

STEP THERAPY CRITERIA FOR MEDICARE PART B DRUGS

This list is current as of 10/1/2026 and pertains to the following Independent Health Medicare Advantage Plans for 2027:

Independent Health's Encompass 65® RED 042 (HMO)
Independent Health's Encompass 65® RED 044 (HMO)
Independent Health's Encompass 65® RED 045 (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)
Independent Health's Medicare Advantage Employer Group's Part D Formulary

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
- YESAFILI SOLUTION PREFILLED SYRINGE 2 MG/0.05ML INTRAVITREAL

Details

Criteria	For approval, 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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10/1/2026

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 Onpattro. This specific requirement applies to new starts only.
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10/1/2026

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.
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10/1/2026

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.
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10/1/2026

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. 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.
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10/1/2026

Avgemsi

Products Affected

- AVGEMSI SOLUTION 1 GM/26.3ML
INTRAVENOUS
- AVGEMSI SOLUTION 2 GM/52.6ML
INTRAVENOUS

Details

Criteria	For approval of Avgemsi, the patient must have tried and failed to have an adequate response to intravenous gemcitabine. This specific requirement applies to new starts only. This requirement does not apply to patients using Avgemsi for any indication not shared by intravenous gemcitabine.
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10/1/2026

Avopef

Products Affected

- AVOPEF SOLUTION 100 MG/5ML
INTRAVENOUS
- AVOPEF SOLUTION 500 MG/25ML
INTRAVENOUS

Details

Criteria	For approval of Avopef, the patient must have tried and failed to have an adequate response to or has a contraindication to generic etoposide injection (J9181). These requirements apply to new starts only.
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10/1/2026

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), bendamustine Avyxa (J9066), Bendeka (J9034), or Vivimusta (J9056), the patient must have tried and failed to have an adequate response to Treanda or its generics (J9033), unless contraindicated or not tolerated. This specific requirement applies to new starts only and does not apply to patients using any non-preferred product for any indication not shared with Treanda.
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10/1/2026

Beovu

Products Affected

- 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 and does not apply to patients using Beovu for any off-label indication not shared with bevacizumab.
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10/1/2026

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

Details

Criteria	For approval of Alymsys, Avastin, Jobevne, 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.
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10/1/2026

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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10/1/2026

Briumvi

Products Affected

- BRIUMVI SOLUTION 150 MG/6ML
INTRAVENOUS

Details

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.
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10/1/2026

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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10/1/2026

Carboplatin

Products Affected

- KYNATA SOLUTION 500 MG/50ML
INTRAVENOUS
- KYNATA SOLUTION 80 MG/8ML
INTRAVENOUS

Details

Criteria	For approval of Kynata, the patient must have tried and failed to have an adequate response to carboplatin. This specific requirement applies to new starts only. This requirement does not apply to patients using Kynata for any indication not shared by carboplatin.
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10/1/2026

Denosumab

Products Affected

- AUKELSO SOLUTION 120 MG/1.7ML SUBCUTANEOUS
- BOMYNTRA SOLUTION 120 MG/1.7ML SUBCUTANEOUS
- BOMYNTRA SOLUTION PREFILLED SYRINGE 120 MG/1.7ML SUBCUTANEOUS
- BOSAYA SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- CONEXXENCE SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- ENOBY SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- JUBEREQ SOLUTION 120 MG/1.7ML SUBCUTANEOUS
- OSENVLT SOLUTION 120 MG/1.7ML SUBCUTANEOUS
- OSPOMYV SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- OSVYRTI SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- PROLIA SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- STOBOCLO SOLUTION PREFILLED SYRINGE 60 MG/ML SUBCUTANEOUS
- XGEVA SOLUTION 120 MG/1.7ML SUBCUTANEOUS
- XTRENBO SOLUTION 120 MG/1.7ML SUBCUTANEOUS

