

Questions about Step Therapy?

**Cigna Healthcare
has the answers.**

What is Step Therapy?

Step Therapy is a required process that applies to certain Part B prescription drugs.

How does Step Therapy work?

Step Therapy requires customers to first try a preferred medication over non-preferred medications that treat the same condition.

What if the preferred medication is ineffective?

If the preferred medication is proven ineffective or causes negative side-effects, then a non-preferred medication may be covered.



What if the preferred drug has been tried in the past?

If the preferred medication was tried in the past 365 days, a non-preferred medication may be covered. If the preferred medication hasn't been tried in the past 365 days, Step Therapy is required.

How do I find out what drugs require Part B Step Therapy?

The Step Therapy chart applies to all Cigna Medicare markets.



Step Therapy Drug Class	Preferred* Medications	Non-Preferred Medications
<u>Antiemetic - Serotonin Receptor Antagonists (Injectable) for Oncology</u>	<ul style="list-style-type: none"> • Aloxi • Granisetron • Ondansetron 	<ul style="list-style-type: none"> • Sustol
<u>Antiemetic - Substance P/Neurokinin-1 Receptor Antagonists (Injectable) for Oncology</u>	<ul style="list-style-type: none"> • Emend 	<ul style="list-style-type: none"> • Akynzeo • Cinvanti
<u>Bevacizumab (Oncology)</u>	<ul style="list-style-type: none"> • Mvasi • Zirabev 	<ul style="list-style-type: none"> • Alymsys • Avastin • Vegzelma
<u>Colony Stimulating Factors</u> Short-Acting	<ul style="list-style-type: none"> • Nivestym • Zarxio 	<ul style="list-style-type: none"> • Granix • Neupogen • Releuko
<u>Colony Stimulating Factors</u> Long-Acting	<ul style="list-style-type: none"> • Neulasta/Neulasta Onpro • Nyvepria • Udenyca 	<ul style="list-style-type: none"> • Fulphila • Fylnetra • Rolvedon • Stimufend • Ziextenzo
<u>Immunomodulators</u>	<ul style="list-style-type: none"> • Avsola • Inflectra • Renflexis 	<ul style="list-style-type: none"> • Remicade, infliximab (authorized generic)
<u>Intravenous Iron</u>	<ul style="list-style-type: none"> • Venofer 	<ul style="list-style-type: none"> • Feraheme • Injectafer • Monoferric
<u>Ophthalmic Disorders</u> Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors	<ul style="list-style-type: none"> • Avastin 	<ul style="list-style-type: none"> • Beovu • Byooviz • Cimerli • Eylea • Eylea HD • Lucentis • Vabysmo
<u>Paclitaxel Medications</u>	<ul style="list-style-type: none"> • Paclitaxel 	<ul style="list-style-type: none"> • Abraxane • Paclitaxel protein-bound
<u>Rituximab</u>	<ul style="list-style-type: none"> • Riabni • Ruxience • Truxima 	<ul style="list-style-type: none"> • Rituxan Hycela • Rituxan IV
<u>Systemic Lupus Erythematosus (SLE)</u> [Lupus]	<ul style="list-style-type: none"> • Benlysta IV 	<ul style="list-style-type: none"> • Saphnelo
<u>Trastuzumab</u>	<ul style="list-style-type: none"> • Kanjinti • Ogivri • Trazimera 	<ul style="list-style-type: none"> • Herceptin • Hylecta • Herceptin IV • Herzuma • Ontruzant

<u>Viscosupplements</u>	<ul style="list-style-type: none"> • Monovisc • Orthovisc • Synvisc • Synvisc One 	<ul style="list-style-type: none"> • Durolane • Euflexxa • Gel-One • Gelsyn-3 • GenVisc 850 • Hyalgan • Hymovis 	<ul style="list-style-type: none"> • Sodium Hyaluronate 1% • Supartz FX • Synojoont • Triluron • TriVisc • Visco-3
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*Preferred medications may require precertification.

