



PROVIDENCE

Medicare Advantage Plans

A division of Providence Health Assurance

PROVIDENCE MEDICARE ADVANTAGE PLANS

2022 STEP THERAPY CRITERIA FOR PART B DRUGS

This list pertains to the following Providence Medicare Advantage Plans:

BRIDGE 1 + Rx (HMO-POS), BRIDGE 2 + Rx (HMO-POS), CHOICE + Rx 001 (HMO-POS), CHOICE + Rx 002 (HMO-POS), COMPASS + Rx (HMO-POS), COTTONWOOD + Rx (HMO-POS), DUAL PLUS (HMO D-SNP), ENRICH + Rx (HMO), EXTRA PART B ONLY + Rx (HMO), EXTRA + Rx 001 (HMO), EXTRA + Rx 002 (HMO), FOCUS MEDICAL (HMO), HARBOR + Rx (HMO), LATITUDE +Rx (HMO-POS), PINE + Rx (HMO), PRIME + Rx (HMO), SELECT MEDICAL (HMO-POS), SUMMIT + Rx (HMO-POS), TIMBER + Rx (HMO), ALIGN GROUP PLANS + RX (HMO), DISCOVER GROUP PLAN + RX (HMO-POS), EXPLORE GROUP PLAN + RX (HMO-POS)

Updated 7/15/2022

For more recent information or other questions, please contact Providence Health Assurance Customer Service at 503-574-8000 or 1-800-603-2340 (TTY users should call 711), seven days a week, between 8 a.m. and 8 p.m. (Pacific Time), or visit [ProvidenceHealthAssurance.com](https://www.ProvidenceHealthAssurance.com).

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Medicare Part B Step Therapy

- Some medically administered Part B medications, like injectable drugs or biologics, may have special requirements or coverage limits, such as step therapy.
- Step therapy requires a trial of a preferred drug to treat a medical condition before covering a non-preferred drug.
- The step therapy requirement does not apply to members who have already received treatment with the non-preferred drug within the past 365 days.
- Both preferred and non-preferred drugs may still be subject to prior authorization or quantity limits.
- The step therapy criteria 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 your plan.

How Step Therapy Works

In the list below, you'll see drugs labeled as either Step 1 (Preferred drug), Step 2 (Non-Preferred drug) or Step 3 (Non-Preferred drug). Step 2 and Step 3 drugs require step therapy. For example: Before you can get a Step 3 drug, you have to first try a Step 1 and a Step 2 drug.

Step 1 drugs usually require prior authorization. That means before you can take this drug, your doctor has to send us information that explains why you need it. If a Step 1 drug doesn't require prior authorization, we tell you in the list below.

Step 2 drugs always require prior authorization. Your doctor also needs to let us know one of the following:

- Why the Step 1 drug didn't work for you or why you can't take the Step 1 drug
- Why the Step 2 drug is best for your needs
- Details from your doctor to show that you've taken the Step 2 drug in the past 365 days

Step 3 drugs always require prior authorization. Your doctor also needs to let us know one of the following:

- Why the Step 1 and Step 2 drugs didn't work for you or why you can't take them.
- Why the Step 3 drug is best for your needs
- Details from your doctor to show that you've taken the Step 1 and/or the Step 2 drug in the past 365 days

The drugs within this list may change at any time. You will receive notice when necessary.

2022 Medicare Part B Step Therapy Drug List

*Prior Authorization required

HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
Allergy And Asthma Agents				
J2357	XOLAIR*	Omalizumab	<p>For Asthma - Step 1: combination of medium/high-dose inhaled corticosteroids AND Step 2: a long-acting inhaled beta2-agonist</p> <p>For Idiopathic urticaria- Step 1: second-generation non-sedating H1 antihistamine AND Step 2: ONE from the following classes: leukotiene receptor antagonists, first generation H1 antihistamine or histamine H2-receptor antagonist</p> <p>For nasal polyps - Step 1: oral systemic corticosteroids OR intranasal corticosteroids</p>	1/1/2022
J2356	TEZSPIRE	Tezepelumab-ekko	<p>For Severe Asthma: Step 1: high-dose inhaled corticosteroid (ICS) plus and inhaled long-acting beta-2 agonist (LABA)</p> <p>For Eosinophilic asthma or steroid-dependent asthma: Step 1: Dupixent* (dupilumab)</p>	7/1/2022
Anti-Infective Agents				
J3490	PREVYMIS*	Letermovir	<p>Step 1: One of the following - GVHD requiring greater than or equal to 1mg/kg/day use of prednisone (or equivalent), or lymphocyte depleting therapy (antithymocyte globulin [ATG], antithymocyte globulin equine [ATGAM], alemtuzumab, fludarabine)</p> <p>Step 2: rationale for not using the oral formulation</p>	1/1/2022
Endocrine Agents				
J2502	SIGNIFOR LAR*	Pasireotide pamoate	For Acromegaly - Step 1: Short-acting octreotide OR lanreotide subcutaneous depot*	1/1/2022
J1930	SOMATULINE DEPOT*	Lanreotide acetate	Step 1: Short-acting octreotide	1/1/2022
J2353	SANDOSTATIN LAR DEPOT*	Octreotide acetate, microspheres	<p>For Chemotherapy induced diarrhea – Step 1: loperamide AND Step 2: Short-acting octreotide</p> <p>For AIDS-related diarrhea – Step 1: loperamide and diphenoxylate (Lomotil) AND Step 2: Short-acting octreotide</p>	1/1/2022

