Part B Step Therapy Program
Prior Authorization Criteria

HCPCS Code	Drug Name	Drug Status	Quantity Limits	Approval Limits
J9035, C9257	Bevacizumab (Avastin)	Medical Benefit Restricted	None	None
J1449	Eflapegrastim (Rolvedon)	Medical Benefit Restricted	None	None
J0885	Epoetin Alfa (Procrit, Epogen)	Medical Benefit Restricted	None	None
J1442	Filgrastim (Neupogen)	Medical Benefit Restricted	None	None
J7318, J7320, J7321, J7326, J7328, J7322, J7327, J7324, J7331, J7332, J7329	Hyaluronidase products (Durolane, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Orthovisc, Monovisc, Supartz FX, Synojoynt, TriVisc, Triluron, Visco-3)	Medical Benefit Restricted	None	None
J1745	Infliximab (Remicade)	Medical Benefit Restricted	None	None
J2506, Q5108, Q5111, Q5122	Pegfilgrastim (Neulasta, Nyvepria, Fulphila, Udenyca, Udenyca Autoinjector, Fylnetra, Stimufend)	Medical Benefit Restricted	None	None
J9312	Rituximab (Rituxan)	Medical Benefit Restricted	None	None
J9355	Trastuzumab (Herceptin)	Medical Benefit Restricted	None	None

CRITERIA FOR COVERAGE:
Applicable Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals also apply. For the most up-to-date Medicare policies and coverage, please search the Medicare Coverage Database. In addition, the following step therapy restrictions apply:

Drug Class / Product Name	Preferred Drug	Non-Preferred Drug
Bevacizumab *	Alymsys, Mvasi, Vegzelma, Zirabev	Avastin (**Note**- when administered as an intravitreal injection, coverage of Avastin does NOT require trial and failure, contraindication, or intolerance to listed preferred drugs)
Colony Stimulating Factors (Long Acting)	Ziextenzo	Neulasta, Neulasta Onpro, Nyvepria, Fulphila, Udenyca, Udenyca Autoinjector, Fylnetra, Stimufend, Rolvedon
Hyaluronidase products *	Euflexxa, Synvisc, Synvisc-One	Durolane, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Orthovisc, Monovisc, Supartz FX, Synojoynt, TriVisc, Triluron, Visco-3
Colony Stimulating Factors (Short Acting)	Nivestym, Granix, Zarxio, Releuko	Neupogen
Epoetin Alfa †	Retacrit	Procrit, Epogen
Infliximab *	Inflectra, Renflexis, Avsola, Infliximab	Remicade
Rituximab ‡	Riabni, Ruxience, Truxima	Rituxan

Drug Class / Product Name	Preferred Drug	Non-Preferred Drug
Trastuzumab *	Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera	Herceptin

* LCD also applies: L33394 (Drugs and Biologicals, Coverage of, for Label and Off-Label Uses)
† NCD may also apply: NCD 110.21 (Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions)
‡ LCD also applies: L39297 (Off-label Use of Rituximab and Rituximab Biosimilars)

Bevacizumab – Non-ophthalmic uses only

- **Preferred Drug(s)-** Alymsys, Mvasi, Vegzelma, Zirabev
- **Non-Preferred Drug(s)-** Avastin
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to TWO of the following: Alymsys, Mvasi, Vegzelma, Zirabev

Colony Stimulating Factors (Long Acting)

- **Preferred Drug(s)-** Ziextenzo
- **Non-Preferred Drug(s)-** Neulasta, Neulasta Onpro, Nyvepria, Fulphila, Udenyca, Udenyca Autoinjector, Fylnetra, Stimufend, Rolvedon
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to Ziextenzo

Colony Stimulating Factors (Short Acting)

- **Preferred Drug(s)-** Nivestym, Granix, Zarxio, Releuko
- **Non-Preferred Drug(s)-** Neupogen
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to TWO of the following: Nivestym, Granix, Zarxio, Releuko

Hyaluronidase products

- **Preferred Drug(s)-** Euflexxa, Synvisc, Synvisc-One
- **Non-Preferred Drug(s)-** Durolane, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Orthovisc, Monovisc, Supartz FX, Synojoynt, TriVisc, Triluron, Visco-3
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to TWO of the following: Euflexxa, Synvisc, Synvisc-One

Epoetin Alfa

- **Preferred Drug(s)-** Retacrit
- **Non-Preferred Drug(s)-** Procrit, Epogen
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance Retacrit

Infliximab

- **Preferred Drug(s)-** Avsola, Inflectra, Renflexis, Infliximab
- **Non-Preferred Drug(s)-** Remicade
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to TWO of the following: Inflectra, Renflexis, Avsola, Infliximab

Rituximab

- **Preferred Drug(s)-** Riabni, Ruxience, Truxima
- **Non-Preferred Drug(s)-** Rituxan
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to TWO of the following: Riabni, Ruxience, Truxima

Trastuzumab

- **Preferred Drug(s)-** Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera
- **Non-Preferred Drug(s)-** Herceptin
  - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to TWO of the following: Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera

CRITERIA FOR CONTINUATION OF THERAPY:

- Continuation of prior therapy within the past 365 days.

REFERENCES:

1. **Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses** (5/23/2019) https://www.federalregister.gov/documents/2019/05/23/2019-10521/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocketexpenses
2. CMS Memorandum titled **Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage** (8/7/2018) https://www.cms.gov/medicare/healthplans/healthplansgeninfo/downloads/ma_step_therapy_hpms_memo_8_7_2018.pdf

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