

Medicare Part B
Step Therapy Program

Questions about Step Therapy?

Cigna Healthcare has
the answers.



What is Step Therapy?

Step Therapy is a required process that applies to certain Part B prescription drugs.

How does Step Therapy work?

Step Therapy requires customers to first try a preferred medication over non-preferred medications that treat the same condition.

What if the preferred medication is ineffective?

If the preferred medication is proven ineffective or causes negative side-effects, then a non-preferred medication may be covered.

What if the preferred drug has been tried in the past?

If the preferred medication was tried in the past 365 days, a non-preferred medication may be covered. If the preferred medication hasn't been tried in the past 365 days, Step Therapy is required.

How do I find out what drugs require Part B Step Therapy?

The Step Therapy chart applies to all Cigna HealthcareSM Medicare markets.



Step Therapy drug class	Preferred* medications	Non-preferred medications
Antiemetic - Serotonin Receptor Antagonists (Injectable) for Oncology	• Granisetron • Ondansetron • Palonosetron	Sustol
Antiemetic - Substance P/Neurokinin-1 Receptor Antagonists (Injectable) for Oncology	Emend	• Akynzeo • Cinvanti
Bevacizumab (Oncology)	• Alymsys • Mvasi	• Zirabev • Avastin • Vegzelma
Botulinum Toxins	• Botox • Daxxify • Dysport • Xeomin	Myobloc
Colony Stimulating Factors Short-Acting	• Nivestym • Zarxio	• Granix • Neupogen • Releuko
Colony Stimulating Factors Long-Acting	• Neulasta/Neulasta Onpro • Nyvepria • Udenyca	• Fulphila • Fylnetra • Rolvedon • Stimufend • Ziextenzo
Immune Globulins IV	• Flebogamma DIF • Gammagard Liquid • Gammagard S/D • Gammaked • Gammaplex • Gamunex-C • Octagam • Privigen	• Alyglo • Asceniv • Bivigam • Panzyga
Immune Globulins SC	• Cutaquig • Gammagard Liquid • Gammaked • Gamunex-C • Hizentra • Xembify	• Cuvitru • HyQvia
Immunomodulators	• Avsola • Inflectra • Renflexis	Remicade, infliximab (authorized generic)
Intravenous Iron	Venofer	• Feraheme • Injectafer • Monoferric
Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors	Avastin	• Beovu • Byooviz • Cimerli • Eylea • Eylea HD • Lucentis • Pavblu • Vabysmo

*Preferred medications may require prior authorization.

Step Therapy drug class	Preferred* medications	Non-preferred medications
Paclitaxel Medications	Paclitaxel	• Abraxane • Paclitaxel protein-bound
Rituximab	• Riabni • Ruxience • Truxima	• Rituxan Hycela • Rituxan IV
Somatostatin Analogs Long-Acting	• Somatuline Depot (J1930) • Lanreotide (J1930)	• Lanreotide (J1932) • Sandostatin LAR
Systemic Lupus Erythematosus (SLE) [Lupus]	Benlysta IV	Saphnelo
Testosterone Injectable	• Depo-Testosterone (testosterone cypionate) • Delatestryl (testosterone enanthate)	• Aveed • Testopel • Xyosted
Trastuzumab	• Kanjinti • Ogivri • Trazimera	• Herceptin • Hylecta • Herceptin IV • Herzuma • Ontruzant
Viscosupplements	• Monovisc • Orthovisc • Synvisc • Synvisc One	• Durolane • Euflexxa • Gel-One • Gelsyn-3 • GenVisc 850 • Hyalgan • Hymovis • Sodium Hyaluronate 1% • Supartz FX • Synjoynt • Triluron • TriVisc • Visco-3

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Step Therapy drug class	Preferred* medications	Non-preferred medications
Calcitonin Gene-Related Peptide Inhibitors**	Preferred Part D medications (reference Part D Drug List and Part D UM requirements)	Vyepti
Proprotein Convertase Subtilisin/Kexin Type 9 (PSCK9) Inhibitors**	Preferred Part D medications (reference Part D Drug List and Part D UM requirements)	Leqvio

*Preferred medications may require prior authorization.

**Applies to MAPD plans only.

Coverage criteria

Antiemetic – Serotonin Receptor Antagonists (injectable) for oncology

Preferred* medications	Non-preferred medications
• Granisetron • Ondansetron • Palonosetron	Sustol

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Sustol may be covered for chemotherapy-induced nausea and vomiting prevention when the criteria listed below is satisfied:

- History of use (brand or generic) of one injectable preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Antiemetic – Substance P/Neurokinin-1 Receptor Antagonists (injectable) for oncology

Preferred* medications	Non-preferred medications
Emend	• Akynzeo • Cinvanti

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Akynzeo or Cinvanti may be covered for chemotherapy-induced nausea and vomiting prevention when the criteria listed below is satisfied:

- History of use of intravenous preferred medication (brand or generic) **or**
- Continuation of prior therapy or use within the past 365 days.

Bevacizumab (Oncology)

Preferred* medications	Non-preferred medications
• Alymsys • Mvasi • Zirabev	• Avastin • Vegzelma

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Avastin or Vegzelma may be covered for oncology indications when the criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Botulinum Toxins

Preferred* medications	Non-preferred medications
• Botox • Daxxify • Dysport • Xeomin	Myobloc

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, NGS J6, NGS JK.

Myobloc may be covered when the criteria listed below is satisfied:

- Myobloc is being prescribed to treat one of the following conditions:
 - › Chronic Sialorrhea or
 - › Urinary Incontinence Associated with a Neurological Condition or
 - › Primary Axillary Hyperhidrosis or
- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL.

Myobloc may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM.

Myobloc may be covered when the criteria listed below is satisfied:

- Myobloc is being prescribed to treat one of the following conditions:
 - › Overactive Bladder with Symptoms of Urge Urinary Incontinence, Urgency, and Frequency **or**
 - › Urinary Incontinence Associated with a Neurological Condition **or**
 - › Primary Axillary Hyperhidrosis **or**
- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: WPS J5, WPS J8.

