8ML INJECTION17
SYRINGE 546 MG/1.75ML	NORDITROPIN FLEXPRO SOLUTION PEN-
INTRAMUSCULAR23	INJECTOR 10 MG/1.5ML SUBCUTANEOUS18
INVEGA TRINZA SUSPENSION PREFILLED	NORDITROPIN FLEXPRO SOLUTION PEN-
SYRINGE 819 MG/2.63ML	INJECTOR 15 MG/1.5ML SUBCUTANEOUS18
INTRAMUSCULAR23	NORDITROPIN FLEXPRO SOLUTION PEN-
KHAPZORY SOLUTION RECONSTITUTED	INJECTOR 30 MG/3ML SUBCUTANEOUS18
175 MG INTRAVENOUS24	NORDITROPIN FLEXPRO SOLUTION PEN-
levoleucovorin calcium pf solution 175	INJECTOR 5 MG/1.5ML SUBCUTANEOUS18
mg/17.5ml intravenous24	NUTROPIN AQ NUSPIN 10 SOLUTION PEN-
levoleucovorin calcium pf solution 250	INJECTOR 10 MG/2ML SUBCUTANEOUS18
mg/25ml intravenous24	NUTROPIN AQ NUSPIN 20 SOLUTION PEN-
levoleucovorin calcium solution	INJECTOR 20 MG/2ML SUBCUTANEOUS18
reconstituted 50 mg intravenous24	NUTROPIN AQ NUSPIN 5 SOLUTION PEN-
LUCENTIS SOLUTION 0.3 MG/0.05ML	INJECTOR 5 MG/2ML SUBCUTANEOUS18
INTRAVITREAL30	NYVEPRIA SOLUTION PREFILLED SYRINGE 6
LUCENTIS SOLUTION PREFILLED SYRINGE	MG/0.6ML SUBCUTANEOUS28
0.3 MG/0.05ML INTRAVITREAL30	OGIVRI SOLUTION RECONSTITUTED 150
LUCENTIS SOLUTION PREFILLED SYRINGE	MG INTRAVENOUS37
0.5 MG/0.05ML INTRAVITREAL30	OGIVRI SOLUTION RECONSTITUTED 420
MONOVISC SOLUTION PREFILLED SYRINGE	MG INTRAVENOUS37
88 MG/4ML INTRA-ARTICULAR41	OMNITROPE SOLUTION CARTRIDGE 10
MYOBLOC SOLUTION 10000 UNIT/2ML	MG/1.5ML SUBCUTANEOUS18
INTRAMUSCULAR9	OMNITROPE SOLUTION CARTRIDGE 5
	MG/1.5ML SUBCUTANEOUS18

OMNITROPE SOLUTION RECONSTITUTED	RITUXAN SOLUTION 500 MG/50ML
5.8 MG SUBCUTANEOUS18	INTRAVENOUS32
ONTRUZANT SOLUTION RECONSTITUTED	ROLVEDON SOLUTION PREFILLED SYRINGE
150 MG INTRAVENOUS37	13.2 MG/0.6ML SUBCUTANEOUS 28
ONTRUZANT SOLUTION RECONSTITUTED	SAIZEN SOLUTION RECONSTITUTED 5 MG
420 MG INTRAVENOUS37	INJECTION18
OPDUALAG SOLUTION 240-80 MG/20ML	SAIZEN SOLUTION RECONSTITUTED 8.8
INTRAVENOUS26	MG INJECTION18
ORTHOVISC SOLUTION PREFILLED SYRINGE	SAIZENPREP SOLUTION RECONSTITUTED
30 MG/2ML INTRA-ARTICULAR41	8.8 MG INJECTION18
paclitaxel protein-bound part suspension	SOLIRIS SOLUTION 300 MG/30ML
reconstituted 100 mg intravenous27	INTRAVENOUS33
PEMFEXY SOLUTION 500 MG/20ML	SPINRAZA SOLUTION 12 MG/5ML
INTRAVENOUS29	INTRATHECAL34
