

Drug Policy

Policy:	201936	Initial Effective Date: 01/01/2020
Code(s):	See Table Below	Annual Review Date: 10/12/2020
SUBJECT:	Medicare Part B Step Therapy	Last Revised Date: 7/1/2021

POLICY STATEMENT

This policy applies to initial authorizations only. If it is believed that a member has already satisfied the step therapy requirement or a non-preferred agent is medically necessary, the provider should follow the Medical Mutual of Ohio coverage determination process to request the non-preferred agent.

Preferred Products*	Non-Preferred Products
Retacrit (Q5106)	Epogen/Procrit (J0885) Mircera (J0888) Aranesp (J0881)
Pamidronate (J2430) or Zoledronic Acid (J3489)	Xgeva (J0897) [Step therapy only applies to bone metastases, multiple myeloma, hypercalcemia (Excluding prostate cancer)] (Osteoporosis does not require prior authorization)
Zarxio (Q5101)	Neupogen (J1442) Nivestym (Q5110) Granix (J1447)
Inflectra (Q5103) or Renflexis (Q5104) or Remicade (J1745) <i>New preferred product effective January 1, 2021</i>	Orencia IV (J0129) Ilumya (J3245) Avsola (Q5121)

Drug Policy

<p>Inflectra (Q5103) or Renflexis (Q5104) or Remicade (J1745)</p> <p><i>New preferred product effective January 1, 2021</i></p>	<p>Actemra IV (J3262) [Step therapy only applies to rheumatoid arthritis]</p>
<p>Docetaxel (J9171) or Paclitaxel (J9267)</p>	<p>Abraxane (J9264) [Step therapy only applies to non-small cell lung cancer and breast cancer (Excluding triple negative breast cancer)]</p>
<p>Vincristine sulfate (J9370)</p>	<p>Marqibo (J9371)</p>
<p>Euflexxa (J7323) [No prior authorization required for Euflexxa as of 1/1/2021]</p>	<p>Durolane (J7318) Genvisc 850 (J7320) Orthovisc (J7324) Monovisc (J7327) Gel-One (J7326) Hyalgan (J7321) Hymovis (J7322) Supartz & Supartz FX (J7321) Synvisc & Synvisc- One (J7325) Synojoynt (J3490) Triluron (J3490) TriVisc (J7329) Visco-3 (J7321)</p>
<p>Doxorubicin, conventional (J9000)</p>	<p>Doxil (Q2050)</p>
<p>Kanjinti (Q5117) or Trazimera (Q5116) or Ogivri (Q5114) or Herzuma (Q5113) or Ontruzant (Q5112)</p> <p><i>New Requirement effective February 4, 2021</i></p>	<p>Herceptin (J9355)</p>

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Drug Policy

<p>Truxima (Q5115) or Ruxience (Q5119)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Rituxan (J9312) Riabni (J9999)</p>
<p>Truxima (Q5115) or Ruxience (Q5119)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Rituxan Hyclea (J9311)</p>
<p>Avastin (J9035) or Mvasi (Q5107) or Zirabev (Q5118)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Eylea (J0178), Lucentis (J2778) Visudyne (J3396) Beovu (J0179) Macugen (J2305)</p>
<p>Triamcinolone inj. (J3302)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Zilretta (J3304)</p>
<p>Kanjinti (Q5117) or Trazimera (Q5116) or Ogivri (Q5114) or Herzuma (Q5113) or Ontruzant (Q5112)</p> <p><i>New Requirement effective February 4, 2021</i></p>	<p>Herceptin Hylecta (J9356)</p>
<p>Leucovorin (J0640)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Khapzory (J0642) Fusilev (J0641)</p>
<p>Mvasi (Q5107) or Zirabev (Q5118)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Avastin (J9035) (oncology)</p>
<p>Ultomiris (J1303)</p> <p><i>New Requirement effective January 1, 2021</i></p>	<p>Soliris (J1300) [ST only applies for Atypical hemolytic uremic syndrome (aHUS) and Paroxysmal nocturnal hemoglobinuria (PNH)]</p>
<p>Neulasta (J2505) or Fulphila (Q5108)</p> <p><i>New Requirement effective August 1, 2021</i></p>	<p>Nyvperia (Q5122) Udenyca (Q5111) Ziextenzo (Q5120)</p>

