Medicare Part B Step Therapy Policy

Effective: January 1, 2022

OVERVIEW

Some medically administered Part B drugs may have additional requirements or limits on coverage. These requirements and limits may include step therapy. This is when we require you to first try certain preferred drugs to treat your medical condition before we will cover another non-preferred drug for that condition.

This policy supplements Medicare Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) for the purpose of determining coverage under Medicare Part B medical benefits and applies a step therapy for the following drugs/products.

A Member cannot be required under this policy to change a current drug/product. For the purposes of this policy, a current drug/product means the member has a paid claim for the drug/product within the past 365 days or there is clinical documentation of the member utilizing the non-preferred drug. For example, a new plan Member currently using a particular drug/product will not be required to switch to the preferred drug/product upon enrollment. Similarly, an existing member currently using a particular drug/product will not be required to change drug/products in the event this policy is updated.

This policy applies a step therapy for the following drugs/products. This list indicates the common uses for which the drug is prescribed. This list can change from time to time.

Drug Class	Non-preferred Product(s)	Preferred Product(s)
Autoimmune	Avsola	Inflectra
	Renflexis	Remicade
Bendamustine HCI Injection	Treanda	Bendeka
		Belrapzo
Bevacizumab – oncology	Avastin	Mvasi
		Zirabev
Iron Preparation, Parenteral	Feraheme	Ferrlecit
	Injectafer	Infed
	Monoferric	Venofer
Leucovorin / LEVOleucovorin Injection	Fusilev	leucovorin injection
	Khapzory	
Neutropenia Colony Stimulating Agents – long acting	Nyvepria	Fulphila
	Udenyca	Neulasta
	Ziextenzo	
Neutropenia Colony Stimulating Agents – short acting	Granix	Zarxio
	Leukine	
	Neupogen	
	Nivestym	
Paroxysmal nocturnal hemoglobinuria, atypical hemolytic uremic syndrome	Soliris	Ultomiris
Retinal Disorders	Beovu	Avastin

Drug Class	Non-preferred Product(s)	Preferred Product(s)
	Eylea	
	Lucentis	
	Macugen	
	Susivmo	
	Visudyne	
Rituximab	Rituxan	Riabni
	Rituxan Hycela	Ruxience
		Truxima
Trastuzumab	Herceptin	Herzuma
	Herceptin Hylecta	Kanjinti
		Ogivri
		Ontruzant
		Trazimera
Triamcinolone Acetonide Injection	Zilretta	triamcinolone acetonide injection
Viscosupplements	Durolane	Euflexxa
	Gel-One	
	Gel-Syn	
	Genvisc 850	
	Hyalgan	
	Hymovis	
	Monovisc	
	Orthovisc	
	Supartz	
	Synojoynt	
	Synvisc	
	Synvisc One	
	Triluron	
	Trivisc	
	Visco-3	

In addition to any LCD/NCD policies required by the Plan, a non-preferred product must satisfy the following criteria. If a provider administers a non-preferred product without obtaining prior authorization, CarePartners of Connecticut may deny claims for the non-preferred product.

1. Documentation of **one (1)** of the following:
    a. History of use of at least one preferred product resulting in a substandard response to therapy
    b. History of intolerance or adverse event to at least one preferred product
    c. Rationale that the preferred product(s) is not clinically appropriate (**Note:** Convenience does not qualify as clinical rationale for inappropriateness of a preferred product)
    d. Continuation of prior therapy with the requested non-preferred product within the past 365 days