STEP THERAPY CRITERIA FOR MEDICARE PART B DRUGS

This list is current as of 10/1/2025 and pertains to the following Independent Health Medicare Advantage Plans for 2026:

Independent Health's Encompass 65® RED 042 (HMO)
Independent Health's Encompass 65® RED 043 (HMO)
Independent Health's Encompass 65® RED 044 (HMO)
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.

Aflibercept

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
- PAVBLU SOLUTION 2 MG/0.05ML INTRAVITREAL
- PAVBLU 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. |
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Amvuttra

Products Affected

• AMVUTTRA SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS

| | ient must have tried and failed to have an adequate b. This specific requirement applies to new starts |
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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

| Criteria | For approval, patient must have tried and had an intolerance to or has a |
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| | 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. This specific |
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| | 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

- BELRAPZO SOLUTION 100 MG/4ML INTRAVENOUS
- bendamustine hcl solution 100 mg/4ml intravenous
- BENDEKA SOLUTION 100 MG/4ML INTRAVENOUS
- vivimusta solution 100 mg/4ml intravenous

Details

Criteria For approval of Belrapzo/bendamustine Apotex/Baxter (J9036), Bendeka (J9034), or Vivimusta (J9056), the patient must have tried and failed to have an adequate response to Treanda (J9033), unless contraindicated or not tolerated. This specific requirement applies to new starts only and does not apply to patients using Belrapzo/bendamustine Apotex/Baxter, Bendeka, or Vivimusta for any indication not shared with Treanda.

Beovu

Products Affected

• 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. |
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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
- 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 Mvasi or Zirabev. 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 Mvasi or Zirabev.

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

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. |
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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 |
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| | response to Ocrevus. This specific requirement applies to new starts only. |

Camcevi

Products Affected

• CAMCEVI PREFILLED SYRINGE 42 MG SUBCUTANEOUS

Details

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

Products Affected

- PROLIA SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- XGEVA SOLUTION 120 MG/1.7ML SUBCUTANEOUS

Details

| to have an adequate response to Wyost. This specific requirement applies to new starts only. | starts only. For approval of Xgeva, the patient must have tried and failed | Criteria For approval of Prolia, the patient must have adequate response to Jubbonti. This specifies | fic requirement applies to new |
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Docetaxel

Products Affected

- DOCIVYX SOLUTION 160 MG/16ML INTRAVENOUS
- DOCIVYX SOLUTION 20 MG/2ML

INTRAVENOUS

 DOCIVYX SOLUTION 80 MG/8ML INTRAVENOUS

Details

| For approval of Docivyx (J9172) or Beizray (J9174), the patient must have tried and failed to have an adequate response to docetaxel (J9171). This specific requirement applies to new starts only. |
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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. |
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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.

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. |
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Feiba

Products Affected

- FEIBA SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS
- FEIBA SOLUTION RECONSTITUTED 2500 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. |
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Filgrastim

Products Affected

- GRANIX SOLUTION 300 MCG/ML 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
- NYPOZI SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION
- NYPOZI 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

Details

| Criteria | For approval of Granix, Neupogen, Nivestym, Nypozi, 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. |
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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 of the following: generic infliximab or Remicade or one other on-formulary biologic agent for the treatment of psoriasis (on-formulary adalimumab biosimilars, Enbrel, Humira, Skyrizi, on-formulary ustekinumab biosimilars). |
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Imjudo

Products Affected

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

Details

| 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.

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

| 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. |
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Leucovorins

Products Affected

• KHAPZORY SOLUTION RECONSTITUTED 175 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 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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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. |
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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 and does not apply to patients using Abraxane for any indication not shared with generic paclitaxel. |
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| | 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
- NEULASTA ONPRO PREFILLED SYRINGE KIT 6 MG/0.6ML SUBCUTANEOUS
- NEULASTA 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, Neulasta, Nyvepria, Rolvedon, Stimufend, or Ziextenzo, the patient must have tried and failed to have an adequate response to Udenyca. 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

- AXTLE SOLUTION RECONSTITUTED 100 MG INTRAVENOUS
- AXTLE SOLUTION RECONSTITUTED 500 MG INTRAVENOUS
- PEMFEXY SOLUTION 500 MG/20ML

INTRAVENOUS

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

Details

Criteria For approval of Axtle (J9292), Pemfexy (J9304), or Pemrydi RTU (J9324), the patient must have tried and failed to have an adequate response to one of the following drugs: pemetrexed (J9294, J9296, J9297, J9305, J9314, J9322, J9323) unless contraindicated or not tolerated. This specific requirement applies to new starts only and does not apply to patients using Axtle, Pemfexy, or Pemrydi for an indication not shared with preferred agents.