Myobloc may be covered when the criteria listed below is satisfied:

- Myobloc is being prescribed to treat one of the following conditions:
 - › Palmar Hyperhidrosis **or**
 - › Primary Axillary Hyperhidrosis **or**
- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Colony Stimulating Factors Short-Acting

Preferred* medications	Non-preferred medications
• Nivestym • Zarxio	• Granix • Neupogen • Releuko

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Granix, Neupogen or Releuko may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Colony Stimulating Factors Long-Acting

Preferred* medications	Non-preferred medications
• Neulasta/Neulasta Onpro • Nyvepria • Udenyca/Autoinjector/Onbody	• Fulphila • Fynetra • Rolvedon • Stimufend • Ziextenzo

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Fulphila, Fynetra, Stimufend or Ziextenzo may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Rolvedon may be covered when criteria listed below is satisfied:

- History of use of one pegfilgrastim medication **or**
- Continuation of prior therapy or use within the past 365 days.

Immune Globulins IV

Preferred* medications	Non-preferred medications
• Flebogamma DIF • Gammagard Liquid • Gammagard S/D • Gammaked • Gammaplex • Gamunex-C • Octagam • Privigen	• Alyglo • Asceniv • Bivigam • Panzyga

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5. Additional MAC regions are listed below.

Alyglo, may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:

- > Immune Thrombocytopenia (ITP), or
- > Human Immunodeficiency Virus (HIV)-Infected Infants and Children to Prevent Recurrent Infections, or
- > Guillain Barre Syndrome, or
- > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
- > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
- > Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy, or
- > Multifocal Motor Neuropathy (MMN), or
- > Dermatomyositis or Polymyositis, or
- > Myasthenia Gravis, or
- > Lambert-Eaton Myasthenic Syndrome (LEMS), or
- > Autoimmune Hemolytic Anemia, or
- > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Asceniv, may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient),**or**
- Asceniv is being prescribed to treat one of the following conditions:
 - > Immune Thrombocytopenia (ITP), or
 - > Human Immunodeficiency Virus (HIV)-Infected Infants and Children to Prevent Recurrent Infections, or
 - > Guillain Barre Syndrome, or
 - > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy, or
 - > Multifocal Motor Neuropathy (MMN), or
 - > Dermatomyositis or Polymyositis, or
 - > Myasthenia Gravis, or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Autoimmune Hemolytic Anemia, or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam or Panzyga, may be covered when the criteria listed below are satisfied:

- Bivigam or Panzyga is being prescribed to treat one of the following conditions:
 - > Immune Thrombocytopenia (ITP), or
 - > Human Immunodeficiency Virus (HIV)-Infected Infants and Children to Prevent Recurrent Infections, or
 - > Guillain Barre Syndrome, or
 - > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy, or
 - > Multifocal Motor Neuropathy (MMN), or
 - > Dermatomyositis or Polymyositis, or
 - > Myasthenia Gravis, or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Autoimmune Hemolytic Anemia, or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: FCSO JN, Novitas JH, Novitas JL. Additional MAC regions are listed below.

Alyglo, may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:
 - Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - Autoimmune Hemolytic Anemia, or
 - Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - Neuromyelitis Optica (Devia Syndrome), or
 - Treatment of Autoimmune Encephalitis, or
 - Dermatomyositis or Polymyositis, or
 - Inclusion Body Myositis, or
 - Immune-Mediated Necrotizing Myopathy, or
 - Overlap Syndrome with Myositis (Including Anti-Synthetase Syndrome), or
 - Systemic Lupus Erythematosus, or
 - Thyroid Eye Disease (Grave's Disease), or
 - Immune Thrombocytopenia (ITP), or
 - Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - Myasthenia Gravis, or
 - Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Asceniv, may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
 - Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - Autoimmune Hemolytic Anemia, or
 - Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - Neuromyelitis Optica (Devia Syndrome), or
 - Treatment of Autoimmune Encephalitis, or
 - Dermatomyositis or Polymyositis, or
 - Inclusion Body Myositis, or
 - Immune-Mediated Necrotizing Myopathy, or
 - Overlap Syndrome with Myositis (Including Anti-Synthetase Syndrome), or
 - Systemic Lupus Erythematosus, or
 - Thyroid Eye Disease (Grave's Disease), or
 - Immune Thrombocytopenia (ITP), or
 - Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - Myasthenia Gravis, or
 - Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam or Panzyga, may be covered when the criteria listed below are satisfied:

- Bivigam or Panzyga is being prescribed to treat one of the following conditions:
 - Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or

- > Autoimmune Hemolytic Anemia, or
- > Lambert-Eaton Myasthenic Syndrome (LEMS), or
- > Neuromyelitis Optica (Devia Syndrome), or
- > Treatment of Autoimmune Encephalitis, or
- > Dermatomyositis or Polymyositis, or
- > Inclusion Body Myositis, or
- > Immune-Mediated Necrotizing Myopathy, or
- > Overlap Syndrome with Myositis (Including Anti-Synthetase Syndrome), or
- > Systemic Lupus Erythematosus, or
- > Thyroid Eye Disease (Grave's Disease), or
- > Immune Thrombocytopenia (ITP), or
- > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
- > Myasthenia Gravis, or
- > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions are listed below.

Alyglo, may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor Xla is needed based on a comorbidity of the patient, per prescriber,**or**
- Alyglo is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
 - > Autoimmune Retinopathy, or
 - > Systemic Lupus Erythematosus, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Immune-Mediated Necrotizing Myopathy, or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Asceniv, may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient),**or**
- Asceniv is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
 - > Autoimmune Retinopathy, or
 - > Systemic Lupus Erythematosus, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Immune-Mediated Necrotizing Myopathy, or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam or Panzyga, may be covered when the criteria listed below are satisfied:

- Bivigam or Panzyga is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or

- › Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- › Autoimmune Retinopathy, or
- › Systemic Lupus Erythematosus, or
- › Dermatomyositis or Polymyositis, or
- › Immune Thrombocytopenia (ITP), or
- › Immune-Mediated Necrotizing Myopathy, or
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: Noridian JE, Noridian JF. Additional MAC regions are listed below.

