Providence
Medicare Advantage Plans

PROVIDENCE MEDICARE ADVANTAGE PLANS

2023 STEP THERAPY CRITERIA FOR PART B DRUGS

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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.

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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.

Code	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective 1/1/2023 *unless otherwise noted*
Allergy And Asthma Agents				
J2356	TEZSPIRE	Tezepelumab-ekko	**<u>For Severe Asthma</u> - Step 1:** high-dose inhaled corticosteroid (ICS) plus and inhaled long-acting beta-2 agonist (LABA) **<u>For Eosinophilic asthma or steroid-dependent asthma</u> - Step 1:** DUPIXENT* (dupilumab)	
J2357	XOLAIR*	Omalizumab	**<u>For Asthma</u>** - **Step 1**: combination of medium/high-dose inhaled corticosteroids **AND Step 2**: a long-acting inhaled beta2-agonist **<u>For Idiopathic urticaria</u>- 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 **<u>For nasal polyps</u> - 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.	
Anti-Infective Agents				
J3490	PREVYMIS*	Letermovir	**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®) *	3/1/2023 Update includes NEXVIAZYME*

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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*	
Hormonal Agents				
J3145	AVEED*	Testosterone undecanoate	**Step 1:** Generic topical testosterone 1% or generic topical testosterone 1.62% pump **and** generic testosterone cypionate	
J3490	CETROTIDE*	Cetrorelix acetate	**For treatment of infertility - Step 1:** GANIRELIX*	
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 (LOMOTIL) **AND Step 2:** Short-acting octreotide	
J2502	SIGNIFOR LAR*	Pasireotide pamoate	**For Acromegaly - Step 1:** Short-acting octreotide OR lanreotide subcutaneous depot*	
J3490	TESTOPEL*	Testosterone (pellet)	**Step 1:** Generic topical testosterone 1% or generic topical testosterone 1.62% pump **and** generic testosterone cypionate	
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 Hyperesosinophilic 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				
J0879	KORSUVA*	Difelikefalin	**For moderate to severe Pruritis associated with chronic kidney disease- Step1**: 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	

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			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:** a preferred rituximab product (RUXIENCE*or TRUXIMA*)	
Oncology Agents				
Q5126	ALYMSYS*	Bevacizumab-maly	**Step 1:** ZIRABEV* and MVASI*	
J9035	AVASTIN*	Bevacizumab	**Step 1:** ZIRABEV*and MVASI*	
J9355	HERCEPTIN*	Trastuzumab	**Step 1:** KANJINTI*and OGIVRI*	

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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*	**4/1/2023: Update includes VEGZELMA***
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 (aflibercept)	
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 (aflibercept) **And Step 3:** BYOOVIZ (ranibizumab-nuna) **For Myopic Choroidal Neovascularization (mCNV): Step 1:** BYOOVIZ (ranibizumab-nuna)	**2/1/2023: Update includes CIMERLI***

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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 includes 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) in combination with mycophenolate a. For patients who have intolerance or contraindication to mycophenolate: Trial and failure of at least two weeks of monotherapy with high-dose intravenous (IV) glucocorticoid therapy will be required unless the patient is unable to use intravenous (IV) glucocorticoids due to a contraindication	

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Rare Disease Agents				
J0791	ADAKVEO*	Crizanlizumab-tmca	**Step 1:** Hydroxyurea	
J0224	OXLUMO*	Lumasiran sodium	**Step 1:** High fluid intake >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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			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	
			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	
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	**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	
			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	

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Q5115	TRUXIMA*	Rituximab-abbs	**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	
			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	
Therapeutic Immunomodulators				
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*or INFLECTRA*)	
			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*)	
			For Cytokine Release Syndrome – Step 1: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*)	
Q5121	AVSOLA*	Infliximab-axxq	**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*).)	

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

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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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			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*)	
			For all other FDA-Approved indications – Step 1: failure, intolerance, or contraindication to both preferred infliximab products (RENFLEXIS***AND** INFLECTRA*)	
Q5104	RENFLEXIS*	Infliximab-abda	**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	
J1602	SIMPONI 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*or INFLECTRA*)	
			For ankylosing spondylitis – Step 1: a preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*)	
J2327	SKYRIZI* (IV)	Risankizumab-rzaa	**For Crohn's disease – Step 1: a** preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or ENTYVIO* ***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.*	
			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*)	
			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*)	

Code	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective 1/1/2023 *unless otherwise noted*
J3358	STELARA* (IV)	Ustekinumab	**For Crohn's disease and Ulcerative colitis – Step 1: a** preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or ENTYVIO* ***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.*	
Thrombocytopenia Medications				
J2796	NPLATE*	Romiplostim	**For Immune Thrombocytopenia (ITP) – Pharmacologic Step 1:** systemic corticosteroids **or Step 2:** Immune globulin **or Step 3:** a preferred rituximab product (RUXIENCE* or TRUXIMA*)	

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 – MANUFACURED 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 – MANUFACURED 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.	