



Providence

Medicare Advantage Plans

PROVIDENCE MEDICARE ADVANTAGE PLANS

2023 STEP THERAPY CRITERIA FOR PART B DRUGS

Last Updated 5/31/2023

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

H9047_2023AM39_C

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.

Code	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective 1/1/2023 unless otherwise noted
Allergy And Asthma Agents				
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>	
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: leukotriene receptor antagonists, first generation H1 antihistamine or histamine H2-receptor antagonist</p> <p>For nasal polyps - Step 1: oral systemic corticosteroids or surgery; step 2: inadequate response to intranasal corticosteroids mono therapy. Intranasal corticosteroid therapy must be continued for those who tolerate.</p>	
Anti-Infective Agents				
J3490	PREVYMIS*	Letemovir	Step 1: Medical rationale for not using the oral formulation	
Central Nervous System Agents				
G2082 G2083	SPRAVATO*	Esketamine nasal spray	For treatment-resistant depression (TRD) – Step 1: Inadequate response to at least three oral antidepressants in two different therapeutic classes for at least eight weeks of treatment at a therapeutic dose for major depressive disorder (MDD). AND Step 2: Inadequate response to augmentation therapy (i.e., two antidepressants with different mechanisms of action used concomitantly or an antidepressant and a second-generation antipsychotic, lithium, thyroid hormone, or anticonvulsant used concomitantly)	
Enzyme Replacement Therapy				
J3590	NEXVIAZYME*	Avalglucosidase alfa	Step1: Patients weighing less than 30 kg must have a documented trial, failure, intolerance or contraindication to alglucosidase alfa (Lumizyme®)*	Effective 3/1/2023

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Hereditary Angioedema Agents				
J0597	BERINERT*	C1 esterase inhibitor	Step 1: generic icatibant*	
J0598	CINRYZE*	C1 esterase inhibitor	For HAE with normal C1-INH or HAE Type III: Step 1: HAEGARDA*	
J1290	KALBITOR*	Ecallantide	Step 1: generic icatibant*	
J0596	RUCONEST*	C1 esterase inhibitor, recombinant	Step 1: generic icatibant*	
Endocrine and Metabolic Agents				
J3145	AVEED*	Testosterone undecanoate	Step 1: Generic formulary topical testosterone (such as generic topical testosterone 1% or generic topical testosterone 1.62% pump)	
J3490	CETROTIDE*	Cetrorelix acetate	For treatment of infertility - Step 1: GANIRELIX*	
J0584	CRYSVITA*	Burosumab-twza	For tumor-induced osteomalacia (TIO) - Step 1: calcitriol with an oral phosphate agent	6/1/2023
J3490	GONAL F*	Follitropin alfa	For treatment of infertility - Step 1: FOLLISTIM AQ*	
J0725	OVIDREL*	Chorionic gonadotropin	For treatment of infertility - Step 1: NOVAREL*OR PREGNYL*OR generic chorionic gonadotropin*	
J2353	SANDOSTATIN LAR DEPOT*	Octreotide acetate, microspheres	For Chemotherapy induced diarrhea – Step 1: loperamide AND Step 2: Short-acting octreotide	
			For AIDS-related diarrhea – Step 1: loperamide and diphenoxylate/atropine (LOMOTIL) AND Step 2: Short-acting octreotide	
J2502	SIGNIFOR LAR*	Pasireotide pamoate	For Acromegaly - Step 1: octreotide injection therapy OR lanreotide subcutaneous depot*	
J3490	TESTOPEL*	Testosterone (pellet)	Step 1: Generic formulary topical testosterone (such as generic topical testosterone 1% or generic topical testosterone 1.62% pump)	
IL-5 Inhibitors				
J2786	CINQAIR*	Reslizumab	For eosinophilic asthma - Step 1: medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	