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J3490	TESTOPEL*	Testosterone (pellet)	Step 1: Generic topical testosterone 1% or generic topical testosterone 1.62% pump and generic testosterone cypionate	1/1/2022
J3145	AVEED*	Testosterone undecanoate	Step 1: Generic topical testosterone 1% or generic topical testosterone 1.62% pump and generic testosterone cypionate	1/1/2022
Hereditary Angioedema Agents				
J0597	BERINERT*	C1 esterase inhibitor	Step 1: generic icatibant*	1/1/2022
J0596	RUCONEST*	C1 esterase inhibitor, recombinant	Step 1: generic icatibant*	1/1/2022
J1290	KALBITOR*	Ecallantide	Step 1: generic icatibant*	1/1/2022
J0598	CINRYZE*	C1 esterase inhibitor	For HAE with normal C1-INH or HAE Type III: Step 1: HAEGARDA*	1/1/2022
IL-5 Inhibitors				
J2786	CINQAIR*	Reslizumab	For eosinophilic asthma - Step 1: oral glucocorticoids or Step 2: medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	1/1/2022
J0517	FASENRA*	Benralizumab	For eosinophilic asthma - Step 1: oral glucocorticoids or Step 2: medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	1/1/2022

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J2181	NUCALA*	Mepolizumab	<p>For eosinophilic asthma - Step 1: oral glucocorticoids or Step 2: medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)</p> <p>For EGPA - Step 1: relapse requiring an increase in glucocorticoid dose, initiation or increase in other immunosuppressive therapy, or hospitalization in previous two years while receiving at least 7.5mg/day prednisone (or equivalent) OR Step2: glucocorticoid in combination with an immunosuppressant such as cyclophosphamide, azathioprine, methotrexate or mycophenolate mofetil)</p> <p>For Hyperesoinophilic Syndrome (HES) - Step 1: one of the following: chronic or episodic oral corticosteroids, immunosuppressive therapy or, cytotoxic therapy</p> <p>For Adjunct Therapy for Chronic Rhinosinusitis with Nasal Polyp (CRSwNP): Step 1: oral systemic corticosteroids, Step 2: three-month trial of intranasal corticosteroids (e.g., fluticasone) or documented intolerance/contraindication to ALL intranasal corticosteroids</p>	1/1/2022
Migraine Agents				
J3032	VYEPTI*	Eptinezumab-jjmr	<p>Step 1: One of the following categories- Anticonvulsants (i.e, divalproex, valproate, topiramate), Beta-blockers (i.e., metoprolol, propranolol, timolol), Antidepressants (i.e., amitriptyline, venlafaxine) AND Step 2: TWO preferred CGRP agents (AIMOVIG* and EMGALITY*)</p>	1/1/2022
Neurologic Agents				
J0202	LEMTRADA*	Alemtuzumab	<p>Step 1: OCREVUS AND Step 2: One of the following: Interferon-Beta 1a, Interferon-Beta 1b, Generic Dimethyl Fumarate, Copaxone, Tysabri, Aubagio, Gilenya, Vumerity, Zeposia, OR Mayzent</p>	1/1/2022