Alyglo, may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:
 - › Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - › Immune Thrombocytopenia (ITP), or
 - › Dermatomyositis or Polymyositis, or
 - › Guillain Barre Syndrome, or
 - › Myasthenia Gravis, or
 - › Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy, or
 - › Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - › Multifocal Motor Neuropathy (MMN), or
 - › Lambert-Eaton Myasthenic Syndrome (LEMS), or
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Asceniv, may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient), **or**
- Asceniv is being prescribed to treat one of the following conditions:
 - › Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - › Immune Thrombocytopenia (ITP), or
 - › Dermatomyositis or Polymyositis, or
 - › Guillain Barre Syndrome, or
 - › Myasthenia Gravis, or
 - › Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy, or
 - › Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - › Multifocal Motor Neuropathy (MMN), or
 - › Lambert-Eaton Myasthenic Syndrome (LEMS), or
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam or Panzyga, may be covered when the criteria listed below are satisfied:

- Bivigam or Panzyga is being prescribed to treat one of the following conditions:
 - › Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - › Immune Thrombocytopenia (ITP), or
 - › Dermatomyositis or Polymyositis, or
 - › Guillain Barre Syndrome, or

- > Myasthenia Gravis, or
 - > Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy, or
 - > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - > Multifocal Motor Neuropathy (MMN), or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions are listed below.

Alyglo, may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient, per prescriber,**or**
- Alyglo is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Myasthenia Gravis, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - > Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype. or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome). or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Asceniv, may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient),**or**
- Asceniv is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Myasthenia Gravis, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or
 - > Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype, or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam or Panzyga, may be covered when the criteria listed below are satisfied:

- Bivigam or Panzyga is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatrical Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Myasthenia Gravis, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Multiple Sclerosis (MS), Acute Severe Exacerbation or Relapses, or

- > Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype, or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: WPS J5, WPS J8.

Alyglo, may be covered when the criteria listed below are satisfied:

- A product with minimal content of coagulation factor Xia is needed based on a comorbidity of the patient, per prescriber, **or**
- Alyglo is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Severe Vasculitic Syndromes, Systemic (Polyarteritis nodosa), Churg-Strauss Vasculitis, and Livedoid Vasculitis (Atrophie Blanche), or
 - > Pyoderma Gangrenosum, or
 - > Immune-Mediated Neutropenia, or
 - > Stevens-Johnson Syndrome and/or Toxic Epidermal Necrolysis, or
 - > Systemic Lupus Erythematosus, or
 - > Autoimmune Hemolytic Anemia, or
 - > Thrombocytopenia, Feto-neonatal Alloimmune, or
 - > Myasthenia Gravis, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype, or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Asceniv, may be covered when the criteria listed below are satisfied:

- Patient requires an immune globulin with elevated levels of respiratory syncytial virus (RSV) antibodies, per prescriber (such as a patient requiring elevated levels of RSV antibodies for repeated RSV infections despite adequate immune globulin dosing in a compliant patient),**or**
- Asceniv is being prescribed to treat one of the following conditions:
 - > Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - > Severe Vasculitic Syndromes, Systemic (Polyarteritis nodosa), Churg-Strauss Vasculitis, and Livedoid Vasculitis (Atrophie Blanche), or
 - > Pyoderma Gangrenosum, or
 - > Immune-Mediated Neutropenia, or
 - > Stevens-Johnson Syndrome and/or Toxic Epidermal Necrolysis, or
 - > Systemic Lupus Erythematosus, or
 - > Autoimmune Hemolytic Anemia, or
 - > Thrombocytopenia, Feto-neonatal Alloimmune, or
 - > Myasthenia Gravis, or
 - > Dermatomyositis or Polymyositis, or
 - > Immune Thrombocytopenia (ITP), or
 - > Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
 - > Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - > Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype, or
- History of use of two preferred medications,**or**
- Continuation of prior therapy or use within the past 365 days.

Bivigam or Panzyga, may be covered when the criteria listed below are satisfied:

- Bivigam or Panzyga is being prescribed to treat one of the following conditions:
 - › Autoimmune Mucocutaneous Blistering Diseases (Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Mucous Membrane Pemphigoid [Cicatricial Pemphigoid], and Epidermolysis Bullosa Acquisita), or
 - › Severe Vasculitic Syndromes, Systemic (Polyarteritis nodosa), Churg-Strauss Vasculitis, and Livedoid Vasculitis (Atrophie Blanche), or
 - › Pyoderma Gangrenosum, or
 - › Immune-Mediated Neutropenia, or
 - › Stevens-Johnson Syndrome and/or Toxic Epidermal Necrolysis, or
 - › Systemic Lupus Erythematosus, or
 - › Autoimmune Hemolytic Anemia, or
 - › Thrombocytopenia, Feto-neonatal Alloimmune, or
 - › Myasthenia Gravis, or
 - › Dermatomyositis or Polymyositis, or
 - › Immune Thrombocytopenia (ITP), or
 - › Stiff-Person Syndrome (Moersch-Woltman Syndrome), or
 - › Lambert-Eaton Myasthenic Syndrome (LEMS), or
 - › Pure Red Blood Cell Aplasia (PRCA), Immunologic Subtype, or
- History of use of two preferred medications, **or**
- Continuation of prior therapy or use within the past 365 days.

Immune Globulins^{SC}

Preferred* medications		Non-preferred medications
• Cutaquig • Gammagard Liquid • Gammaked	• Gamunex-C • Hizentra • Xembify	• Cuvitru • HyQvia

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Cuvitru may be covered when the criteria listed below are satisfied:

- Patient with hyperprolinemia, the patient has tried Xembify, or
- Patient with a hypersensitivity to polysorbate 80, or
- History of use of two preferred medications, or
- Continuation of prior therapy or use within the past 365 days.

HyQvia may be covered when the criteria listed below are satisfied:

- Patient is being treated for chronic inflammatory demyelinating polyneuropathy, the patient has tried Hizentra, or
- History of use of two preferred medications, or
- Continuation of prior therapy or use within the past 365 days.

Immunomodulators

Preferred* medications	Non-preferred medications
• Avsola • Inflectra • Renflexis	Remicade, including Infliximab (authorized generic)

Non-preferred medication Step Therapy criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions listed below.

Remicade, including Infliximab (authorized generic) may be covered when the criteria listed below is satisfied:

- Infliximab is being prescribed to treat one of the following conditions:
 - › Behcet's Disease
 - › Sarcoidosis
 - › Microscopic Colitis, Refractory, or
- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions listed below.