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J0517	FASENRA*	Benralizumab	For eosinophilic asthma - Step 1: medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	
J2182	NUCALA*	Mepolizumab	For eosinophilic asthma - Step 1: medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	
			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)	
			For Hyperesoinophilic Syndrome (HES) - Step 1: one of the following: chronic or episodic oral corticosteroids, immunosuppressive therapy or, cytotoxic therapy	
			For Adjunct Therapy for Chronic Rhinosinusitis with Nasal Polyp (CRSwNP): Step 1: oral systemic corticosteroids, Step 2: inadequate response to 3-month trial of intranasal corticosteroid monotherapy (e.g., (fluticasone) or documented intolerance/contraindication to ALL intranasal corticosteroids. Intranasal corticosteroid therapy must be continued for those who tolerate.	
Migraine Agents				
J3032	VYEPTI*	Eptinezumab-jjmr	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*, EMGALITY*, AJOVY* or QULIPTA*)	
Miscellaneous Therapeutics				

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J0879	KORSUVA*	Difelikefalin	For moderate to severe Pruritis associated with chronic kidney disease- Step 1: optimized use of topical emollients and Step 2: inadequate response to at least two weeks trial of an oral antihistamine or intolerance/contraindication to antihistamine therapy AND Step 3: inadequate response to at least two weeks trial of pregabalin or gabapentin, or intolerance/contraindication to both pregabalin and gabapentin	
Neurologic Agents				
J0202	LEMTRADA*	Alemtuzumab	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	
J1300	SOLIRIS*	Eculizumab	For gMG – Step 1: TWO immunosuppressive therapies (i.e., azathioprine, mycophenolate mofetil, cyclosporine and tacrolimus, corticosteroids) OR ONE immunosuppressive therapy of either IVIg* or plasma exchange AND Step 2: ULTOMIRIS* For NMOSD: Step 1: a preferred rituximab product (RUXIENCE* or TRUXIMA*) AND Step 2: either satralizumab (ENSPRINYNG*) or inebilizumab (UPLIZNA*)	
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 moderate to severe Crohn's Disease – Step 1: documented trial and failure, intolerance or contraindication to a preferred infliximab product (RENFLEXIS* or INFLECTRA*) and/or adalimumab (HUMIRA*)	
J1303	ULTOMIRIS*	Ravulizumab-cwvz	For gMG – Step 1: Failed treatment for at least a year with ONE of the following: (A.) At least TWO immunosuppressive therapies (ie. azathioprine, mycophenolate mofetil, cyclosporine and tacrolimus, corticosteroids) OR (B.) ONE immunosuppressive therapy of either IVIg* or plasma exchange	
J1823	UPLIZNA*	Inebilizumab-cdon	For NMOSD: Step 1: Rituximab*	
Oncology Agents				
Q5126	ALYMSYS*	Bevacizumab-maly	Step 1: ZIRABEV* and MVASI*	

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J9035	AVASTIN*	Bevacizumab	Step 1: ZIRABEV*and MVASI*	
J9355	HERCEPTIN*	Trastuzumab	Step 1: KANJINTI*and OGIVRI*	
J9356	HERCEPTIN* HYLECTA	Trastuzumab and hyaluronidase-oysk	Step 1: KANJINTI* and OGIVRI*	
Q5113	HERZUMA*	Trastuzumab-pkrb	Step 1: KANJINTI* and OGIVRI*	
Q5112	ONTRUZANT*	Trastuzumab-dttb	Step 1: KANJINTI* and OGIVRI*	
Q5116	TRAZIMERA*	Trastuzumab-qyyp	Step 1: KANJINTI* and OGIVRI*	
Q5129	VEGZELMA*	Bevacizumab-adcd	Step 1: ZIRABEV* and MVASI*	Effective 4/1/2023
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	
Ophthalmic Agents				
J0179	BEOVU*	Brolucizumab-dbll	For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema or Diabetic retinopathy: Step 1: Bevacizumab (For Ophthalmology Use) And Step 2: EYLEA (afibercept)	
Q5128	CIMERLI*	Ranibizumab-eqrn	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 (afibercept) And Step 3: BYOOVIZ (ranibizumab-nuna) For Myopic Choroidal Neovascularization (mCNV): Step 1: BYOOVIZ (ranibizumab-nuna)	Effective 2/1/2023

