STEP THERAPY CRITERIA FOR MEDICARE PART B DRUGS

This list is current as of 11/01/2019 and pertains to the following Independent Health Medicare Advantage Plans for 2020:

- 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)

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.
## Avastin

### Products Affected
- AVASTIN SOLUTION 100 MG/4ML INTRAVENOUS
- AVASTIN SOLUTION 400 MG/16ML INTRAVENOUS

### Details

| Criteria | For approval for oncology (cancer) indications, the patient must have tried and failed to have an adequate response to Mvasi. 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 Avastin and Mvasi (ovarian, fallopian tube, or primary peritoneal cancer indications). |

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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

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<th>Criteria</th>
<th>For approval, the patient must have tried and failed to have an adequate response to Retacrit. This specific requirement applies to new starts only.</th>
</tr>
</thead>
</table>
Eylea

Products Affected

- EYLEA SOLUTION 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. |

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## Feiba

**Products Affected**

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

**Details**

<table>
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<tr>
<th>Criteria</th>
<th>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.</th>
</tr>
</thead>
</table>
**Granix**

**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

**Details**

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<td>For approval of 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.</td>
</tr>
</tbody>
</table>
**Herceptin**

**Products Affected**
- HERCEPTIN HYLECTA SOLUTION 600-10000 MG-UNT/5ML SUBCUTANEOUS
- HERCEPTIN SOLUTION RECONSTITUTED 150 MG INTRAVENOUS

**Details**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>For approval, the patient must have tried and failed to have an adequate response to Kanjinti. This specific requirement applies to new starts only.</th>
</tr>
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IL-5 antagonists

Products Affected
- CINQAIR SOLUTION 100 MG/10ML INTRAVENOUS
- FASENRA SOLUTION PREFILLED SYRINGE 30 MG/ML SUBCUTANEOUS
- NUCALA SOLUTION RECONSTITUTED 100 MG SUBCUTANEOUS

Details

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<th>Criteria</th>
<th>For approval, the patient must have tried and failed to have an adequate response to Dupixent. This specific requirement applies to new starts only.</th>
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</table>
## Ilumya

### Products Affected
- ILUMYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS

### Details

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<th>Criteria</th>
<th>For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to at least two preferred formulary biologic agents for the treatment of psoriasis (Cimzia, Cosentyx, Enbrel, Otezla, Stelara, Taltz, Tremfya), one of which is an IL-17 inhibitor (Cosentyx, Taltz). This specific requirement applies to new starts only.</th>
</tr>
</thead>
</table>

This specific requirement applies to new starts only.
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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>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.</th>
</tr>
</thead>
</table>
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). This specific requirement applies to new starts only.
# Neupogen

## Products Affected
- 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

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<th>Criteria</th>
<th>For approval of Neupogen for any indication other than Hematopoietic Syndrome of Acute Radiation Syndrome, 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.</th>
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Perforomist

Products Affected

- PERFOROMIST NEBULIZATION SOLUTION 20 MCG/2ML INHALATION

Details

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<th>Criteria</th>
<th>For approval, the patient must have tried and failed to have an adequate response to Brovana. This specific requirement applies to new starts only.</th>
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</table>
## 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
- SYNVISC SOLUTION PREFILLED SYRINGE 16 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. |

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Zilretta

Products Affected

- ZILRETTA SUSPENSION RECONSTITUTED ER
  32 MG INTRA-ARTICULAR

Details

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<th>Criteria</th>
<th>For approval, the patient must have tried and failed to have an adequate response to injectable triamcinolone (generic Kenalog). This specific requirement applies to new starts only.</th>
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