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Step Therapy Drug Class	Preferred* Medications	Non-Preferred Medications
<u>Calcitonin Gene-Related Peptide Inhibitors**</u>	<ul style="list-style-type: none"> • Preferred Part D medications (reference Part D Drug List and Part D UM requirements) 	<ul style="list-style-type: none"> • Vyepti
<u>Proprotein Convertase Subtilisin/Kexin Type 9 (PSCK9) Inhibitors**</u>	<ul style="list-style-type: none"> • Preferred Part D medications (reference Part D Drug List and Part D UM requirements) 	<ul style="list-style-type: none"> • Leqvio
<u>Systemic Lupus Erythematosus (SLE)**</u> [Lupus]	<ul style="list-style-type: none"> • Preferred Part D medications (reference Part D Drug List and Part D UM requirements) 	<ul style="list-style-type: none"> • Saphnelo

*Preferred medications may require precertification.

**Applies to MAPD plans only.

Coverage Criteria

Antiemetic - Serotonin Receptor Antagonists (Injectable) for Oncology

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none"> • Aloxi • Granisetron • Ondansetron 	<ul style="list-style-type: none"> • Sustol

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Sustol may be covered for chemotherapy induced nausea and vomiting prevention when the criteria listed below is satisfied:

- History of use (brand or generic) of one injectable preferred medication **or**
- Continuation of prior therapy or use within the past 365 days.

Antiemetic – Substance P/Neurokinin-1 Receptor Antagonists (Injectable) for Oncology

Preferred* Medications	Non-Preferred Medications
• Emend	• Akynzeo • Cinvanti

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Akynzeo or Cinvanti may be covered for chemotherapy induced nausea and vomiting prevention when the criteria listed below is satisfied:

- History of use of intravenous preferred medication (brand or generic); **or**
- Continuation of prior therapy or use within the past 365 days.

Bevacizumab (Oncology)

Preferred* Medications	Non-Preferred Medications
• Mvasi • Zirabev	• Alymsys • Avastin • Vegzelma

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Alymsys, Avastin, or Vegzelma may be covered for oncology indications when the criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Colony Stimulating Factors Short-Acting

Preferred* Medications	Non-Preferred Medications
• Nivestym • Zarxio	• Granix • Neupogen • Releuko

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Granix, Neupogen, or Releuko may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Colony Stimulating Factors Long-Acting

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">• Neulasta/Neulasta Onpro• Nyvepria• Udenyca	<ul style="list-style-type: none">• Fulphila• Fylnetra• Rolvedon <ul style="list-style-type: none">• Stimufend• Zixtenzo

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Fulphila, Fylnetra, Stimufend, or Zixtenzo may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Rolvedon may be covered when criteria listed below is satisfied:

- History of use of one pegfilgrastim medication; **or**
- Continuation of prior therapy or use within the past 365 days.

Immunomodulators

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">• Avsola• Inflectra• Renflexis	<ul style="list-style-type: none">• Remicade, including Infliximab (authorized generic)

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions listed below.

Remicade, including Infliximab (authorized generic) may be covered when the criteria listed below is satisfied:

- Infliximab is being prescribed to treat one of the following conditions:
 - Behcet's Disease
 - Sarcoidosis; **or**
- History of use of one preferred medication; **and**

- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions listed below.

Remicade, including Infliximab (authorized generic) may be covered when criteria listed below is satisfied:

- Infliximab is being prescribed to treat one of the following conditions:
 - Crohn's Disease
 - Plaque Psoriasis
 - Ulcerative Colitis
 - Behcet's Disease (Behcet's Syndrome)
 - Hidradenitis Suppurativa
 - Sarcoidosis
 - Spondyloarthritis (SpA), Other Subtypes; **or**
- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, Noridian JE, Noridian JF, Novitas JH, Novitas JL, WPS J5, WPS J8.

Remicade, including Infliximab (authorized generic) may be covered when criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Intravenous Iron

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none"> • Venofer 	<ul style="list-style-type: none"> • Feraheme • Injectafer • Monoferic

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Feraheme, Injectafer, or Monoferic may be covered when the criteria listed below is satisfied:

- Used for iron deficiency anemia in a patient with chronic kidney disease who is on dialysis; **or**

- For other conditions:
 - History of use of the preferred medication; **or**
 - Continuation of prior therapy or use within the past 365 days.

Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none"> • Avastin 	<ul style="list-style-type: none"> • Beovu • Byooviz • Cimerli • Eylea <ul style="list-style-type: none"> • Eylea HD • Lucentis • Vabysmo

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Beovu or Vabysmo may be covered when the criteria listed below is satisfied:

- History of use of the preferred ophthalmic medication; **and**
- Inadequate efficacy or intolerance was demonstrated; **or**
- Safety of using the repackaged ophthalmic Avastin injection or the supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion; **or**
- Continuation of prior therapy or use within the past 365 days.

Eylea or Eylea HD may be covered when criteria listed below is satisfied:

- History of use of the preferred ophthalmic medication; **and**
- Inadequate efficacy or intolerance was demonstrated; **or**
- Has diabetic macular edema and a baseline visual acuity worse than 20/40 according to the prescriber; **or**
- Has diabetic macular edema with significant retinal thickening according to the prescriber; **or**
- Has diabetic retinopathy (without diabetic macular edema); **or**
- Safety of using the repackaged ophthalmic Avastin injection or the supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion; **or**
- Continuation of prior therapy or use within the past 365 days.

Byooviz, Cimerli, or Lucentis may be covered when criteria listed below is satisfied:

- History of use of the preferred ophthalmic medication; **and**
- Inadequate efficacy or intolerance was demonstrated; **or**
- Has diabetic retinopathy (without diabetic macular edema); **or**
- Safety of using the repackaged ophthalmic Avastin injection or the supplier of the repackaged ophthalmic Avastin injection is of significant concern, in the prescriber's professional opinion; **or**
- Continuation of prior therapy or use within the past 365 days.

Paclitaxel Medications

Preferred* Medications	Non-Preferred Medications
• Paclitaxel	• Abraxane • Paclitaxel protein-bound

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Abraxane or paclitaxel protein-bound may be covered when the criteria listed below is satisfied:

- For non-small cell lung cancer:
 - Hypersensitivity reaction to paclitaxel intravenous infusion or docetaxel intravenous infusion; **or**
 - Contraindication to the standard pre-medications; **or**
 - Used as subsequent therapy with advanced or metastatic disease; **or**
 - Continuation of prior therapy or use within the past 365 days
- For breast cancer, cervical cancer, endometrial cancer, melanoma, ovarian cancer:
 - Hypersensitivity reaction to paclitaxel intravenous infusion or docetaxel intravenous infusion; **or**
 - Contraindication to the standard pre-medications; **or**
 - Continuation of prior therapy or use within the past 365 days

Rituximab

Preferred* Medications	Non-Preferred Medications
• Riabni • Ruxience • Truxima	• Rituxan Hycela • Rituxan IV

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15. Additional MAC regions listed below.

Rituxan intravenous may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy within the past 365 days; **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
 - Graft Versus Host Disease (GVHD); **or**
 - Immune Thrombocytopenia (ITP); **or**
 - Multiple Sclerosis; **or**
 - Neuromyelitis Optica (NMO) Spectrum Disorder; **or**
 - Systemic Lupus Erythematos (SLE) [Lupus]; **or**
 - Thrombotic Thrombocytopenic Purpura (Acquired); **or**
 - Evans Syndrome; **or**
 - Bullous Pemphigoid; **or**

- Immunotherapy-Related Encephalitis; **or**
- Immune-Mediated Myopathy/Idiopathic Inflammatory Myopathy; **or**
- Immunoglobulin G4-Related Disease (IgG4-RD); **or**
- Myasthenia Gravis; **or**
- Minimal Change Disease; **or**
- Antibody-Mediated Rejection (AMR).

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication; **or**
- Inability to obtain or maintain intravenous access; **or**
- Continuation of prior therapy or use within the past 365 days.

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: NGS J6, NGS JK. Additional MAC regions listed below.

Rituxan intravenous may be covered when criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy within the past 365 days; **or**
- Rituxan intravenous is being prescribed to treat one of the following conditions:
 - Immune Thrombocytopenia (ITP); **or**
 - Multiple Sclerosis; **or**
 - Antibody-Mediated Rejection (AMR); **or**
 - Immune-Mediated Myopathy/Idiopathic Inflammatory Myopathy; **or**
 - Hemophilia (Acquired); **or**
 - Thrombotic Thrombocytopenic Purpura (Acquired); **or**
 - Immunoglobulin G4-Related Disease (IgG4-RD); **or**
 - Minimal Change Disease; **or**
 - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP); **or**
 - Sjogren's Syndrome and Systemic Sclerosis.