Ranibizumab

Products Affected

- BYOOVIZ SOLUTION 0.5 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 Byooviz for a diagnosis of neovascular (wet) age-related macular degeneration, macular edema following retinal vein occlusion, or myopic choroidal neovascularization, the patient must have tried and failed to have an adequate response to bevacizumab (Avastin). For Lucentis or Susvimo 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 Byooviz, aflibercept (Eylea/Eylea HD), brolucizumab (Beovu), or faricimab (Vabysmo). These requirements apply to new starts only.

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 500 MG/50ML

INTRAVENOUS

- TRUXIMA SOLUTION 100 MG/10ML INTRAVENOUS
- TRUXIMA SOLUTION 500 MG/50ML INTRAVENOUS

Details

| have tried and failed to have an adequate response to Riabni or Ruxience. 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 Riabni or Ruxience. | Criteria | Ruxience. This specific requirement applies to new starts only. This requirement does not apply to patients using a rituximab agent for any |
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Rystiggo

Products Affected

- RYSTIGGO SOLUTION 280 MG/2ML SUBCUTANEOUS
- RYSTIGGO SOLUTION 420 MG/3ML SUBCUTANEOUS
- RYSTIGGO SOLUTION 560 MG/4ML SUBCUTANEOUS
- RYSTIGGO SOLUTION 840 MG/6ML SUBCUTANEOUS

Details

| Criteria | For a diagnosis of generalized myasthenia gravis who are anti-AChR |
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| | antibody-positive, the patient must have tried and failed to have an |
| | adequate response to or had an intolerance to or contraindication to |
| | Vyvgart or Vyvgart Hytrulo. These requirements apply to new starts only. |
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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 or Vyvgart Hytrulo. |
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| | 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 adequat response to or had an intolerance to or contraindication to Evrysdi. This specific requirement applies to new starts only. |
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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. |
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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
- HERCESSI SOLUTION RECONSTITUTED 150 MG INTRAVENOUS
- HERCESSI SOLUTION RECONSTITUTED 420 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, Hercessi, Herzuma, Ogor Ontruzant, the patient must have tried and failed to have an ade | |
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| response to Kanjinti or Trazimera. This specific requirement applie | |
| | new starts only. This requirement does not apply to patients using a trastuzumab agent for any indication not shared by Kanjinti or Trazimera. |

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 or Vyvgart Hytrulo. These requirements apply to new starts only. |
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Ustekinumab

Products Affected

• STELARA SOLUTION 130 MG/26ML INTRAVENOUS

Details

| adequat | oval of Stelara, the patient must have tried and failed to have an e response to Selarsdi or Yesintek. This specific requirement o new starts only. |
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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. |
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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.

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 HYTRULO SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML

SUBCUTANEOUS

 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. |
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Zilretta