Remicade, including Infliximab (authorized generic) may be covered when criteria listed below is satisfied:

- Infliximab is being prescribed to treat one of the following conditions:
 - › Crohn's Disease
 - › Plaque Psoriasis
 - › Ulcerative Colitis
 - › Behcet's Disease (Behcet's Syndrome)
 - › Hidradenitis Suppurativa
 - › Sarcoidosis
 - › Spondyloarthritis (SpA), other subtypes or
- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL, WPS J5, WPS J8.

Remicade, including Infliximab (authorized generic) may be covered when criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Intravenous Iron

Preferred* medications	Non-preferred medications
Venofer	• Feraheme • Monoferic • Injectafer

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Feraheme, Injectafer or Monoferic may be covered when the criteria listed below is satisfied:

- Used for iron deficiency anemia in a patient with chronic kidney disease who is on dialysis **or**
- For other conditions:
 - › History of use of the preferred medication or
 - › Continuation of prior therapy or use within the past 365 days.

Preferred* medications	Non-preferred medications
Avastin	• Beovu • Eylea • Eylea HD • Lucentis • Pavblu • Vabysmo

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Beovu may be covered when the criteria listed below is satisfied:

- History of use of the preferred ophthalmic medication **and**
- Inadequate efficacy or intolerability was demonstrated **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- Continuation of prior therapy or use within the past 365 days.

Eylea, Eylea HD or Pavblu may be covered when criteria listed below is satisfied:

- History of use of the preferred ophthalmic medication **and**
- Inadequate efficacy or intolerability was demonstrated **or**
- Has diabetic macular edema and a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) of 20/50 or worse (< 69 ETDRS letters) according to the prescriber **or**
- Has diabetic macular edema with significant retinal thickening according to the prescriber **or**
- Has diabetic retinopathy (without diabetic macular edema) **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- Continuation of prior therapy or use within the past 365 days.

Byooviz, Cimerli or Lucentis may be covered when criteria listed below is satisfied:

- History of use of the preferred ophthalmic medication **and**
- Inadequate efficacy or intolerability was demonstrated **or**
- Has diabetic retinopathy (without diabetic macular edema) **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- Continuation of prior therapy or use within the past 365 days.

Vabysmo may be covered when the criteria listed below are satisfied::

- History of use of the preferred ophthalmic medication, **and**
- Inadequate efficacy or intolerability was demonstrated **or**
- Has diabetic macular edema and a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) of 20/50 or worse (< 69 ETDRS letters) according to the prescriber **or**
- Safety of using the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- The supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion **or**
- Continuation of prior therapy or use within the past 365 days.

Paclitaxel Medications

Preferred* medications	Non-preferred medications
Paclitaxel	• Abraxane • Paclitaxel protein-bound

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Abraxane or Paclitaxel protein-bound may be covered when the criteria listed below is satisfied:

- For non-small cell lung cancer:
 - › Hypersensitivity reaction to Paclitaxel intravenous infusion or Docetaxel intravenous infusion **or**
 - › Contraindication to the standard pre-medications **or**
 - › Used as subsequent therapy with advanced or metastatic disease **or**
 - › Continuation of prior therapy or use within the past 365 days
- For breast cancer, cervical cancer, endometrial cancer, melanoma, ovarian cancer:
 - › Hypersensitivity reaction to Paclitaxel intravenous infusion or Docetaxel intravenous infusion **or**
 - › Contraindication to the standard pre-medications **or**
 - › Continuation of prior therapy or use within the past 365 days

Rituximab

Preferred* medications	Non-preferred medications
• Riabni • Ruxience • Truxima	• Rituxan Hycela • Rituxan IV

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5. Additional MAC regions listed below.

Rituxan intravenous may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy within the past 365 days **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
 - › Graft Versus Host Disease (GVHD) **or**
 - › Immune Thrombocytopenia (ITP) **or**
 - › Multiple Sclerosis **or**
 - › Neuromyelitis Optica (NMO) Spectrum Disorder **or**
 - › Systemic Lupus Erythematosus (SLE) [Lupus] **or**
 - › Thrombotic Thrombocytopenic Purpura (Acquired) **or**
 - › Evans Syndrome **or**
 - › Bullous Pemphigoid **or**
 - › Immunotherapy-Related Encephalitis **or**
 - › Immune-Mediated Myopathy/Idiopathic Inflammatory Myopathy **or**
 - › Immunoglobulin G4-Related Disease (IgG4-RD) **or**
 - › Myasthenia Gravis **or**
 - › Minimal Change Disease **or**
 - › Antibody-Mediated Rejection (AMR).

Rituxan Hycela may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication **or**
- Inability to obtain or maintain intravenous access **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions listed below.

Rituxan intravenous may be covered when criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy within the past 365 days **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
 - > Immune Thrombocytopenia (ITP) **or**
 - > Multiple Sclerosis **or**
 - > Antibody-Mediated Rejection (AMR) **or**
 - > Immune-Mediated Myopathy/Idiopathic Inflammatory Myopathy **or**
 - > Hemophilia (Acquired) **or**
 - > Thrombotic Thrombocytopenic Purpura (Acquired) **or**
 - > Immunoglobulin G4-Related Disease (IgG4-RD) **or**
 - > Minimal Change Disease **or**
 - > Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) **or**
 - > Sjogren's Syndrome and Systemic Sclerosis.

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication **or**
- Inability to obtain or maintain intravenous access **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions listed below.

Rituxan intravenous may be covered when criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy within the past 365 days **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
 - > Rheumatoid Arthritis (RA) **or**
 - > Graft Versus Host Disease (GVHD) **or**
 - > Multiple Sclerosis **or**
 - > Autoimmune Hemolytic Anemia **or**
 - > Multifocal Motor Neuropathy (MMN) **or**
 - > Polymyositis **or**
 - > Prior to Autologous Stem Cell Rescue for Progressive or Relapsed Disease.

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication **or**
- Inability to obtain or maintain intravenous access **or**
- Continuation of prior therapy or use within the past 365 days.

Non-preferred medication Step Therapy criteria

Applicable MAC regions: FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL, WPS J5, WPS J8.

Rituxan intravenous may be covered when criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication **or**
- Inability to obtain or maintain intravenous access **or**
- Continuation of prior therapy or use within the past 365 days.