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HPCPS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J1300	SOLIRIS*	Eculizumab	For gMG – Step 1: TWO immunosuppressive therapies (ie. azathioprine, mycophenolate mofetil, cyclosporine and tacrolimus, corticosteroids) OR ONE immunosuppressive therapy of either IVIg* or plasma exchange For NMOSD: Step 1: a preferred rituximab product (RUXIENCE*, TRUXIMA*) AND Step 2: either satralizumab (Ensprinyng*) or Inebilizumab (Uplizna*)	1/1/2022
J1823	UPLIZNA*	Inebilizumab-cdon	For NMOSD: Step 1: a preferred rituximab product (RUXIENCE*, TRUXIMA*)	1/1/2022
J2323	TYSABRI*	Natalizumab	For Multiple Sclerosis - Step 1: ONE of the following: Interferon-Beta 1a, Interferon-Beta 1b, Generic Dimethyl Fumarate, Copaxone, Aubagio, Gilenya, Zeposia, Mayzent OR OCREVUS For Crohn's Disease – Step 1: Humira* or preferred infliximab product (RENFLEXIS*, INFLECTRA*)	1/1/2022
Oncology Agents				
J9035	AVASTIN*	Bevacizumab	Step 1: ZIRABEV*, MVASI*	1/1/2022
J9355	HERCEPTIN*	Trastuzumab	Step 1: KANJINTI*, OGIVRI*	1/1/2022
Q5112	ONTRUZANT*	Trastuzumab-dttb	Step 1: KANJINTI*, OGIVRI*	1/1/2022
J9356	HERCEPTIN* HYLECTA	Trastuzumab-hyaluronidase-oysk	Step 1: KANJINTI*, OGIVRI*	1/1/2022
Q5113	HERZUMA*	Trastuzumab-pkrb	Step 1: KANJINTI*, OGIVRI*	1/1/2022
Q5116	TRAZIMERA*	Trastuzumab-qyyp	Step 1: KANJINTI*, OGIVRI*	1/1/2022
J9332	VYVGART*	Efgartigimod alfa - fcab	For Generalized Myasthenia Gravis (gMG): Step 1: at least two immunosuppressive agents (such as azathioprine, methotrexate, cyclosporine, mycophenolate, corticosteroids) or an intolerance or contraindication to these therapies	7/1/2022

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
Ophthalmic Agents				
J0179	BEOVU*	Brolucizumab-dbll	For Neovascular (wet) age-related macular degeneration (AMD) Step 1: Bevacizumab (For Ophthalmology Use) And Step 2: Eylea (Aflibercept)	1/1/2022
J7351	DURYSTA*	Bimatoprost	Two ophthalmic products from TWO different pharmacological classes, one of which is an ophthalmic prostaglandin Step 1 Drugs: Ophthalmic prostaglandins: bimatoprost, latanoprost, travoprost, LUMIGAN, VYZULTA XELPROS Step 2 Drugs: Ophthalmic beta-adrenergic blocking agents: betaxolol, BETIMOL, carteolol, levobunolol, timolol maleate Ophthalmic intraocular pressure lowering agents, other: ALPHAGAN P, apraclonidine, brimonidine tartrate, brinzolamide, dorolamide, methazolamide, PHOSPHOLINE IODIDE, pilocarpine hcl, RHOPRESSA, SIMBRINZA	1/1/2022
J0178	EYLEA	Aflibercept	For Neovascular (wet) age-related macular degeneration (AMD) Step 1: Bevacizumab (For Ophthalmology Use)	1/1/2022 - 8/14/2022 8/15/2022: Retired Step Therapy & Prior Authorization criteria for Eylea
J2778	LUCENTIS*	Ranibizumab	For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema, Diabetic retinopathy, or Macular edema following retinal vein occlusion: Step 1: Bevacizumab (For Ophthalmology Use) And Step 2: Eylea (Aflibercept) And Step 3: Byooviz (Ranibizumab-nuna) For Myopic Choroidal Neovascularization (mCNV): Step 1: Byooviz (Ranibizumab-nuna)	1/1/2022 - 8/14/2022 8/15/2022: Policy update: add Byooviz (Ranibizumab-nuna) prerequisite
J2779	SUSVIMO*	Ranibizumab	For Neovascular (wet) age-related macular degeneration (AMD) Step 1: Bevacizumab (For Ophthalmology Use) AND Step 2: Eylea (Aflibercept) AND Step 3: at least two intravitreal injections of Lucentis* (ranibizumab) or Byooviz (Ranibizumab-nuna)	8/15/2022 Policy update: add Suvimo* (Ranibizumab)
C9097 J3590	VABYSMO*	Faricimab	For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema or Diabetic retinopathy: Step 1: Bevacizumab (For Ophthalmology Use) And Step 2: Eylea (Aflibercept)	8/15/2022 Policy update: add Vabysmo* (Faricimab)