Products Affected

 ZILRETTA SUSPENSION RECONSTITUTED ER 32 MG INTRA-ARTICULAR

| 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. |
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| ABRAXANE SUSPENSION RECONSTITUTED | AXTLE SOLUTION RECONSTITUTED 500 MG |
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| 100 MG INTRAVENOUS27 | INTRAVENOUS29 |
| ACTEMRA SOLUTION 200 MG/10ML | BELRAPZO SOLUTION 100 MG/4ML |
| INTRAVENOUS36 | INTRAVENOUS6 |
| ACTEMRA SOLUTION 400 MG/20ML | bendamustine hcl solution 100 mg/4ml |
| INTRAVENOUS36 | intravenous6 |
| ACTEMRA SOLUTION 80 MG/4ML | BENDEKA SOLUTION 100 MG/4ML |
| INTRAVENOUS36 | INTRAVENOUS6 |
| adynovate solution reconstituted 1000 unit | BEOVU SOLUTION PREFILLED SYRINGE 6 |
| intravenous25 | MG/0.05ML INTRAVITREAL7 |
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| intravenous25 | INTRAVENOUS10 |
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| intravenous25 | INTRAVITREAL30 |
| adynovate solution reconstituted 250 unit | CAMCEVI PREFILLED SYRINGE 42 MG |
| intravenous25 | SUBCUTANEOUS11 |
| adynovate solution reconstituted 3000 unit | DAXXIFY SOLUTION RECONSTITUTED 100 |
| intravenous25 | UNIT INTRAMUSCULAR9 |
| adynovate solution reconstituted 500 unit | DOCIVYX SOLUTION 160 MG/16ML |
| intravenous25 | INTRAVENOUS13 |
| adynovate solution reconstituted 750 unit | DOCIVYX SOLUTION 20 MG/2ML |
| intravenous25 | INTRAVENOUS13 |
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| INTRAVENOUS8 | MG/3ML INTRA-ARTICULAR41 |
| AMVUTTRA SOLUTION PREFILLED SYRINGE | DYSPORT SOLUTION RECONSTITUTED 300 |
| 25 MG/0.5ML SUBCUTANEOUS 2 | UNIT INTRAMUSCULAR9 |
| APHEXDA SOLUTION RECONSTITUTED 62 | DYSPORT SOLUTION RECONSTITUTED 500 |
| MG SUBCUTANEOUS3 | UNIT INTRAMUSCULAR9 |
| APRETUDE SUSPENSION EXTENDED | ELOCTATE SOLUTION RECONSTITUTED |
| RELEASE 600 MG/3ML INTRAMUSCULAR 4 | 1000 UNIT INTRAVENOUS25 |
| ASCENIV SOLUTION 5 GM/50ML | ELOCTATE SOLUTION RECONSTITUTED |
| INTRAVENOUS5 | 2000 UNIT INTRAVENOUS25 |
| AVASTIN SOLUTION 100 MG/4ML | ELOCTATE SOLUTION RECONSTITUTED 250 |
| INTRAVENOUS8 | UNIT INTRAVENOUS25 |
| AVASTIN SOLUTION 400 MG/16ML | ELOCTATE SOLUTION RECONSTITUTED |
| INTRAVENOUS8 | 4000 UNIT INTRAVENOUS25 |
| AVSOLA SOLUTION RECONSTITUTED 100 | ELOCTATE SOLUTION RECONSTITUTED |
| MG INTRAVENOUS21 | 6000 UNIT INTRAVENOUS25 |
| AXTLE SOLUTION RECONSTITUTED 100 MG | ENJAYMO SOLUTION 1100 MG/22ML |
| INTRAVENOUS29 | INTRAVENOUS14 |