Somatostatin Analogs Long-Acting

Preferred* medications	Non-preferred medications
• Somatuline Depot (J1930) • Lanreotide (J1930)	• Lanreotide (J1932) • Sandostatin LAR

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Lanreotide (J1932) may be covered when the criteria listed below is satisfied:

For Acromegaly:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

For Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas):

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Sandostatin LAR may be covered when the criteria listed below is satisfied:

For Acromegaly:

- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

For Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas):

- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

For Pheochromocytoma and Paraganglioma:

- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Systemic Lupus Erythematosus (SLE) Lupus

Preferred* medications	Non-preferred medications
Benlysta IV	Saphnelo

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Saphnelo may be covered when the criteria listed below is satisfied:

- History of Benlysta use **or**
- History of depression or suicidality, according to prescriber **or**
- Continuation of prior therapy or use within the past 365 days.

Testosterone Injectable

Preferred* medications	Non-preferred medications
• Depo-Testosterone (testosterone cypionate) • Delatestryl (testosterone enanthate)	• Aveed • Testopel • Xyosted

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Aveed, Testopel or Xyosted may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Trastuzumab

Preferred* medications	Non-preferred medications
• Kanjinti • Ogivri • Trazimera	• Herceptin Hylecta • Herceptin IV • Herzuma • Ontruzant

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Herceptin intravenous, Herzuma or Ontruzant may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction **or**
- Continuation of prior therapy or use within the past 365 days.

Herceptin Hylecta may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication **or**
- Inability to obtain or maintain intravenous access **or**
- Continuation of prior therapy or use within the past 365 days.

Viscosupplements

Preferred* medications	Non-preferred medications
• Monovisc • Orthovisc • Synvisc • Synvisc One	• Durolane • Euflexxa • Gel-One • Gelsyn-3 • GenVisc 850 • Hyalgan • Hymovis • Sodium Hyaluronate 1% • Supartz FX • Synjojoynt • Triluron • TriVisc • Visco-3

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL. Does not apply to all other MAC regions not listed.

Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Sodium Hyaluronate 1%, Supartz FX, Synjojoynt, Triluron, TriVisc or Visco-3 may be covered when the criteria listed below is satisfied:

- History of two different preferred medication therapy courses **or**
- Continuation of prior therapy or use within the past 365 days.

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Calcitonin Gene-Related Peptide Inhibitors**

Preferred* medications	Non-preferred medications
Preferred Part D medication (reference Part D Drug List and Part D UM requirements)	Vyepti

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Vyepti may be covered when the criteria listed below is satisfied:

- History of use of one preferred Part D subcutaneous calcitonin gene-related peptide inhibitor for migraine prophylaxis **or**
- Continuation of prior therapy or use within the past 365 days.

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**

Preferred* medications	Non-preferred medications
Preferred Part D medication (reference Part D Drug List and Part D UM requirements)	Leqvio

Non-preferred medication Step Therapy criteria

Applicable MAC regions: CGS JI5, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Leqvio may be covered when the criteria listed below is satisfied:

- History of use of one preferred Part D proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor **and**
- Inadequate efficacy or significant intolerance, according to prescriber **or**
- Continuation of prior therapy or use within the past 365 days.

Applicable codes

Antiemetic - Serotonin Receptor Antagonists (injectable) for oncology

HCPSC code	Description
Preferred	
J1626	Injection, granisetron hydrochloride, 100 mcg
J2405	Injection, ondansetron hydrochloride, per 1 mg
J2469	Injection, palonosetron HCl, 25 mcg
Non-preferred	
J1627	Injection, granisetron, extended-release, 0.1 mg

Antiemetic - Substance P/Neurokinin-1 Receptor Antagonists (injectable) for oncology

HCPSC code	Description
Preferred	
J1453	Injection, fosaprepitant, 1 mg
Non-preferred	
J0185	Injection, aprepitant, 1 mg
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg

Bevacizumab (oncology)

HCPSC code	Description
Preferred	
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Non-preferred	
J9035	Injection, bevacizumab, 10 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg

Botulinum Toxins

HCPSC code	Description
Preferred	
J0585	Injection, onabotulinumtoxinA, 1 unit
J0589	Injection, daxibotulinumtoxinA-lanm, 1 unit
J0586	Injection, abobotulinumtoxinA, 5 units
J0588	Injection, incobotulinumtoxinA, 1 unit
Non-preferred	
J0587	Injection, rimabotulinumtoxinB, 100 units

Colony Stimulating Factors Short-Acting

HCPSC code	Description
Preferred	
Q510I	Injection, filgrastim-sndz, biosimilar, (Zarxio) 1 mcg
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 mcg
Non-preferred	
J1442	Injection, filgrastim (G-CSF), (Neupogen) excludes biosimilars, 1 mcg
J1447	Injection, tbo-filgrastim, (Granix) 1 mcg
Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg

Colony Stimulating Factors Long-Acting

HCPSC code	Description
Preferred	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg
Q511I	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg
Q5122	Injection, pegfilgrastim-apgf (Nyvepria), biosimilar, 0.5 mg
Non-preferred	
J1449	Injection, eflapegrastim-xnst, 0.1 mg
Q5108	Injection, pegfilgrastim-jmdb (Fulphila), biosimilar, 0.5 mg
Q5120	Injection, pegfilgrastim-bmez, (Ziextenzo), biosimilar, 0.5 mg
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg

Immune Globulins IV

HCPSC code	Description
Preferred	
J1572	Injection, Immune globulin (Flebogamma), 500 mg
J1569	Injection, Immune globulin (Gammagard liquid), 500 mg
J1566	Injection, Immune globulin (powder), 500 mg
J1561	Injection, Immune globulin (Gamunex-C/Gammaked), 500 mg
J1557	Injection, Immune globulin (Gammaplex), 500 mg
J1568	Injection, Immune globulin (Octagam), 500 mg
J1459	Injection, immune globulin (Privigen), 500 mg
Non-preferred	
J1599	Injection, Immune globulin, (liquid), 500 mg
J1554	Injection, Immune globulin (Asceniv), 500 mg
J1556	Injection, Immune globulin (Bivigam), 500 mg
J1576	Injection, Immune globulin (Panzyga), 500 mg

Immune Globulins SC

HCPSC code	Description
Preferred	
J1551	Injection, Immune globulin (Cutaquig), 100 mg
J1569	Injection, Immune globulin (Gammagard liquid), 500 mg
J1561	Injection, Immune globulin (Gamunex-C/Gammaked), 500 mg
J1559	Injection, Immune globulin (Hizentra), 100 mg
J1558	Injection, immune globulin (Xembify), 100 mg
Non-preferred	
J1555	Injection, Immune globulin (Cuvitru), 100 mg
J1575	Injection, Immune globulin (Hyqvia), 100 mg

