CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines:
Medical Benefit Drugs

Medicare Part B Step Therapy

Effective: January 1, 2024

Guideline Type	☐ Prior Authorization ☐ Non-Formulary ☒ Step-Therapy ☐ Administrative

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956

☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

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)
Acromegaly	Lanreotide (cipla) Signifor LAR	Sandostatin LAR Somatuline Depot
Antiemetics	Akynzeo Aponvie Cinvanti Sustol	fosaprepitant granisetron ondansetron palonosetron Aloxi Emend
Autoimmune	Avsola Renflexis	Inflectra Remicade Infliximab
Bendamustine HCl Injection	Treanda Vivimusta	bendamustine Bendeka Belrapzo
Bevacizumab – oncology	Avastin Alymsys Vegzelma	Mvasi Zirabev
Bone Resorption Inhibitors	Evenity Prolia Xgeva	ibandronate pamidronate zoledronic acid
Botulinum Toxins	Daxxify Dysport Myobloc	Botox Xeomin
Gaucher's Disease	Elelyso	Cerezyme Vpriv
Iron Preparation, Parenteral	Feraheme Injectafer Monoferric	Ferrlecit Infed Venofer
Leucovorin / LEVOleucovorin Injection	Fusilev Khapzory LEVOleucovorin	leucovorin injection
Neutropenia Colony Stimulating Agents – long acting	Fylnetra Nyvepria Rolvedon Stimufend Udenyca Ziextenzo	Fulphila Neulasta
Neutropenia Colony Stimulating Agents – short acting	Granix Leukine Neupogen Nivestym Releuko	Zarxio
Rare Disease	Soliris	Ultomiris
Retinal Disorders	Beovu Byooviz Cimerli Eylea Eylea HD Lucentis Susvimo Vabysmo Visudyne	Avastin

Rituximab	Rituxan Rituxan Hycela Riabni	Ruxience Truxima
Trastuzumab	Herceptin Herceptin Hylecta Herzuma Ogivri Ontruzant	Kanjinti Trazimera
Triamcinolone Acetonide Injection	Zilretta	triamcinolone acetonide injection
Viscosupplements	Durolane Gel-One Gelsyn-3 Genvisc 850 Hyalgan Hymovis Monovisc Orthovisc Supartz FX Synojoynt Synvisc Synvisc One Triluron Trivisc Visco-3	Euflexxa

Clinical Guideline Coverage Criteria

In addition to any prior authorization requirements by the plan, a non-preferred product must satisfy the following criteria. If a provider administers a non-preferred product without obtaining prior authorization, the plan 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

Approval And Revision History

February 14, 2023: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

- February 15, 2023: Reviewed by the Medical Policy Approval Committee (MPAC)
- Originally approved September 13, 2022 by P&T and September 21, 2022 by MPAC committees
- December 2022 added Vegzelma as non-preferred Bevacizumab oncology product effective February 1, 2023
- March 2023 added Stimufend and Rolvedon as non-preferred Neutropenia Colony Stimulating Agents – long acting products effective April 1, 2023
- June 22, 2023: Added bendamustine and Vivimusta to the Medical Necessity Guideline (effective July 1, 2023)
- September 12, 2023: Added the following new Part B Step Therapy strategies: Acromegaly, Antiemetics, Bone Resorption Inhibitors, and Botulinum Toxins. Updated the Gaucher Disease strategy to make Cerezyme a preferred product and Elelyso a non-preferred product. Updated the Leucovorin/LEVOleucovorin strategy by adding LEVOleucovorin as a non-preferred product. Updated the Trastuzumab strategy by moving Ogivri to a non-preferred product (effective January 1, 2024).
- December 12, 2023: Added Eylea HD and Daxxify to the Medical Necessity Guideline (effective January 1, 2024).

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.