PEMRYDI RTU SOLUTION 100 MG/10ML	STIMUFEND SOLUTION PREFILLED
INTRAVENOUS29	SYRINGE 6 MG/0.6ML SUBCUTANEOUS 28
PEMRYDI RTU SOLUTION 500 MG/50ML	SUPARTZ FX SOLUTION PREFILLED
INTRAVENOUS29	SYRINGE 25 MG/2.5ML INTRA-ARTICULAR 41
PROCRIT SOLUTION 10000 UNIT/ML	SUSVIMO (IMPLANT 1ST FILL) SOLUTION
INJECTION13	10 MG/0.1ML INTRAVITREAL30
PROCRIT SOLUTION 2000 UNIT/ML	SUSVIMO (IMPLANT REFILL) SOLUTION 10
INJECTION13	MG/0.1ML INTRAVITREAL30
PROCRIT SOLUTION 20000 UNIT/ML	SYNOJOYNT SOLUTION PREFILLED SYRINGE
INJECTION13	20 MG/2ML INTRA-ARTICULAR41
PROCRIT SOLUTION 3000 UNIT/ML	SYNVISC SOLUTION PREFILLED SYRINGE 16
INJECTION13	MG/2ML INTRA-ARTICULAR41
PROCRIT SOLUTION 4000 UNIT/ML	TEZSPIRE SOLUTION PREFILLED SYRINGE
INJECTION13	210 MG/1.91ML SUBCUTANEOUS 35
PROCRIT SOLUTION 40000 UNIT/ML	TOFIDENCE SOLUTION 200 MG/10ML
INJECTION13	INTRAVENOUS36
REBYOTA SUSPENSION 150 ML RECTAL31	TOFIDENCE SOLUTION 400 MG/20ML
releuko solution prefilled syringe 300	INTRAVENOUS36
mcg/0.5ml subcutaneous17	TOFIDENCE SOLUTION 80 MG/4ML
releuko solution prefilled syringe 480	INTRAVENOUS36
mcg/0.8ml subcutaneous17	TREANDA SOLUTION RECONSTITUTED 100
RENFLEXIS SOLUTION RECONSTITUTED	MG INTRAVENOUS6
100 MG INTRAVENOUS21	TREANDA SOLUTION RECONSTITUTED 25
RITUXAN HYCELA SOLUTION 1400-23400	MG INTRAVENOUS6
MG -UT/11.7ML SUBCUTANEOUS32	TRILURON SOLUTION PREFILLED SYRINGE
RITUXAN HYCELA SOLUTION 1600-26800	20 MG/2ML INTRA-ARTICULAR41
MG -UT/13.4ML SUBCUTANEOUS32	TRIVISC SOLUTION PREFILLED SYRINGE 25
RITUXAN SOLUTION 100 MG/10ML	MG/2.5ML INTRA-ARTICULAR41
INTRAVENOUS32	TRUXIMA SOLUTION 100 MG/10ML
	INTRAVENOUS32

TRUXIMA SOLUTION 500 MG/50ML	
INTRAVENOUS	32
ULTOMIRIS SOLUTION 1100 MG/11ML	
INTRAVENOUS	38
ULTOMIRIS SOLUTION 300 MG/3ML	
INTRAVENOUS	38
UPLIZNA SOLUTION 100 MG/10ML	
INTRAVENOUS	39
VABYSMO SOLUTION 6 MG/0.05ML	
INTRAVITREAL	40
VEGZELMA SOLUTION 100 MG/4ML	
INTRAVENOUS	8
VEGZELMA SOLUTION 400 MG/16ML	
INTRAVENOUS	8
VYEPTI SOLUTION 100 MG/ML	
INTRAVENOUS	42
VYVGART HYTRULO SOLUTION 180-2000	
MG-UNIT/ML SUBCUTANEOUS	43
VYVGART SOLUTION 400 MG/20ML	
INTRAVENOUS	43
ZIEXTENZO SOLUTION PREFILLED SYRINGE	
6 MG/0.6ML SUBCUTANEOUS	28
ZILRETTA SUSPENSION RECONSTITUTED ER	
32 MG INTRA-ARTICULAR	44