Details

Criteria	For approval of Prolia or a non-preferred denosumab biosimilar to Prolia, the patient must have tried and failed to have an adequate response to Bilyos or Jubbonti. This specific requirement applies to new starts only. This requirement does not apply to patients using a non-preferred denosumab agent for any indication not shared by Bilyos or Jubbonti. For approval of Xgeva or a non-preferred denosumab biosimilar to Xgeva, the patient must have tried and failed to have an adequate response to Bilprevda or Wyost. This specific requirement applies to new starts only. This requirement does not apply to patients using a non-preferred denosumab agent for any indication not shared by Bilprevda or Wyost.
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10/1/2026

Docetaxel

Products Affected

- BEIZRAY CONCENTRATE 20 MG/ML INTRAVENOUS
- BEIZRAY SOLUTION 2 X 80 MG/4ML & 25%(50 ML) INTRAVENOUS
- DOCIVYX SOLUTION 160 MG/16ML INTRAVENOUS
- DOCIVYX SOLUTION 20 MG/2ML INTRAVENOUS
- DOCIVYX SOLUTION 80 MG/8ML INTRAVENOUS

Details

Criteria	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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10/1/2026

Eculizumab

Products Affected

- BKEMV SOLUTION 300 MG/30ML INTRAVENOUS
- EPYSQLI SOLUTION 300 MG/30ML INTRAVENOUS
- 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. These requirements apply to new starts only.
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10/1/2026

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 Riabni (or another rituximab product). This specific requirement applies to new starts only.
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10/1/2026

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.
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10/1/2026

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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10/1/2026

Exdensur

Products Affected

- *exdensur solution prefilled syringe 100 mg/ml subcutaneous*

Details

Criteria	For approval of Exdensur (depemokimab-ulaa), the patient must have tried and failed to have an adequate response to dupilumab or mepolizumab, unless contraindicated or not tolerated. This specific requirement applies to new starts only.
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10/1/2026

Favlyxa

Products Affected

- FAVLYXA SOLUTION 2.5 GM/100ML
INTRAVENOUS
- FAVLYXA SOLUTION 250 MG/10ML
INTRAVENOUS

Details

Criteria	For approval of Favlyxa, the patient must have tried and failed to have an adequate response to or has a contraindication to generic fluorouracil (J9190). These requirements apply to new starts only.
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10/1/2026

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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10/1/2026

Filgrastim

Products Affected

- FILKRI SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION
- FILKRI SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML INJECTION
- 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 Filkri, 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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10/1/2026

Fosaprepitant

Products Affected

- *focinvez solution 150 mg/50ml intravenous* MG INTRAVENOUS
- NAVITRUX SOLUTION RECONSTITUTED 150

Details

Criteria	For approval of Focinvez (J1434) or Navitrux, the patient must have tried and failed to have an adequate response to or have a contraindication to generic fosaprepitant. These requirements apply to new starts only.
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10/1/2026

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, Skyrizi, on-formulary ustekinumab biosimilars).
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10/1/2026

Imaavy

Products Affected

- IMAAVY SOLUTION 1200 MG/6.5ML
INTRAVENOUS
- IMAAVY SOLUTION 300 MG/1.62ML
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 Rystiggo (rozanolixizumab). These specific requirements apply to new starts only.
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10/1/2026

Imjudo

Products Affected

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

Details

Criteria	For approval for non-small cell lung cancer, the patient must have an adequate response to or had an intolerance or contraindication to regimens containing cemiplimab (Libtayo).
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10/1/2026

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.
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10/1/2026

Inlexzo

Products Affected

- INLEXZO IMPLANT 225 MG INTRAVESICAL

Details

Criteria	For approval, the patient must have tried and failed to have an adequate response to intravesicular gemcitabine. This specific requirement applies to new starts only. This requirement does not apply to patients using Inlexzo for any indication not shared by intravesicular gemcitabine.
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10/1/2026

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.
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10/1/2026

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.
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10/1/2026

Leucovorins

Products Affected

- KHAPZORY SOLUTION RECONSTITUTED 175 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 and does not apply to patients using levoleucovorin for any indication not shared with leucovorin.
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10/1/2026

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
- 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.
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10/1/2026

Melphalan

Products Affected

- EVOMELA SOLUTION RECONSTITUTED 50 MG INTRAVENOUS
- *ivra solution 90 mg/ml intravenous*