| EPOGEN SOLUTION 10000 UNIT/ML | GRANIX SOLUTION 300 MCG/ML |
|--|--------------------------------------|
| INJECTION15 | SUBCUTANEOUS18 |
| EPOGEN SOLUTION 2000 UNIT/ML | GRANIX SOLUTION PREFILLED SYRINGE |
| INJECTION15 | 300 MCG/0.5ML SUBCUTANEOUS18 |
| EPOGEN SOLUTION 20000 UNIT/ML | GRANIX SOLUTION PREFILLED SYRINGE |
| INJECTION15 | 480 MCG/0.8ML SUBCUTANEOUS18 |
| EPOGEN SOLUTION 3000 UNIT/ML | HERCEPTIN HYLECTA SOLUTION 600-10000 |
| INJECTION15 | MG-UNT/5ML SUBCUTANEOUS37 |
| EPOGEN SOLUTION 4000 UNIT/ML | HERCEPTIN SOLUTION RECONSTITUTED |
| INJECTION15 | 150 MG INTRAVENOUS37 |
| ESPEROCT SOLUTION RECONSTITUTED | HERCESSI SOLUTION RECONSTITUTED 150 |
| 1000 UNIT INTRAVENOUS25 | MG INTRAVENOUS37 |
| ESPEROCT SOLUTION RECONSTITUTED | HERCESSI SOLUTION RECONSTITUTED 420 |
| 1500 UNIT INTRAVENOUS25 | MG INTRAVENOUS37 |
| ESPEROCT SOLUTION RECONSTITUTED | HERZUMA SOLUTION RECONSTITUTED 150 |
| 2000 UNIT INTRAVENOUS25 | MG INTRAVENOUS37 |
| ESPEROCT SOLUTION RECONSTITUTED | HERZUMA SOLUTION RECONSTITUTED 420 |
| 3000 UNIT INTRAVENOUS25 | MG INTRAVENOUS37 |
| ESPEROCT SOLUTION RECONSTITUTED 500 | HYALGAN SOLUTION 20 MG/2ML INTRA- |
| UNIT INTRAVENOUS25 | ARTICULAR41 |
| EVKEEZA SOLUTION 1200 MG/8ML | HYALGAN SOLUTION PREFILLED SYRINGE |
| INTRAVENOUS16 | 20 MG/2ML INTRA-ARTICULAR41 |
| EVKEEZA SOLUTION 345 MG/2.3ML | HYMOVIS SOLUTION PREFILLED SYRINGE |
| INTRAVENOUS16 | 24 MG/3ML INTRA-ARTICULAR41 |
| EYLEA HD SOLUTION 8 MG/0.07ML | ILUMYA SOLUTION PREFILLED SYRINGE |
| INTRAVITREAL 1 | 100 MG/ML SUBCUTANEOUS 19 |
| EYLEA SOLUTION 2 MG/0.05ML | IMJUDO SOLUTION 25 MG/1.25ML |
| INTRAVITREAL 1 | INTRAVENOUS20 |
| EYLEA SOLUTION PREFILLED SYRINGE 2 | IMJUDO SOLUTION 300 MG/15ML |
| MG/0.05ML INTRAVITREAL1 | INTRAVENOUS20 |
| FEIBA SOLUTION RECONSTITUTED 1000 | INFLECTRA SOLUTION RECONSTITUTED |
| UNIT INTRAVENOUS17 | 100 MG INTRAVENOUS21 |
| FEIBA SOLUTION RECONSTITUTED 2500 | INVEGA HAFYERA SUSPENSION PREFILLED |
| UNIT INTRAVENOUS17 | SYRINGE 1092 MG/3.5ML |
| FULPHILA SOLUTION PREFILLED SYRINGE 6 | INTRAMUSCULAR22 |
| MG/0.6ML SUBCUTANEOUS28 | INVEGA HAFYERA SUSPENSION PREFILLED |
| FYLNETRA SOLUTION PREFILLED SYRINGE 6 | SYRINGE 1560 MG/5ML INTRAMUSCULAR 22 |
| MG/0.6ML SUBCUTANEOUS28 | INVEGA TRINZA SUSPENSION PREFILLED |
| GEL-ONE PREFILLED SYRINGE 30 MG/3ML | SYRINGE 273 MG/0.88ML |
| INTRA-ARTICULAR41 | INTRAMUSCULAR23 |
| GELSYN-3 SOLUTION PREFILLED SYRINGE | INVEGA TRINZA SUSPENSION PREFILLED |
| 16.8 MG/2ML INTRA-ARTICULAR41 | SYRINGE 410 MG/1.32ML |
| GENVISC 850 SOLUTION PREFILLED | INTRAMUSCULAR23 |
| SYRINGE 25 MG/2.5ML INTRA-ARTICULAR 41 | |