Immunomodulators

HCPSC code	Description
Preferred	
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg
Non-preferred	
J1745	Injection, infliximab, excludes biosimilar, 10 mg

Intravenous Iron

HCPSC code	Description
Preferred	
J1756	Injection, iron sucrose, 1 mg
Non-preferred	
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg

Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors

HCPSC code	Description
Preferred	
C9257	Injection, bevacizumab (Avastin), 0.25 mg
J7999	Compounded drug, not otherwise classified
J9035	Injection, bevacizumab (Avastin), 10 mg
Non-preferred	
J0178	Injection, aflibercept, 1 mg
J0179	Injection, brolocizumab-dbl, 1 mg
J0177	Injection, aflibercept hd, 1 mg
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
Q5147	Injection, aflibercept-ayyh, (Pavblu), 1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg
Q5128	Injection, ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg

Paclitaxel Medications

HCPCS code	Description
Preferred	
J9267	Injection, paclitaxel, 1 mg
Non-preferred	
J9259	Injection, paclitaxel protein-bound particles (American Regent) not therapeutically equivalent to J9264, 1 mg
J9264	Injection, paclitaxel protein-bound particles, 1 mg

Rituximab

HCPCS code	Description
Preferred	
Q51I5	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg
Q51I9	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg
Q5123	Injection, rituximab-arxx, biosimilar, (Riabni), 10 mg
Non-preferred	
J931I	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg

Somatostatin Analogs Long-Acting

HCPCS code	Description
Preferred	
J1930	Injection, lanreotide, 1 mg
Non-preferred	
J1932	Injection, lanreotide, (ciplq), 1 mg
J2353	Injection, octreotide depot, 1 mg

Systemic Lupus Erythematosus (SLE) Lupus

HCPCS code	Description
Preferred	
J0490	Injection, belimumab, 10 mg
Non-preferred	
J0491	Injection, anifrolumab-fnia, 1 mg

Testosterone Injectable

HCPCS code	Description
Preferred	
J1071	Injection, testosterone cypionate, 1 mg
J3121	Injection, testosterone enanthate, 1 mg
Non-preferred	
J3145	Injection, testosterone undecanoate, 1 mg
J3490	Unclassified drugs, Testopel
J3490	Unclassified drugs, Xyosted

Trastuzumab

HCPCS code	Description
Preferred	
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg
Non-preferred	
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg

Viscosupplements

HCPCS code	Description
Preferred	
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
Non-preferred	
J7318	Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
J7320	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg
J7329	Hyaluronan or derivative, TriVisc, for intra-articular injection, 1 mg
J7331	Hyaluronan or derivative, Synjoynt, for intra-articular injection, 1 mg
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Calcitonin Gene-Related Peptide Inhibitors**

HCPCS code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Non-preferred	
J3032	Injection, eptinezumab-jjmr, 1 mg

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**

HCPCS code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Non-preferred	
J1306	Injection, inclisiran, 1 mg

References

1. Centers for Medicare and Medicaid Services, National Government Services, Inc, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) applicable coverage policies. Available at <https://www.cms.gov/medicare-coverage-database/search.aspx>
2. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®). Available at www.nccn.org

Antiemetic - Serotonin Receptor Antagonists (Injectable) for Oncology

1. Palonosetron intravenous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; December 2020.
2. Ondansetron intramuscular injection or intravenous infusion [prescribing information]. Lake Zurich, IL: Fresenius Kabi; March 2020.
3. Granisetron intravenous infusion [prescribing information]. Rockford, IL: Fresenius Kabi; December 2019.
4. Sustol® extended-release subcutaneous injection [prescribing information]. Redwood City, CA: Heron; June 2023.
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Antiemetic – Substance P/Neurokinin-1 Receptor Antagonists (Injectable) for Oncology

1. Cinvanti™ intravenous infusion [prescribing information]. San Diego, CA: Heron; September 2023.
2. Emend® intravenous infusion [prescribing information]. Whitehouse Station, NJ: Merck; May 2022.
3. Akynzeo® intravenous infusion [prescribing information]. Iselin, NJ: Helsinn; February 2023.

Bevacizumab (Oncology)

1. Avastin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; December 2020.
2. Mvasi® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; November 2021.
3. Zirabev™ intravenous infusion [prescribing information]. New York, NY: Pfizer; February 2021.
4. Alymsys® intravenous infusion [prescribing information]. Bridgewater, NJ: Amneal; April 2022.
5. Vegzelma™ intravenous infusion [prescribing information]. Incheon, Republic of Korea: Celltrion; September 2022.
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Botulinum Toxins

1. Botox® injection [prescribing information]. Madison, NJ: Allergan; August 2022.
2. Daxxify® injection [prescribing information]. Newark, CA: Revance; August 2023.
3. Dysport® injection [prescribing information]. Cambridge, MA and Fort Worth, TX: Ipsen/Galderma; July 2020.
4. Myobloc® injection [prescribing information]. San Francisco, CA: Solstice Neurosciences; September 2020.
5. Xeomin® injection [prescribing information]. Raleigh, NC: Merz; August 2021.
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Colony Stimulating Factors Short-Acting

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Colony Stimulating Factors Long-Acting

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2. Fulphila® subcutaneous injection [prescribing information]. Rockford, IL: Mylan; July 2023.
3. Udenyca™ subcutaneous injection [prescribing information]. Redwood City, CA: Coherus; March 2023.
4. Ziextenzo™ subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; December 2022.
5. Nyvepria™ subcutaneous injection [prescribing information]. New York, NY: Pfizer; June 2023.
6. Fylintra® subcutaneous injection [prescribing information]. Bridgewater, NJ: Amneal; May 2022.
7. Stimufend® subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; September 2022.
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Immune Globulins IV