Details

Criteria	For approval of Ivra (J9249) or Evomela (J9246), the patient must have tried and failed to have an adequate response or have a contraindication to melphalan intravenous (J9245). These requirements apply to new starts only.
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10/1/2026

Natalizumab

Products Affected

- TYSABRI CONCENTRATE 300 MG/15ML
INTRAVENOUS

Details

Criteria	For approval of Tysabri (natalizumab), the patient must have tried and failed to have an adequate response to Tyruko (natalizumab-sztn). This specific requirement applies to new starts only. This requirement does not apply to patients using Tysabri (natalizumab) for any indication not shared by Tyruko (natalizumab-sztn).
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10/1/2026

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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10/1/2026

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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10/1/2026

Pegfilgrastim

Products Affected

- FULPHILA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- FYLNETRA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- NEULASTA ONPRO SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- NEULASTA SOLUTION 4 MG/0.4ML 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
- RYZNEUTA SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS
- STIMUFEND SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- ZIEXTENZO SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS

Details

Criteria	For approval of a non-preferred pegfilgrastim biosimilar or Ryzneuta, 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 or Ryzneuta for any indication not shared with a preferred pegfilgrastim product.
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10/1/2026

Pemetrexed

Products Affected

- AXTLER SOLUTION RECONSTITUTED 100 MG INTRAVENOUS
- AXTLER SOLUTION RECONSTITUTED 500 MG INTRAVENOUS
- PEMFEXY SOLUTION 500 MG/20ML
- 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.
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10/1/2026

Piasky

Products Affected

- PIASKY SOLUTION 340 MG/2ML INJECTION

Details

Criteria	For approval of Piasky, the patient must have tried and failed to have an adequate response to eculizumab or ravulizumab, unless contraindicated or not tolerated. This specific requirement applies to new starts only.
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10/1/2026

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 PREFILLED SYRINGE 0.3 MG/0.05ML INTRAVITREAL
- LUCENTIS SOLUTION PREFILLED SYRINGE 0.5 MG/0.05ML INTRAVITREAL
- SUSVIMO (IMPLANT REFILL) SOLUTION 10 MG/0.1ML INTRAVITREAL

Details

Criteria	For approval of Cimerli or ranibizumab-eqrn, the patient must have tried and failed to have an adequate response to bevacizumab (Avastin). For Lucentis or a non-preferred ranibizumab product 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 Cimerli or ranibizumab-eqrn. These requirements apply to new starts only.
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10/1/2026

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

Criteria	For approval of Rituxan, Rituxan Hycela, or Truxima, the patient must 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.
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10/1/2026

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, 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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10/1/2026

Rytelo

Products Affected

- RYTELO SOLUTION RECONSTITUTED 188 MG INTRAVENOUS
- RYTELO SOLUTION RECONSTITUTED 47 MG INTRAVENOUS

Details

Criteria	For approval, the patient must have tried and failed or had an intolerance to or contraindication to Reblozyl when patient has myelodysplastic syndrome defined as IPSS-R (very low, low intermediate) that is NOT del(5q) mutated and has either (a) ring sideroblasts less than 15% (or less than 5% with an SF3B1 mutation) with a serum erythropoietin less than or equal to 500 mU/mL, or (b) ring sideroblasts greater than or equal to 15% (or ring sideroblasts greater than or equal to 5% with an SF3B1 mutation). This specific requirement applies to new starts only.
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10/1/2026

Spinraza

Products Affected

- SPINRAZA SOLUTION 12 MG/5ML
INTRATHECAL
- SPINRAZA SOLUTION 28 MG/5ML
- SPINRAZA SOLUTION 50 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.
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10/1/2026

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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10/1/2026