| INVEGA TRINZA SUSPENSION PREFILLED | NYVEPRIA SOLUTION PREFILLED SYRINGE 6 | |
|---------------------------------------|--|---|
| SYRINGE 546 MG/1.75ML | MG/0.6ML SUBCUTANEOUS2 | 8 |
| INTRAMUSCULAR23 | OGIVRI SOLUTION RECONSTITUTED 150 | |
| INVEGA TRINZA SUSPENSION PREFILLED | MG INTRAVENOUS3 | 7 |
| SYRINGE 819 MG/2.63ML | OGIVRI SOLUTION RECONSTITUTED 420 | |
| INTRAMUSCULAR23 | MG INTRAVENOUS3 | 7 |
| KHAPZORY SOLUTION RECONSTITUTED | ONTRUZANT SOLUTION RECONSTITUTED | |
| 175 MG INTRAVENOUS24 | 150 MG INTRAVENOUS 3 | 7 |
| LUCENTIS SOLUTION PREFILLED SYRINGE | ONTRUZANT SOLUTION RECONSTITUTED | |
| 0.3 MG/0.05ML INTRAVITREAL30 | 420 MG INTRAVENOUS 3 | 7 |
| LUCENTIS SOLUTION PREFILLED SYRINGE | OPDUALAG SOLUTION 240-80 MG/20ML | |
| 0.5 MG/0.05ML INTRAVITREAL30 | INTRAVENOUS2 | 6 |
| MONOVISC SOLUTION PREFILLED SYRINGE | ORTHOVISC SOLUTION PREFILLED SYRINGE | |
| 88 MG/4ML INTRA-ARTICULAR41 | 30 MG/2ML INTRA-ARTICULAR4 | 1 |
| MYOBLOC SOLUTION 10000 UNIT/2ML | paclitaxel protein-bound part suspension | |
| INTRAMUSCULAR9 | reconstituted 100 mg intravenous2 | 7 |
| MYOBLOC SOLUTION 2500 UNIT/0.5ML | PAVBLU SOLUTION 2 MG/0.05ML | |
| INTRAMUSCULAR9 | INTRAVITREAL | 1 |
| MYOBLOC SOLUTION 5000 UNIT/ML | PAVBLU SOLUTION PREFILLED SYRINGE 2 | |
| INTRAMUSCULAR9 | MG/0.05ML INTRAVITREAL | 1 |
| NEULASTA ONPRO PREFILLED SYRINGE KIT | PEMFEXY SOLUTION 500 MG/20ML | |
| 6 MG/0.6ML SUBCUTANEOUS28 | INTRAVENOUS2 | 9 |
| NEULASTA SOLUTION PREFILLED SYRINGE | PEMRYDI RTU SOLUTION 100 MG/10ML | |
| 6 MG/0.6ML SUBCUTANEOUS28 | INTRAVENOUS2 | 9 |
| NEUPOGEN SOLUTION 300 MCG/ML | PEMRYDI RTU SOLUTION 500 MG/50ML | |
| INJECTION18 | INTRAVENOUS2 | 9 |
| NEUPOGEN SOLUTION 480 MCG/1.6ML | PROCRIT SOLUTION 10000 UNIT/ML | |
| INJECTION18 | INJECTION1 | 5 |
| NEUPOGEN SOLUTION PREFILLED SYRINGE | PROCRIT SOLUTION 2000 UNIT/ML | |
| 300 MCG/0.5ML INJECTION18 | INJECTION1 | 5 |
| NEUPOGEN SOLUTION PREFILLED SYRINGE | PROCRIT SOLUTION 20000 UNIT/ML | |
| 480 MCG/0.8ML INJECTION18 | INJECTION1 | 5 |
| NIVESTYM SOLUTION 300 MCG/ML | PROCRIT SOLUTION 3000 UNIT/ML | |
| INJECTION18 | INJECTION1 | 5 |
| NIVESTYM SOLUTION 480 MCG/1.6ML | PROCRIT SOLUTION 4000 UNIT/ML | |
| INJECTION18 | INJECTION1 | 5 |
| NIVESTYM SOLUTION PREFILLED SYRINGE | PROCRIT SOLUTION 40000 UNIT/ML | |
| 300 MCG/0.5ML INJECTION18 | INJECTION1 | 5 |
| NIVESTYM SOLUTION PREFILLED SYRINGE | PROLIA SOLUTION PREFILLED SYRINGE 60 | |
| 480 MCG/0.8ML INJECTION18 | MG/ML SUBCUTANEOUS1 | 2 |
| NYPOZI SOLUTION PREFILLED SYRINGE 300 | releuko solution prefilled syringe 300 | |
| MCG/0.5ML INJECTION18 | mcg/0.5ml subcutaneous1 | 8 |
| NYPOZI SOLUTION PREFILLED SYRINGE 480 | releuko solution prefilled syringe 480 | |
| MCG/0.8ML INJECTION18 | mcg/0.8ml subcutaneous1 | 8 |