1. Bivigam® 10% intravenous solution [prescribing information]. Boca Raton, FL: ADMA Biologics; December 2022.
2. Flebogamma® 5% DIF intravenous solution [prescribing information]. Los Angeles, CA: Grifols; September 2019.
3. Flebogamma DIF 10% intravenous solution [prescribing information]. Los Angeles, CA: Grifols; September 2019.
4. Gammagard® Liquid 10% solution [prescribing information]. Lexington, MA: Takeda; January 2024.
5. Gammagard® S/D IgA <1 mcg/mL in a 5% intravenous solution [prescribing information]. Lexington, MA: Takeda; March 2023.
6. Gammaked™ 10% solution [prescribing information]. Fort Lee, NJ: Kedrion; January 2020.
7. Gammaplex® 5% intravenous solution [prescribing information]. Durham, NC: BPL; November 2021.
8. Gammaplex 10% intravenous solution [prescribing information]. Durham, NC: BPL; November 2021.
9. Gamunex®-C 10% solution [prescribing information]. Los Angeles, CA: Grifols; January 2020.
10. Octagam® 5% intravenous solution [prescribing information]. Paramus, NJ: Octapharma; April 2022.
11. Octagam® 10% intravenous solution [prescribing information]. Paramus, NJ: Octapharma; April 2022.
12. Privigen® 10% intravenous solution [prescribing information]. Kankakee, IL: CSL Behring; March 2022.
13. Panzyga 10% intravenous solution [prescribing information]. New York, NY: Pfizer; February 2021.
14. Asceniv 10% intravenous solution [prescribing information]. Boca Raton, FL: ADMA Biologics; April 2019.
15. Alyglo™ 10% intravenous solution [prescribing information]. Teaneck, NJ: GC Biopharma; December 2023.
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Immune Globulins SC

1. Gammagard® Liquid 10% [prescribing information]. Lexington, MA: Takeda; January 2024.
2. Gammaked™ 10% solution [prescribing information]. Fort Lee, NJ: Kedrion; January 2020.
3. Gamunex®-C 10% solution [prescribing information]. Research Triangle Park, NC: Grifols; January 2020.
4. Hizentra® 20% subcutaneous solution [prescribing information]. Kankakee, IL: CSL Behring; April 2023.

5. HyQvia® 10% subcutaneous solution with recombinant human hyaluronidase [prescribing information]. Lexington, MA: Takeda; January 2024.
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8. Cuvitru™ 20% subcutaneous solution [prescribing information]. Lexington, MA: Takeda; March 2023.
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Immunomodulators

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2. Inflectra™ injection for IV use [prescribing information]. Lake Forest, IL: Hospira/Pfizer; April 2016.
3. Renflexis injection for IV use [prescribing information]. Whitehouse Station, NJ: Samsung Bioepis/Merck; April 2017.
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Intravenous Iron

1. Injectafer® intravenous infusion or injection [prescribing information]. Shirley, NY: American Regent; May 2023.
2. Venofer® intravenous infusion or injection [prescribing information]. Shirley, NY: American Regent; July 2022.
3. Feraheme® intravenous infusion [prescribing information]. Waltham, MA: AMAG Pharmaceuticals; June 2022.
4. Monofer® intravenous infusion [prescribing information]. Morristown, NJ: Pharmacosmos Therapeutics; August 2022.
5. Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Work Group. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. *Kidney Int*. 2012;2(Suppl):279-335.
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Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors

1. Beovu® intravitreal injection [prescribing information]. Hanover, NJ: Novartis; December 2022.
2. Eylea® intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; February 2023.
3. Lucentis® intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; October 2020.
4. Byooviz™ intravitreal injection [prescribing information]. Cambridge, MA: Biogen; June 2023.
5. Vabysmo™ intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; January 2023.
6. Cimerli™ intravitreal injection [prescribing information]. Redwood City, CA: Coherus; November 2022.
7. Eylea™ HD intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; August 2023.
8. Pavblu™ intravitreal injection [prescribing information]. Thousand Oaks, CA: Amgen; August 2024.
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Paclitaxel Medications

1. Paclitaxel intravenous infusion [prescribing information]. Lake Forest, IL: Hospira; April 2021.
2. Abraxane® intravenous infusion [prescribing information]. Summit, NJ: Celgene; August 2020.
3. Shroff RT, Javle MM, Xiao L, et al. Gemcitabine, cisplatin, and nab-paclitaxel for the treatment of advanced biliary tract cancers. A phase 2 clinical trial. *JAMA Oncol*. 2019;5:824-830.
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Rituximab

1. Rituxan [prescribing information]. South San Francisco, CA: Genentech; December 2021.
2. Ruxience [prescribing information]. New York, NY: Pfizer; November 2021.
3. Truxima [prescribing information]. North Wales, PA: Teva/Celltrion; April 2023.
4. Rituxan Hycela™ injection for SC use [prescribing information]. South San Francisco, CA: Biogen and Genentech/Roche; June 2021.
5. Riabni [prescribing information]. Thousand Oaks, CA: Amgen; June 2022.
6. Chung SA, Langford CA, Maz M, et al. 2021 American College of Rheumatology/Vasculitis Foundation guideline for the management of antineutrophil cytoplasmic antibody-associated vasculitis. *Arthritis Rheumatol*. 2021 Jul 8 [online ahead of print].
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Somatostatin Analogs Long-Acting

1. Somatuline® Depot injection [prescribing information]. Basking Ridge, NJ: Ipsen; February 2023.
2. Lanreotide subcutaneous injection [prescribing information]. Warren, NJ: Cipla; December 2021.
3. Sandostatin® LAR Depot intramuscular injection [prescribing information]. East Hanover, NJ: Novartis; July 2023.
4. Strosberg JR, Halldanarson TR, Bellizzi AR, et al. The North American Neuroendocrine Tumor Society consensus guidelines for surveillance and medical management of midgut neuroendocrine Tumors. *Pancreas*. 2017;46(6):707-714.

