STEP THERAPY CRITERIA FOR MEDICARE PART B DRUGS

This list is current as of 12/01/2021 and pertains to the following Independent Health Medicare Advantage Plans for 2021:

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

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.

Beovu

Products Affected

- BEOVU SOLUTION 6 MG/0.05ML INTRAVITREAL

Details

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

Bevacizumab

Products Affected

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

Details

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

Botulinum toxins

Products Affected

- DYSPORT SOLUTION RECONSTITUTED 300 UNIT INTRAMUSCULAR
- DYSPORT SOLUTION RECONSTITUTED 500 UNIT INTRAMUSCULAR
- MYOBLOC SOLUTION 10000 UNIT/2ML INTRAMUSCULAR
- MYOBLOC SOLUTION 2500 UNIT/0.5ML INTRAMUSCULAR
- MYOBLOC SOLUTION 5000 UNIT/ML INTRAMUSCULAR

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.

Cabenuva

Products Affected

- CABENUVA SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML INTRAMUSCULAR
- CABENUVA SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML INTRAMUSCULAR

Details

Criteria	For approval, the patient must have had run-in therapy with oral cabotegravir and rilpivirine. 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.

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.

Eylea

Products Affected

- EYLEA SOLUTION 2 MG/0.05ML INTRAVITREAL
- EYLEA SOLUTION PREFILLED SYRINGE 2 MG/0.05ML INTRAVITREAL

Details

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

Feiba

Products Affected

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

Details

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

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

Details

Criteria	For approval of Neupogen for any indication other than Hematopoietic Syndrome of Acute Radiation Syndrome or Granix, the patient must have tried and failed to have an adequate response to both preferred Part B formulary filgrastim products (Zarxio and Nivestym). This specific requirement applies to new starts only.

Ilumya

Products Affected

- ILUMYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS

Details

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

Infliximab

Products Affected

- AVSOLA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS
- REMICADE SOLUTION RECONSTITUTED 100 MG INTRAVENOUS
- RENFLEXIS SOLUTION RECONSTITUTED 100 MG INTRAVENOUS

Details

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

Leucovorins

Products Affected

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

Details

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

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 1500 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS
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- ELOCTATE SOLUTION RECONSTITUTED 5000 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 6000 UNIT INTRAVENOUS
- ELOCTATE SOLUTION RECONSTITUTED 750 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.

Lucentis

Products Affected

- LUCENTIS SOLUTION 0.3 MG/0.05ML INTRAVITREAL
- LUCENTIS 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

Details

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

Perforomist

Products Affected

- PERFOROMIST NEBULIZATION SOLUTION 20 MCG/2ML INHALATION

Details

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

Rituximab

Products Affected

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

Details

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

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. This specific requirement applies to new starts only.

Spinraza

Products Affected

- SPINRAZA SOLUTION 12 MG/5ML INTRATHECAL

Details

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

Trastuzumab

Products Affected

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

Details

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

Uplizna

Products Affected

- UPLIZNA SOLUTION 100 MG/10ML INTRAVENOUS

Details

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

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
- *sodium hyaluronate solution prefilled syringe 20 mg/2ml intra-articular*
- SUPARTZ FX SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR
- SYNVISC SOLUTION PREFILLED SYRINGE 16 MG/2ML INTRA-ARTICULAR
- TRILURON SOLUTION PREFILLED SYRINGE 20 MG/2ML INTRA-ARTICULAR
- TRIVISC SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR
- VISCO-3 SOLUTION PREFILLED SYRINGE 25 MG/2.5ML INTRA-ARTICULAR

Details

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

Vyepti

Products Affected

- VYEPTI SOLUTION 100 MG/ML INTRAVENOUS

Details

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

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 injectable corticosteroid. This specific requirement applies to new starts only.

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