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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	
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)	
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), CIMERLI* (ranibizumab-eqrn) or BYOOVIZ (ranibizumab-nuna)	2/1/2023: Update policy to include CIMERLI*
J2777	VABYSMO*	Faricimab	For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema: Step 1: Bevacizumab (For Ophthalmology Use) And Step 2: EYLEA (aflibercept)	
J3241	TEPEZZA*	Teprotumumab-trbw	For moderate-to severe thyroid eye disease/Grave's Orbitopathy – Step 1: Inadequate response to at least two weeks of therapy with high-dose intravenous (IV) glucocorticoid therapy (equivalent to methylprednisolone 0.5 g once weekly) <i>in combination with mycophenolate</i>	6/1/2023: Policy update removing mycophenolate prerequisite therapy
Osteoanabolic Agents				
J3111	EVENITY*	Romosozumab-aqqg	For treatment and prevention of osteoporosis: Patient has a spine or hip BMD T-score less than or equal to -2.5 to -3.0 and one of the following: i. Documented failure to anti-resorptive therapy (such as denosumab, bisphosphonates). Failure is defined as a new fracture or worsening BMD while adherent to therapy ii. Documented contraindication or intolerance to therapy with all the following: 1. denosumab, 2. oral bisphosphonate (such as alendronate), and 3. IV bisphosphonate therapy (such as zoledronic acid)	6/1/2023

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Rare Disease Agents				
J0791	ADAKVEO*	Crizanlizumab-tmca	Step 1: Hydroxyurea	
J0224	OXLUMO*	Lumasiran sodium	Step 1: High fluid intake $\geq 3L/m^2$ BSA AND pyridoxine	
Rituximab				
Q5123	RIABNI*	Rituximab-arrx	For Oncology use - Step 1: Documented trial and failure, intolerance, or contraindication to the use of both of the preferred biosimilar medications: RUXIENCE* and TRUXIMA*	
			For Rheumatology use - Step 1: ENBREL*, HUMIRA*, or a preferred infliximab product (RENFLEXIS* or INFLECTRA*) AND Step 2: Documentation that rituximab-arrx will be used concurrently with methotrexate. If intolerance or contraindication to methotrexate, then in combination with another disease-modifying antirheumatic drug (DMARD) (for example, leflunomide, sulfasalazine, hydroxychloroquine), unless medical rationale is provided to support monotherapy	
			For Immune Thrombocytopenia (ITP) – Step 1: systemic corticosteroids	
			For Refractory Myasthenia Gravis – Step 1: Documented trial, failure, intolerance, or contraindication to at least two of the following conventional therapies: (a) Acetylcholinesterase inhibitors (e.g., pyridostigmine), (b) Corticosteroids (e.g., prednisone, methylprednisolone), (c) Immunosuppressive agents (e.g., azathioprine, cyclosporine, mycophenolate), (d) Plasma exchange	
			For Autoimmune Warm Hemolytic Anemia (AIHA) – Step 1: systemic glucocorticoids	
J9312	RITUXAN*	Rituximab	For Oncology use - Step 1: Documented trial and failure, intolerance, or contraindication to the use of both of the preferred biosimilar medications: RUXIENCE* and TRUXIMA*	

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			<p>For Rheumatology use - Step 1: ENBREL*, HUMIRA, or preferred infliximab product (RENFLEXIS* or INFLECTRA*) AND Step 2: Documentation that rituximab will be used concurrently with methotrexate. If intolerance or contraindication to methotrexate, then in combination with another disease-modifying antirheumatic drug (DMARD) (for example, leflunomide, sulfasalazine, hydroxychloroquine), unless medical rationale is provided to support monotherapy</p> <p>For Immune Thrombocytopenia (ITP) – Step 1: systemic corticosteroids</p> <p>For Refractory Myasthenia Gravis – Step 1: Documented trial, failure, intolerance, or contraindication to at least two of the following conventional therapies: (a) Acetylcholinesterase inhibitors (e.g., pyridostigmine), (b) Corticosteroids (e.g., prednisone, methylprednisolone), (c) Immunosuppressive agents (e.g., azathioprine, cyclosporine, mycophenolate), (d) Plasma exchange</p> <p>For Autoimmune Warm Hemolytic Anemia (AIHA) – Step 1: systemic glucocorticoids</p>	
J9311	RITUXAN HYCELA*	Rituximab/hyaluronidase, human recombinant	For Oncology use - Step 1: Documented trial and failure, intolerance, or contraindication to the use of both of the preferred biosimilar medications: RUXIENCE* and TRUXIMA*	
Q5119	RUXIENCE*	Rituximab-pvvr	<p>For Rheumatology use- Step 1: Preferred infliximab product (RENFLEXIS* or INFLECTRA*) AND Step 2: Documentation that rituximab-pvvr will be used concurrently with methotrexate. If intolerance or contraindication to methotrexate, then in combination with another disease-modifying antirheumatic drug (DMARD) (for example, leflunomide, sulfasalazine, hydroxychloroquine), unless medical rationale is provided to support monotherapy</p> <p>For Immune Thrombocytopenia (ITP) – Step 1: systemic corticosteroids</p> <p>For Refractory Myasthenia Gravis – Step 1: Documented trial, failure, intolerance, or contraindication to at least two of the following conventional therapies: (a) Acetylcholinesterase inhibitors (e.g., pyridostigmine), (b) Corticosteroids (e.g., prednisone, methylprednisolone), (c) Immunosuppressive agents (e.g., azathioprine, cyclosporine, mycophenolate), (d) Plasma exchange</p> <p>For Autoimmune Warm Hemolytic Anemia (AIHA) – Step 1: systemic glucocorticoids</p>	