Systemic Lupus Erythematosus (SLE) Lupus

1. Benlysta® injection [prescribing information]. Rockville, MD: Human Genome Sciences/GlaxoSmithKline; February 2023.
2. Saphnelo® injection [prescribing information]. Wilmington, DE: AstraZeneca; September 2022.
3. Hahn BH, McMahon MA, Wilkinson A, et al. American College of Rheumatology guidelines for screening, treatment, and management of lupus nephritis. *Arthritis Care Res (Hoboken)*. 2012;64(6):797-808.
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Testosterone Injectable

1. Depo®-Testosterone [prescribing information]. New York, NY: Pfizer; August 2018.
2. Testosterone enanthate injection [prescribing information]. Berkeley Heights, NJ: Hikma; January 2021.
3. Testopel® [prescribing information]. Malvern, PA: Endo; August 2018.
4. Aveed™ [prescribing information]. Malvern, PA: Endo; August 2021.
5. Xyosted [prescribing information]. Ewing, NJ: Antares; November 2019.
6. Lee M. Erectile Dysfunction. Urologic Disorders. In: Dipro JT, Talbert RL, Yee GC, et al, eds. *Pharmacotherapy: A pathophysiologic approach*. 8th ed. New York: McGraw Hill Medical; 2008: 1437-1454.
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9. Hembree WC, Cohen-Kettenis P, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017; 102(11):3869-3903.

Trastuzumab

1. Herceptin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; February 2021.
2. Herxuma® intravenous infusion [prescribing information]. North Wales, PA: Teva; May 2019.
3. Kanjinti® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; October 2022.
4. Ogivri® intravenous infusion [prescribing information]. Steinhausen, Switzerland: Mylan; July 2023.
5. Trazimera™ intravenous infusion [prescribing information]. New York, NY: Pfizer; November 2020.

6. Herceptin Hylecta™ subcutaneous injection [prescribing information]. South San Francisco, CA: Genentech; February 2019.
7. Ontruzant® intravenous infusion [prescribing information]. Whitehouse Station, NJ: Merck; March 2020.

Viscosupplements

1. Durolane® intraarticular injection [prescribing information]. Durham, NC: Bioventus; not dated.
2. Euflexxa® intraarticular injection [prescribing information]. Parsippany, NJ: Ferring; July 2016.
3. Gel-One® intraarticular injection [prescribing information]. Warsaw, IN: Zimmer; May 2011.
4. Gelsyn-3® intraarticular injection [prescribing information]. Durham, NC: Bioventus; 2016.
5. GenVisc® 850 intraarticular injection [prescribing information]. Doylestown, PA: OrthogenRx; not dated.
6. Hyalgan® intraarticular injection [prescribing information]. Parsippany, NJ: Fidia Pharma; May 2014.
7. Hymovis® intraarticular injection [prescribing information]. Parsippany, NJ: Fidia Pharma; October 2015/2021.
8. Monovisc® intraarticular injection [prescribing information]. Bedford, MA: DePuy Synthes; not dated.
9. Orthovisc® intraarticular injection [prescribing information]. Raynham, MA: DePuy Synthes; September 2014.
10. Sodium hyaluronate 1% intraarticular injection [prescribing information]. North Wales, PA: Teva; March 2019.
11. Supartz® FX™ intraarticular injection [prescribing information]. Durham, NC: Bioventus; April 2015.
12. Synvisc® intraarticular injection [prescribing information]. Ridgefield, NJ: Genzyme; September 2014.
13. Synvisc-One® intraarticular injection [prescribing information]. Ridgefield, NJ: Genzyme; September 2014.
14. Triluron intraarticular injection [prescribing information]. Florham Park, NJ: Fidia Pharma; March 2019.
15. Trivisc intraarticular injection [prescribing information]. Doylestown, PA: OrthogenRx; not dated.
16. Visco-3 intraarticular injection [prescribing information]. Durham, NC: Bioventus; not dated.
17. SynJoynt™ injection [prescribing information]. Naples, FL: Arthrex; 2022.
18. Kolasinski SH, Neogi T, Hochberg MC, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the management of osteoarthritis of the hand, hip, and knee. *Arthritis Care Res.* 2019;72(2):149-162.
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25. Salk RS, Chang TJ, D'Costa WF, et al. Sodium hyaluronate in the treatment of osteoarthritis of the ankle: a controlled, randomized, double-blind, pilot study. *J Bone Joint Surg Am.* 2006;88(2):295-302.
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32. Tikiz C, Unlu Z, Sener A, et al. Comparison of the efficacy of lower and higher molecular weight viscosupplementation in the treatment of hip osteoarthritis. *Clin Rheumatol.* 2005;24:244-250.
33. Migliore A, Tormetta S, Severino L, et al. The symptomatic effects of intra-articular administration of hylan G-F 20 on osteoarthritis of the hip: clinical data of 6 months follow-up. *Clin Rheumatol.* 2006;25(3):389-393.
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Calcitonin Gene-Related Peptide Inhibitors**

- I. Vyepti® intravenous infusion [prescribing information]. Bothell, WA: Lundbeck; October 2022.
2. Aimovig® injection for subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen; May 2023.
3. Ajovy® injection for subcutaneous use [prescribing information]. North Wales, PA: Teva; October 2022.
4. Emgality® injection for subcutaneous use [prescribing information]. Indianapolis, IN: Lilly; May 2022
5. Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders: 3rd edition. Cephalalgia. 2018;38:1-211.
6. MacGregor EA. In the clinic. Migraine. *Ann Intern Med.* 2017;166(7):ITC49-ITC64.
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8. American Headache Society. The American Headache Society position statement on integrating new migraine treatments into clinical practice. *Headache.* 2019;59:1-18.
9. Ailani J, Burch RC, Robbins MS, on behalf of the Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. *Headache.* 2021;00:1-19.
10. Ashina M, Saper J, Cady R, et al. Eptinezumab in episodic migraine: a randomized, double-blind, placebo-controlled study (PROMISE-I). *Cephalalgia.* 2020;40(3):241-254.
11. Data on file. Eptinezumab-jjmr Pre-Approval Dossier, version 1.7. Lundbeck, Inc.; Deerfield, IL; received on March 2, 2020.
12. Qulipta® tablets [prescribing information]. Madison, NJ: AbbVie; April 2023.
13. Nurtec® ODT [prescribing information]. New Haven, CT: Biohaven; April 2022.
14. Micromedex. Merative LP. Available at: <https://www.micromedexsolutions.com/>. Accessed on August 7, 2023. Search terms: lisinopril, verapamil.
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Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**

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Revision history

Date	Summary of changes
4/1/2025	Coverage criteria • Ophthalmic disorders Intravitreal vascular endothelial growth factor (VEGF) inhibitors > Added Pavblu as Non-Preferred medication Applicable Codes • Ophthalmic disorders Intravitreal vascular endothelial growth factor (VEGF) inhibitors > Added Pavblu as Non-Preferred medication