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Drug Policy

Step Therapy will be required for the medications listed in the table above effective 1/1/2021, provided the following are met:

- a) The requested product meets the definition of a Medicare outpatient (Part B) drug; AND
- b) The proposed use of the requested product has been determined to be a medically accepted indication; AND
- c) The proposed use of the preferred alternative agent has been determined to be a medically accepted indication; AND
- d) The proposed use of the preferred alternative agent will be limited to new administrations of Part B drugs using a 365-day lookback period; AND
- e) The dose, frequency, and duration of use may not exceed the safety and efficacy data supporting the medically accepted indication

Step Therapy Exception Requirements:

The utilization review process shall grant a step therapy exception/override upon receipt of information that includes supporting rationale and documentation from a health care provider which demonstrates that the medication(s) being required by the health insurer:

- a) Is not available due to a national drug shortage (in all dosage strengths and all listed manufacturers) as confirmed by the FDA Drug Shortage webpage; OR
- b) Is not available due to a compounding shortage when the preferred drug is only available in compounded form; OR
- c) Is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the medication; OR
- d) Has been tried by the patient and was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event; OR
- e) Is likely to cause an adverse reaction, decrease the ability of the patient to achieve or maintain reasonable functional ability in performing daily activities, or cause physical or mental harm to the patient; OR
- f) Is expected to be ineffective based on the patient's known clinical history, condition, and prescription drug regimen; OR
- g) Is already stable on the medication(s) being requested by his or her health care professional for his or her medical condition. Stable is defined as receiving the medication for an adequate period of time, have achieved optimal response, and continued favorable outcomes are expected.*

*Except when the medication was initially obtained due to the availability of a drug sample, free patient assistance programs, or a coupon card. These are not considered trial and failure of a preferred drug.

Drug Policy

References

- Centers for Medicare and Medicaid Services, Health Plan Management System (HPMS), MA_Step_Therapy_HPMS_Memo_8_7_18; available at <http://www.cms.gov> - last checked August 31, 2018 and found under Medicare > Health Plans > Health Plans - General Information > Downloads.
- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sec. 50 (Rev. 241, Feb. 2, 2018); available at <http://www.cms.gov> - last checked August 31, 2018 and found under Medicare > Regulations and Guidance > Manuals > Internet- Only Manuals (IOMs).
- Local Coverage Determination (LCD). Centers for Medicare & Medicare Services. <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>.
- National Coverage Determination (NCD). Centers for Medicare & Medicare Services. <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>.
- U.S. Food & Drug Administration. FDA Approved Drug Products. <https://www.accessdata.fda.gov/scripts/cder/daf/>

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Revised:

12/19/2019: New Policy effective 01/01/2020

01/06/2020: Removed Triple Negative Breast Cancer from abraxane ST requirement

10/12/2020: annual review. Removed prostate cancer from Xgeva ST requirement. Revised infliximab preferred products. Added ST for Avastin, Rituxan, Rituxan Hycela, Herceptin, Herceptin Hylecta, VEGF-inhibitors, Zilretta, levoleucovorin, and Soliris effective 1/1/2021.

07/01/2021: Update added ST for pegfilgrastim effective 8/1/2021.

Reviewed:

12/19/2019: Oncologist; Senior Medical Officer, Clinical Operations; Vice President, Pharmacy Management; Clinical Pharmacist, PharmD, Director, Clinical Pharmacy Programs; and Clinical Pharmacist, PharmD.

01/06/2019: Oncologist; Senior Medical Officer, Clinical Operations; Vice President, Pharmacy Management; Clinical Pharmacist, PharmD, Director, Clinical Pharmacy Programs; and Clinical Pharmacist, PharmD.

10/12/2020: Oncologist; Senior Medical Officer, Clinical Operations; Vice President, Pharmacy Management; Clinical Pharmacist, PharmD, Director, Clinical Pharmacy Programs; and Clinical Pharmacist, PharmD.

Drug Policy

07/01/2021: TJ