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Q5115	TRUXIMA*	Rituximab-abbs	<p>For Rheumatology use- Step 1: Preferred infliximab product (RENFLEXIS* or INFLECTRA*) AND Step 2: Documentation that rituximab-abbs will be used concurrently with methotrexate. If intolerance or contraindication to methotrexate, then in combination with another disease-modifying antirheumatic drug (DMARD) (for example, leflunomide, sulfasalazine, hydroxychloroquine), unless medical rationale is provided to support monotherapy</p> <p>For Immune Thrombocytopenia (ITP) – Step 1: systemic corticosteroids</p> <p>For Refractory Myasthenia Gravis – Step 1: Documented trial, failure, intolerance, or contraindication to at least two of the following conventional therapies: (a) Acetylcholinesterase inhibitors (e.g., pyridostigmine), (b) Corticosteroids (e.g., prednisone, methylprednisolone), (c) Immunosuppressive agents (e.g., azathioprine, cyclosporine, mycophenolate), (d) Plasma exchange</p> <p>For Autoimmune Warm Hemolytic Anemia (AIHA) – Step 1: systemic glucocorticoids</p>	
Therapeutic Immunomodulators				
J3262	ACTEMRA*	Tocilizumab	<p>For Rheumatoid Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)</p> <p>For Giant cell arteritis – Step 1: At least one conventional therapy (e.g., systemic corticosteroid therapy), AND Step 2: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)</p> <p>For Cytokine Release Syndrome – Step 1: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)</p>	
Q5121	AVSOLA*	Infliximab-axxq	<p>For Ulcerative Colitis and Crohn’s Disease - Step 1: documentation of failure, intolerance, or contraindication to both preferred infliximab products (INFLECTRA* AND RENFLEXIS*) (regardless of previous use of 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: failure, intolerance, or</p>	

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			<p>contraindication to both preferred infliximab products (RENFLEXIS* AND 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: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS* AND INFLECTRA*)</p> <p>For Immune Checkpoint Inhibitor Related Diarrhea/Colitis – Step 1 IV methylprednisolone, AND Step 2: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS* AND INFLECTRA*)</p> <p>For all other FDA-Approved indications – Step 1: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS* AND INFLECTRA*)</p>	
J0717	CIMZIA* (IV)	Certolizumab	<p>For Crohn's disease – Step 1: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*) or 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* or INFLECTRA*)</p> <p>For moderate to severe Plaque Psoriasis– Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)</p> <p>For ankylosing spondylitis – Step 1: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)</p> <p>For NRAS (non-radiographic axial spondylarthritis- Step 1: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)</p>	
J0638	ILARIS*	Canakinumab/pf	<p>For SJIA and Adult-Onset Still's Disease: Step 1: Documentation of trial and failure, intolerance or contraindication to non-steroidal anti-inflammatory drugs (NSAIDS).</p> <p>For Familial Mediterranean Fever (FMF) – Step 1: Colchicine</p>	

