Part B Step Therapy Program
Prior Authorization Criteria

HCPCS Code	Drug Name	Drug Status	Quantity Limits	Approval Limits
J9361	efbemalenograstim alfa (Ryzneuta)	Medical Benefit Restricted	None	12 months
J1449	Eflapegrastim (Rolvedon)	Medical Benefit Restricted	None	12 months
J0885	Epoetin Alfa (Procrit, Epogen)	Medical Benefit Restricted	None	12 months
J1442	Filgrastim (Neupogen)	Medical Benefit Restricted	None	12 months
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	12 months
J1306	Inclisiran (Leqvio)	Medical Benefit Restricted	3 doses initial, 2 doses renewal	12 months
J1745, Q5104	Infliximab (Remicade, Renflexis, infliximab unbranded)	Medical Benefit Restricted	None	12 months
J2506, Q5120, Q5127, Q5130	Pegfilgrastim (Neulasta, Neulasta Onpro, Fylnetra, Stimufend, Ziextenzo	Medical Benefit Restricted	None	12 months
J9312	Rituximab (Rituxan)	Medical Benefit Restricted	None	12 months
J9355, Q5146, Q5114, Q5113, Q5112	Trastuzumab (Herceptin, Herzuma, Ogivri, Ontruzant, Hercessi)	Medical Benefit Restricted	None	12 months

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(s)	Non-Preferred Drug
Colony Stimulating Factors (Long Acting)	Fulphila, Nyvepria, Udenyca, Udenyca Autoinjector, Udenyca On-body injector	Neulasta, Neulasta Onpro, Fylnetra, Stimufend, Rolvedon, Ryzneuta, Ziextenzo
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)	Granix, Nivestym, Nypozi, Releuko, Zarxio	Neupogen
Epoetin Alfa †	Retacrit	Procrit, Epogen
Inclisiran **	Repatha	Leqvio
Infliximab *	Inflectra, Avsola	Remicade, Renflexis, infliximab unbranded
Rituximab ‡	Riabni, Ruxience, Truxima	Rituxan
Trastuzumab *	Kanjinti, Trazimera	Herceptin, Herzuma, Ogivri, Ontruzant, Hercessi

* 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)
** Requirement applies ONLY to members who have Part D coverage with Quartz.

Colony Stimulating Factors (Long Acting)

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

Colony Stimulating Factors (Short Acting)

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

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

Inclisiran**

- **Preferred Drug(s)-** Repatha
- **/Non-Preferred Drug(s)-** Leqvio
    - **Non-Preferred Product Step Therapy Criteria-** History of trial and failure, contraindication, or intolerance to (1) Repatha AND (2) currently taking high-intensity OR currently taking a maximally tolerated statin OR has a history of contraindication to use of a statin OR history of statin intolerance.

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

CRITERIA FOR CONTINUATION OF THERAPY:

- Continuation of prior therapy within the past 365 days.

** Requirement applies only to members who have Part D coverage with Quartz.

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

Guideline Note

Effective Date:	04/01/2025
P&T Approval Date:	08/16/2022
P&T Review Date:	01/21/2025

Revision History:

Date	Notes
01/09/2025	Remove bevacizumab
04/01/2025	Add Nypozi