Tocilizumab

Products Affected

- ACTEMRA SOLUTION 200 MG/10ML
INTRAVENOUS
- ACTEMRA SOLUTION 400 MG/20ML
INTRAVENOUS
- ACTEMRA SOLUTION 80 MG/4ML
INTRAVENOUS
- AVTOZMA SOLUTION 200 MG/10ML
INTRAVENOUS
- AVTOZMA SOLUTION 400 MG/20ML
INTRAVENOUS
- INTRAVENOUS
- AVTOZMA 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 a non-preferred biosimilar to Actemra, the patient must have tried and failed to have an adequate response to Tyenne or tocilizumab-aazg. This specific requirement applies to new starts only. This requirement does not apply to patients using Actemra or another non-preferred tocilizumab biosimilar agent for any indication not shared with Tyenne or tocilizumab-aazg.
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10/1/2026

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, or a non-preferred trastuzumab biosimilar to Herceptin, the patient must have tried and failed to have an adequate response to Kanjinti or Trazimera. This specific requirement applies to new starts only. This requirement does not apply to patients using a non-preferred trastuzumab agent for any indication not shared by Kanjinti or Trazimera.
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10/1/2026

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 or Vyvgart Hytrulo. These requirements apply to new starts only.
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10/1/2026

Uplizna

Products Affected

- UPLIZNA SOLUTION 100 MG/10ML
INTRAVENOUS

Details

Criteria	For approval for 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. 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 Rystiggo (rozanolixizumab). These specific requirements apply to new starts only and do not apply to patients using Uplizna for any indication not shared with Enspryng or Rystiggo.
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10/1/2026

Ustekinumab

Products Affected

- IMULDOSA SOLUTION 130 MG/26ML INTRAVENOUS
- OTULFI SOLUTION 130 MG/26ML INTRAVENOUS
- PYZCHIVA SOLUTION 130 MG/26ML INTRAVENOUS
- STELARA SOLUTION 130 MG/26ML INTRAVENOUS
- STEQEYMA SOLUTION 130 MG/26ML INTRAVENOUS
- *ustekinumab solution 130 mg/26ml intravenous*
- *ustekinumab-ttwe solution 130 mg/26ml intravenous*
- WEZLANA SOLUTION 130 MG/26ML INTRAVENOUS

Details

Criteria	For approval of Stelara or a non-preferred ustekinumab biosimilar to Stelara, the patient must have tried and failed to have an adequate response to Selarsdi or Starjemza. This specific requirement applies to new starts only. This requirement does not apply to patients using a ustekinumab agent for any indication not shared by Selarsdi or Starjemza.
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10/1/2026

Vabysmo

Products Affected

- VABYSMO SOLUTION 6 MG/0.05ML
INTRAVITREAL

Details

Criteria	For approval, 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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10/1/2026

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 ONE SOLUTION PREFILLED SYRINGE 32 MG/4ML 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
- SYNIVISC 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. 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.
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10/1/2026

Vyepti

Products Affected

- VYEPTI SOLUTION 100 MG/ML
INTRAVENTOUS

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.
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10/1/2026

Vyvgart

Products Affected

- VYVGART HYTRULO SOLUTION 180-2000 MG-UNIT/ML SUBCUTANEOUS
- VYVGART HYTRULO SOLUTION 400 MG/20ML SUBCUTANEOUS
- VYVGART HYTRULO SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML
- 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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10/1/2026

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.
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SUSVIMO (IMPLANT REFILL) SOLUTION 10		VYEPTI SOLUTION 100 MG/ML	
MG/0.1ML INTRAVITREAL.....	42	INTRAVENOUS.....	55

VYVGART HYTRULO SOLUTION 180-2000 MG-UNIT/ML SUBCUTANEOUS.....	56
VYVGART HYTRULO SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML SUBCUTANEOUS.....	56
VYVGART SOLUTION 400 MG/20ML INTRAVENOUS.....	56
WEZLANA SOLUTION 130 MG/26ML INTRAVENOUS.....	52
XGEVA SOLUTION 120 MG/1.7ML SUBCUTANEOUS.....	15
XTRENBO SOLUTION 120 MG/1.7ML SUBCUTANEOUS.....	15
YESAFILI SOLUTION PREFILLED SYRINGE 2 MG/0.05ML INTRAVITREAL.....	1
ZIEXTENZO SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS.....	39
ZILRETTA SUSPENSION RECONSTITUTED ER 32 MG INTRA-ARTICULAR.....	57