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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* or INFLECTRA*)	
Q5103	INFLECTRA*	Infliximab-dyyb	For Ulcerative Colitis and Crohn’s Disease - Step 1: Preferred infliximab products (INFLECTRA* or RENFLEXIS*) or vedolizumab (ENTYVIO*) may be covered.	
			For Rheumatoid Arthritis and Psoriatic Arthritis - Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine)	
			For moderate to severe Plaque Psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol)	
			For immune checkpoint inhibitor related diarrhea/colitis – Step 1: IV methylprednisolone	
J0129	ORENCIA*	Abatacept/maltose	For Rheumatoid Arthritis and Psoriatic Arthritis and Polyarticular Juvenile Idiopathic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS* or INFLECTRA*)	
J1745	REMICADE*	Infliximab	For Ulcerative Colitis and Crohn’s Disease - Step 1: documentation of failure, intolerance, or contraindication to both preferred infliximab products (INFLECTRA* AND RENFLEXIS*) (regardless of previous use of vedolizumab (ENTYVIO*))	
			For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS* AND INFLECTRA*)	
			For moderate to severe Plaque Psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol) AND Step 2: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS* AND INFLECTRA*)	

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			<p>For Immune Checkpoint Inhibitor Related Diarrhea/Colitis – Step 1: IV methylprednisolone, AND Step 2: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS* AND INFLECTRA*)</p> <p>For all other FDA-Approved indications – Step 1: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS*AND INFLECTRA*)</p>	
Q5104	RENFLEXIS*	Infliximab-abda	<p>For Ulcerative Colitis and Crohn’s Disease - Step 1: Preferred infliximab products (INFLECTRA* or RENFLEXIS*) or vedolizumab (ENTYVIO*) may be covered.</p> <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> <p>For immune checkpoint inhibitor related diarrhea/colitis – Step 1: IV methylprednisolone</p>	
J1602	SIMPONIA*	Golimumab	<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*or INFLECTRA*)</p> <p>For ankylosing spondylitis – Step 1: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*)</p>	
J2327	SKYRIZI* (IV)	Risankizumab-rzaa	<p>For Crohn's disease – Step 1: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or ENTYVIO*</p> <p><i>Note: Intravenous risankizumab-rzaa is indicated for three induction doses for Crohn’s disease. Subcutaneous risankizumab-rzaa is eligible for coverage under Medicare Part D for self-administration for subsequent doses.</i></p> <p>For moderate to severe Plaque Psoriasis – Step 1: At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol) AND</p> <p>Step 2: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*)</p>	

Code	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective 1/1/2023 unless otherwise noted
			For Psoriatic Arthritis – Step 1: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND Step 2: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*)	
J3358	STELARA* (IV)	Ustekinumab	For Crohn's disease and Ulcerative colitis – Step 1: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or ENTYVIO* <i>Note: Intravenous ustekinumab is indicated for a one-time induction dose for Crohn's disease and ulcerative colitis. Subcutaneous ustekinumab is eligible for coverage under Medicare Part D for self-administration for subsequent doses.</i>	
Thrombocytopenia Medications				
J2796	NPLATE*	Romiplostim	For Immune Thrombocytopenia (ITP) – Pharmacologic Step 1: systemic corticosteroids or Step 2: Immune globulin or Step 3: Rituximab*	

Diabetic Durable Medical Equipment (DME)

HCPCS CODE	Preferred Products	Non-Preferred Product Criteria	Effective 1/1/2023 unless otherwise noted
A4253	ONETOUCH BLOOD GLUCOSE TEST STRIPS – MANUFACTURED BY LIFESCAN	1. Patient is using and insulin pump that requires a meter that synchronizes with their pump. OR	
	ACCU-CHEK BLOOD GLUCOSE TEST STRIPS - MANUFACTURED BY ROCHE	2. Physical or mental limitations that makes utilizing BOTH of the preferred products (manufactured by Roche and LifeScan) unsafe, inaccurate, or otherwise not feasible.	
E0607	ONETOUCH BLOOD GLUCOSE METERS – MANUFACTURED BY LIFESCAN	1. Patient is using and insulin pump that requires a meter that synchronizes with their pump. OR	
	ACCU-CHEK BLOOD GLUCOSE METERS - MANUFACTURED BY ROCHE	2. Physical or mental limitations that makes utilizing BOTH of the preferred products (manufactured by Roche and LifeScan) unsafe, inaccurate, or otherwise not feasible.	