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication; **or**
- Inability to obtain or maintain intravenous access; **or**
- Continuation of prior therapy or use within the past 365 days.

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: Palmetto JJ, Palmetto JM. Additional MAC regions listed below.

Rituxan intravenous may be covered when criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s)

which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**

- Continuation of prior therapy within the past 365 days; **or**

- Rituxan intravenous is being prescribed to treat one of the following conditions:

- Rheumatoid Arthritis (RA); **or**
- Graft Versus Host Disease (GVHD); **or**
- Multiple Sclerosis; **or**
- Autoimmune Hemolytic Anemia; **or**
- Multifocal Motor Neuropathy (MMN); **or**
- Polymyositis; **or**
- Prior to Autologous Stem Cell Rescue for Progressive or Relapsed Disease.

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication; **or**
- Inability to obtain or maintain intravenous access; **or**
- Continuation of prior therapy or use within the past 365 days.

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: FCSO JN, Noridian JE, Noridian JF, Novitas JH, WPS J5, WPS J8.

Rituxan intravenous may be covered when criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days.

Rituxan Hycela may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication; **or**
- Inability to obtain or maintain intravenous access; **or**
- Continuation of prior therapy or use within the past 365 days.

Systemic Lupus Erythematosus (SLE) Lupus

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">Benlysta IV	<ul style="list-style-type: none">Saphnelo

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Saphnelo may be covered when the criteria listed below is satisfied:

- History of Benlysta use; **or**
- History of depression or suicidality, according to prescriber; **or**
- Continuation of prior therapy or use within the past 365 days.

Trastuzumab

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">• Kanjinti• Ogviri• Trazimera	<ul style="list-style-type: none">• Herceptin Hylecta• Herceptin IV <ul style="list-style-type: none">• Herzuma• Ontruzant

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Herceptin intravenous, Herzuma, or Ontruzant may be covered when the criteria listed below is satisfied:

- History of use of one preferred medication; **and**
- Cannot continue to use the preferred medication due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction; **or**
- Continuation of prior therapy or use within the past 365 days; **or**

Herceptin Hylecta may be covered when criteria listed below is satisfied:

- History of use of one preferred medication, but according to prescriber cannot continue to use the medication; **or**
- Inability to obtain or maintain intravenous access; **or**
- Continuation of prior therapy or use within the past 365 days.

Viscosupplements

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">• Monovisc• Orthovisc• Synvisc• Synvisc One	<ul style="list-style-type: none">• Durolane• Euflexxa• Gel-One• Gelsyn-3• GenVisc 850• Hyalgan• Hymovis <ul style="list-style-type: none">• Sodium Hyaluronate 1%• Supartz FX• Synjoont• Triluron• TriVisc• Visco-3

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL. Does not apply to all other MAC regions not listed.

Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, sodium hyaluronate 1%, Supartz FX, Synojojnt, Triluron, TriVisc, or Visco-3 may be covered when the criteria listed below is satisfied:

- History of one course of therapy with one preferred medication; **or**
- Continuation of prior therapy or use within the past 365 days.

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Calcitonin Gene-Related Peptide Inhibitors**

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">• Preferred Part D medication (reference Part D Drug List and Part D UM requirements)	<ul style="list-style-type: none">• Vyepti

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Vyepti may be covered for when the criteria listed below is satisfied:

- History of use of one preferred Part D subcutaneous calcitonin gene-related peptide inhibitor for migraine prophylaxis; **or**
- Continuation of prior therapy or use within the past 365 days.

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none">• Preferred Part D medication (reference Part D Drug List and Part D UM requirements)	<ul style="list-style-type: none">• Leqvio

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Leqvio may be covered when the criteria listed below is satisfied:

- History of use of one preferred Part D proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor; **and**
- Inadequate efficacy or significant intolerance, according to prescriber; **or**
- Continuation of prior therapy or use within the past 365 days.