| RENFLEXIS SOLUTION RECONSTITUTED | TRILURON SOLUTION PREFILLED SYRINGE |
|--|---------------------------------------|
| 100 MG INTRAVENOUS21 | 20 MG/2ML INTRA-ARTICULAR41 |
| RITUXAN HYCELA SOLUTION 1400-23400 | TRIVISC SOLUTION PREFILLED SYRINGE 25 |
| MG -UT/11.7ML SUBCUTANEOUS31 | MG/2.5ML INTRA-ARTICULAR41 |
| RITUXAN HYCELA SOLUTION 1600-26800 | TRUXIMA SOLUTION 100 MG/10ML |
| MG -UT/13.4ML SUBCUTANEOUS31 | INTRAVENOUS31 |
| RITUXAN SOLUTION 500 MG/50ML | TRUXIMA SOLUTION 500 MG/50ML |
| INTRAVENOUS31 | INTRAVENOUS31 |
| ROLVEDON SOLUTION PREFILLED SYRINGE | ULTOMIRIS SOLUTION 1100 MG/11ML |
| 13.2 MG/0.6ML SUBCUTANEOUS 28 | INTRAVENOUS38 |
| RYSTIGGO SOLUTION 280 MG/2ML | ULTOMIRIS SOLUTION 300 MG/3ML |
| SUBCUTANEOUS32 | INTRAVENOUS38 |
| RYSTIGGO SOLUTION 420 MG/3ML | VABYSMO SOLUTION 6 MG/0.05ML |
| SUBCUTANEOUS32 | INTRAVITREAL40 |
| RYSTIGGO SOLUTION 560 MG/4ML | VEGZELMA SOLUTION 100 MG/4ML |
| SUBCUTANEOUS32 | INTRAVENOUS8 |
| RYSTIGGO SOLUTION 840 MG/6ML | VEGZELMA SOLUTION 400 MG/16ML |
| SUBCUTANEOUS32 | INTRAVENOUS8 |
| SOLIRIS SOLUTION 300 MG/30ML | vivimusta solution 100 mg/4ml |
| INTRAVENOUS33 | intravenous6 |
| SPINRAZA SOLUTION 12 MG/5ML | VYEPTI SOLUTION 100 MG/ML |
| INTRATHECAL34 | INTRAVENOUS42 |
| STELARA SOLUTION 130 MG/26ML | VYVGART HYTRULO SOLUTION 180-2000 |
| INTRAVENOUS39 | MG-UNIT/ML SUBCUTANEOUS43 |
| STIMUFEND SOLUTION PREFILLED | VYVGART HYTRULO SOLUTION PREFILLED |
| SYRINGE 6 MG/0.6ML SUBCUTANEOUS 28 | SYRINGE 1000-10000 MG-UNT/5ML |
| SUPARTZ FX SOLUTION PREFILLED | SUBCUTANEOUS43 |
| SYRINGE 25 MG/2.5ML INTRA-ARTICULAR 41 | VYVGART SOLUTION 400 MG/20ML |
| SUSVIMO (IMPLANT 1ST FILL) SOLUTION | INTRAVENOUS43 |
| 10 MG/0.1ML INTRAVITREAL30 | XGEVA SOLUTION 120 MG/1.7ML |
| SUSVIMO (IMPLANT REFILL) SOLUTION 10 | SUBCUTANEOUS12 |
| MG/0.1ML INTRAVITREAL30 | ZIEXTENZO SOLUTION PREFILLED SYRINGE |
| SYNOJOYNT SOLUTION PREFILLED SYRINGE | 6 MG/0.6ML SUBCUTANEOUS 28 |
| 20 MG/2ML INTRA-ARTICULAR41 | ZILRETTA SUSPENSION RECONSTITUTED ER |
| SYNVISC SOLUTION PREFILLED SYRINGE 16 | 32 MG INTRA-ARTICULAR 44 |
| MG/2ML INTRA-ARTICULAR41 | |
| TEZSPIRE SOLUTION PREFILLED SYRINGE | |
| 210 MG/1.91ML SUBCUTANEOUS 35 | |
| TOFIDENCE SOLUTION 200 MG/10ML | |
| INTRAVENOUS36 | |
| TOFIDENCE SOLUTION 400 MG/20ML | |
| INTRAVENOUS36 | |
| TOFIDENCE SOLUTION 80 MG/4ML | |
| INTRAVENOUS36 | |
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