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
Rare Disease Agents				
J0224	OXLUMO*	Lumasiran sodium	Step 1: Pyridoxine	1/1/2022
J0791	ADAKVEO*	Crizanlizumab-tmca	Step 1: Hydroxyurea	1/1/2022
Rituximab				
J9312	RITUXAN*	Rituximab	For Oncology use - Step 1: a preferred rituximab product (RUXIENCE*, TRUXIMA*) For Rheumatology use - Step 1: Enbrel*, Humira, or preferred infliximab product (RENFLEXIS*, INFLECTRA*)	1/1/2022
J9311	RITUXAN HYCELA*	Rituximab/hyaluronidase, human recombinant	For Oncology use - Step 1: a preferred rituximab product (RUXIENCE*, TRUXIMA*)	1/1/2022
Q5123	RIABNI*	Rituximab-arrx	For Oncology use - Step 1: a preferred rituximab product (RUXIENCE*, TRUXIMA*) For Rheumatology use - Step 1: Enbrel*, Humira*, or a preferred infliximab product (RENFLEXIS*, INFLECTRA*)	1/1/2022
Q5115	TRUXIMA*	Rituximab-abbs	Step 1: Preferred infliximab product (RENFLEXIS*, INFLECTRA*)	1/1/2022
Q5119	RUXIENCE*	Rituximab-pvvr	Step 1: Preferred infliximab product (RENFLEXIS*, INFLECTRA*)	1/1/2022
Therapeutic Immunomodulators				
J0638	ILARIS*	Canakinumab/pf	For SJIA and Adult-Onset Still's Disease: Step 1: One of the following conventional therapies (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND, Step 2: etanercept* And Step 3: adalimumab* For Familial Mediterranean Fever (FMF) – Step 1: Colchicine	1/1/2022
J0129	ORENCIA*	Abatacept/maltose	For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	1/1/2022

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J1745	REMICADE*	Infliximab	<p>For Ulcerative Colitis: Step 1: A preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) or vedolizumab (Entyvio*)</p> <p>For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)</p> <p>For moderate to severe Plaque Psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate tazarotene, topical corticosteroids, calcitriol) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) For all other FDA-Approved indications – Step 1: A preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)</p>	<p>1/1/2022</p> <p>7/1/2022</p> <p>Policy Updated to include Entyvio* (Vedolizumab) as a preferred agent for Ulcerative Colitis</p>
Q5104	RENFLEXIS*	Infliximab-abda	<p>For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine)</p> <p>For moderate to severe plaque psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol)</p>	1/1/2022
Q5121	AVSOLA*	Infliximab-axxq	<p>For Ulcerative Colitis: Step 1: A preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) or vedolizumab (Entyvio*)</p> <p>For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)</p> <p>For moderate to severe Plaque Psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate tazarotene, topical corticosteroids, calcitriol) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)</p>	<p>1/1/2022</p> <p>7/1/2022 Policy Updated to include Entyvio* (Vedolizumab) as a preferred agent for Ulcerative Colitis</p>
Q5103	INFLECTRA*	Infliximab-dyyb	<p>For Rheumatoid Arthritis and Psoriatic Arthritis Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine)</p> <p>For moderate to severe plaque psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol)</p>	1/1/2022

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J3245	ILUMYA*	Tildrakizumab-asmn	For moderate to severe Plaque Psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate tazarotene, topical corticosteroids, calcitriol) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	1/1/2022
J3262	ACTEMRA*	Tocilizumab	For Rheumatoid Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) For Giant cell arteritis – Step 1: At least one conventional therapy (e.g., systemic corticosteroid therapy)	1/1/2022
J3380	ENTYVIO*	Vedolizumab	For Crohn's disease only – Step 1: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	1/1/2022
J1602	SIMPONIA* ARIA*	Golimumab	For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) For ankylosing spondylitis – Step 1: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	1/1/2022
J3358	STELARA* (IV)	Ustekinumab	For Crohn's disease and Ulcerative colitis – Step 1: a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	1/1/2022
Thrombocytopenia Medications				
	NPLATE*	Romiplostim	For Immune Thrombocytopenia (ITP) – Pharmacologic Step 1: systemic corticosteroids AND Step 2: Immune globulin AND Step 3: a preferred rituximab product (RUXIENCE*, TRUXIMA*)	8/15/2022

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Diabetic Durable Medical Equipment (DME)

HCPCS CODE	Preferred Products	Non-Preferred Product Criteria	Effective Date
A4253	ONETOUCH BLOOD GLUCOSE TEST STRIPS – MANUFACTURED BY LIFESCAN	<ol style="list-style-type: none"> 1. Patient is using and insulin pump that requires a meter that synchronizes with their pump. OR 2. Physical or mental limitations that makes utilizing BOTH of the preferred products (manufactured by Roche and LifeScan) unsafe, inaccurate, or otherwise not feasible. 	1/1/2022
	ACCU-CHEK BLOOD GLUCOSE TEST STRIPS - MANUFACTURED BY ROCHE		
E0607	ONETOUCH BLOOD GLUCOSE METERS – MANUFACTURED BY LIFESCAN	<ol style="list-style-type: none"> 1. Patient is using and insulin pump that requires a meter that synchronizes with their pump. OR 2. Physical or mental limitations that makes utilizing BOTH of the preferred products (manufactured by Roche and LifeScan) unsafe, inaccurate, or otherwise not feasible. 	1/1/2022
	ACCU-CHEK BLOOD GLUCOSE METERS - MANUFACTURED BY ROCHE		

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