Systemic Lupus Erythematosus (SLE) Lupus**

Preferred* Medications	Non-Preferred Medications
<ul style="list-style-type: none"> Preferred Part D medication (reference Part D Drug List and Part D UM requirements) 	<ul style="list-style-type: none"> Saphnelo

Non-Preferred Medication Step Therapy Criteria

Applicable MAC regions: CGS J15, FCSO JN, NGS J6, NGS JK, Noridian JE, Noridian JF, Novitas JH, Novitas JL, Palmetto JJ, Palmetto JM, WPS J5, WPS J8.

Saphnelo may be covered when the criteria listed below is satisfied:

- History of Benlysta use; **or**
- History of depression or suicidality, according to prescriber; **or**
- Continuation of prior therapy or use within the past 365 days.

Applicable Codes

Antiemetic - Serotonin Receptor Antagonists (Injectable) for Oncology

HCPCS Code	Description
Preferred	
J1626	Injection, granisetron hydrochloride, 100 mcg
J2405	Injection, ondansetron hydrochloride, per 1 mg
J2469	Injection, palonosetron HCl, 25 mcg
Non-Preferred	
J1627	Injection, granisetron, extended-release, 0.1 mg

Antiemetic - Substance P/Neurokinin-1 Receptor Antagonists (Injectable) for Oncology

HCPCS Code	Description
Preferred	
J1453	Injection, fosaprepitant, 1 mg
Non-Preferred	
J0185	Injection, aprepitant, 1 mg
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg

Bevacizumab (Oncology)

HCPCS Code	Description
Preferred	
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
Non-Preferred	

J9035	Injection, bevacizumab, 10 mg
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg

Colony Stimulating Factors Short-Acting

HCPCS Code	Description
Preferred	
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio) 1 microgram
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram
Non-Preferred	
J1442	Injection, filgrastim (G-CSF), (Neupogen) excludes biosimilars, 1 mcg
J1447	Injection, tbo-filgrastim, (Granix)1 microgram
Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg

Colony Stimulating Factors Long-Acting

HCPCS Code	Description
Preferred	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg
Q5122	Injection, pegfilgrastim-apgf (Nyvepria), biosimilar, 0.5 mg
Non-Preferred	
J1449	Injection, eflapegrastim-xnst, 0.1 mg
Q5108	Injection, pegfilgrastim-jmdb (Fulphila), biosimilar, 0.5 mg
Q5120	Injection, pegfilgrastim-bmez, (Ziextzeno), biosimilar, 0.5 mg
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg

Immunomodulators

HCPCS Code	Description
Preferred	
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10mg
Non-Preferred	
J1745	Injection, infliximab, excludes biosimilar, 10 mg

Intravenous Iron

HCPCS Code	Description
Preferred	

J1756	Injection, iron sucrose, 1 mg
Non-Preferred	
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg

Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors

HCPCS Code	Description
Preferred	
C9257	Injection, bevacizumab (Avastin), 0.25mg
J7999	Compounded drug, not otherwise classified
J9035	Injection, bevacizumab (Avastin), 10mg
Non-Preferred	
J0178	Injection, aflibercept, 1 mg
J0179	Injection, brolucizumab-dbll, 1 mg
J3490/J3590	Unspecified for Eylea HD until permanent code assigned
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg
Q5128	Injection, ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg

Paclitaxel Medications

HCPCS Code	Description
Preferred	
J9267	Injection, paclitaxel, 1 mg
Non-Preferred	
J9259	Injection, paclitaxel protein-bound particles (American Regent) not therapeutically equivalent to j9264, 1 mg
J9264	Injection, paclitaxel protein-bound particles, 1 mg

Rituximab

HCPCS Code	Description
Preferred	
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg
Non-Preferred	
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg

Systemic Lupus Erythematosus (SLE) Lupus

HCPCS Code	Description
Preferred	
J0490	Injection, belimumab, 10 mg
Non-Preferred	
J0491	Injection, anifrolumab-fnia, 1 mg

Trastuzumab

HCPCS Code	Description
Preferred	
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg
Non-Preferred	
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg

Viscosupplements

HCPCS Code	Description
Preferred	
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
Non-Preferred	
J7318	Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
J7320	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg
J7329	Hyaluronan or derivative, TriVisc, for intra-articular injection, 1 mg
J7331	Hyaluronan or derivative, Synjoynt, for intra-articular injection, 1mg
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1mg

