Part B Step Therapy Program
Prior Authorization Criteria

Drug Name	Drug Status	Quantity Limits	Approval Limits
Bevacizumab (Avastin)	Medical Benefit Restricted	None	None
Trastuzumab (Herceptin)	Medical Benefit Restricted	None	None
Pegfilgrastim (Neulasta, Nyvepria, Fulphila, Udenyca, Fylnetra)	Medical Benefit Restricted	None	None
Eflapegrastim (Rolvedon)	Medical Benefit Restricted	None	None
Filgrastim (Neupogen)	Medical Benefit Restricted	None	None
Epoetin Alfa (Procrit, Epogen)	Medical Benefit Restricted	None	None
Infliximab (Remicade)	Medical Benefit Restricted	None	None
Rituximab (Rituxan)	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, 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, Fylnetra, Rolvedon
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
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, 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, Zirabev

Colony Stimulating Factors (Long Acting)

- **Preferred Drug(s)-** Ziextenzo
- **Non-Preferred Drug(s)-** Neulasta, Neulasta Onpro, Nyvepria, Fulphila, Udenyca, Fylnetra, 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

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:

- Documentation from the previous 365 days that shows member has received the requested medication.
- Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage, whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers**.**