For the following classes, preferred medications may be covered under the Part D (pharmacy) benefit:

Calcitonin Gene-Related Peptide Inhibitors**

HCPCS Code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Non-Preferred	
J3032	Injection, eptinezumab-jjmr, 1 mg

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**

HCPCS Code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Non-Preferred	
J1306	Injection, inclisiran, 1 mg

Systemic Lupus Erythematosus (SLE) Lupus**

HCPCS Code	Description
Preferred	
N/A	Preferred Part D medication (reference Part D Drug List and Part D UM requirements)
Non-Preferred	
J0491	Injection, anifrolumab-fnia, 1 mg

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1. Centers for Medicare and Medicaid Services, National Government Services, Inc, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) applicable coverage policies. Available at <https://www.cms.gov/medicare-coverage-database/search.aspx>
2. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®). Available at www.nccn.org

Antiemetic - Serotonin Receptor Antagonists (Injectable) for Oncology

1. Aloxi® intravenous injection [prescribing information]. Iselin, NJ: Helsinn; April 2020.
2. Ondansetron intramuscular injection or intravenous infusion [prescribing information]. Lake Zurich, IL: Fresenius Kabi; March 2020.
3. Granisetron intravenous infusion [prescribing information]. Rockford, IL: Fresenius Kabi; December 2019.
4. Sustol® extended-release subcutaneous injection [prescribing information]. Redwood City, CA: Heron; June 2023.
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Antiemetic – Substance P/Neurokinin-1 Receptor Antagonists (Injectable) for Oncology

1. Cinvanti™ intravenous infusion [prescribing information]. San Diego, CA: Heron; September 2023.

Cigna Medicare Part B Step Therapy Program

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Effective 1/1/2024

INT_24_1119702_C

2. Emend® intravenous infusion [prescribing information]. Whitehouse Station, NJ: Merck; May 2022.
3. Akynzeo® intravenous infusion [prescribing information]. Iselin, NJ: Helsinn; February 2023

Bevacizumab (Oncology)

1. Avastin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; December 2020.
2. Mvasi® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; November 2021.
3. Zirabev™ intravenous infusion [prescribing information]. New York, NY: Pfizer; February 2021.
4. Alymsys® intravenous infusion [prescribing information]. Bridgewater, NJ: Amneal; April 2022.
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Colony Stimulating Factors Short-Acting

1. Neupogen® intravenous or subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; April 2021.
2. Zarxio™ intravenous or subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; March 2021.
3. Nivestym™ intravenous or subcutaneous injection [prescribing information]. Lake Forest, IL: Hospira/Pfizer; August 2023.
4. Releuko® subcutaneous or intravenous injection [prescribing information]. Bridgewater, NJ: Amneal; April 2022.
5. Granix® subcutaneous injection [prescribing information]. North Wales, PA: Teva; April 2020.
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Colony Stimulating Factors Long-Acting

1. Neulasta® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; March 2021.
2. Fulphila® subcutaneous injection [prescribing information]. Rockford, IL: Mylan; July 2023.
3. Udenyca™ subcutaneous injection [prescribing information]. Redwood City, CA: Coherus; March 2023.
4. Zixtenzo™ subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; Decemeber 2022.
5. Nyvepria™ subcutaneous injection [prescribing information]. New York, NY: Pfizer; June 2023.
6. Fylnetra® subcutaneous injection [prescribing information]. Bridgewater, NJ: Amneal; May 2022.
7. Stimufend® subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; September 2022.
8. Rolvedon™ subcutaneous injection [prescribing information]. Irvine, CA: Spectrum; June 2023.

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Immunomodulators

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2. Inflectra™ injection for IV use [prescribing information]. Lake Forest, IL: Hospira/Pfizer; April 2016.
3. Renflexis injection for IV use [prescribing information]. Whitehouse Station, NJ: Samsung Bioepis/Merck; April 2017.
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Intravenous Iron

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2. Venofer® intravenous infusion or injection [prescribing information]. Shirley, NY: American Regent; July 2022.
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Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors

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2. Eylea® intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; February 2023.
3. Lucentis® intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; October 2020.
4. Byooviz™ intravitreal injection [prescribing information]. Cambridge, MA: Biogen; June 2023.
5. Vabysmo™ intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; January 2023.
6. Cimerli™ intravitreal injection [prescribing information]. Redwood City, CA: Coherus; November 2022.
7. Eylea™ HD intravitreal injection [prescribing information]. Tarrytown, NY: Regeneron; August 2023.
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Paclitaxel Medications

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Rituximab

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2. Ruxience [prescribing information]. New York, NY: Pfizer; November 2021.
3. Truxima [prescribing information]. North Wales, PA: Teva/Celltrion; April 2023.
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5. Riabni [prescribing information]. Thousand Oaks, CA: Amgen; June 2022.
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Systemic Lupus Erythematosus (SLE) Lupus

1. Benlysta® injection [prescribing information]. Rockville, MD: Human Genome Sciences/GlaxoSmithKline; February 2023.
2. Saphnelo® injection [prescribing information]. Wilmington, DE: AstraZeneca; September 2022.
3. Hahn BH, McMahon MA, Wilkinson A, et al. American College of Rheumatology guidelines for screening, treatment, and management of lupus nephritis. *Arthritis Care Res (Hoboken).* 2012;64(6):797-808.
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Trastuzumab

1. Herceptin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; February 2021.
2. Herzuma® intravenous infusion [prescribing information]. North Wales, PA: Teva; May 2019.
3. Kanjinti® intravenous infusion [prescribing information]. Thousand Oaks, CA: Amgen; October 2022.
4. Ogviri® intravenous infusion [prescribing information]. Steinhausen, Switzerland: Mylan; July 2023.
5. Trazimera™ intravenous infusion [prescribing information]. New York, NY: Pfizer; November 2020.
6. Herceptin Hylecta™ subcutaneous injection [prescribing information]. South San Francisco, CA: Genentech; February 2019.
7. Ontruzant® intravenous infusion [prescribing information]. Whitehouse Station, NJ: Merck; March 2020.

Viscosupplements

1. Durolane® intraarticular injection [prescribing information]. Durham, NC: Bioventus; not dated.
2. Euflexxa® intraarticular injection [prescribing information]. Parsippany, NJ: Ferring; July 2016.
3. Gel-One® intraarticular injection [prescribing information]. Warsaw, IN: Zimmer; May 2011.
4. Gelsyn-3® intraarticular injection [prescribing information]. Durham, NC: Bioventus; 2016.
5. GenVisc® 850 intraarticular injection [prescribing information]. Doylestown, PA: OrthogenRx; not dated.
6. Hyalgan® intraarticular injection [prescribing information]. Parsippany, NJ: Fidia Pharma; May 2014.
7. Hymovis® intraarticular injection [prescribing information]. Parsippany, NJ: Fidia Pharma; October 20152021.
8. Monovisc® intraarticular injection [prescribing information]. Bedford, MA: DePuy Synthes; not dated.
9. Orthovisc® intraarticular injection [prescribing information]. Raynham, MA: DePuy Synthes; September 2014.
10. Sodium hyaluronate 1% intraarticular injection [prescribing information]. North Wales, PA: Teva; March 2019.
11. Supartz® FX™ intraarticular injection [prescribing information]. Durham, NC: Bioventus; April 2015.
12. Synvisc® intraarticular injection [prescribing information]. Ridgefield, NJ: Genzyme; September 2014.
13. Synvisc-One® intraarticular injection [prescribing information]. Ridgefield, NJ: Genzyme; September 2014.
14. Triluron intraarticular injection [prescribing information]. Florham Park, NJ: Fidia Pharma; March 2019.
15. Trivisc intraarticular injection [prescribing information]. Doylestown, PA: OrthogenRx; not dated.
16. Visco-3 intraarticular injection [prescribing information]. Durhan, NC: Bioventus; not dated.
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Calcitonin Gene-Related Peptide Inhibitors**

1. Vyepti® intravenous infusion [prescribing information]. Bothell, WA: Lundbeck; October 2022.
2. Aimovig® injection for subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen; May 2023.
3. Ajovy® injection for subcutaneous use [prescribing information]. North Wales, PA: Teva; October 2022.
4. Emgality® injection for subcutaneous use [prescribing information]. Indianapolis, IN: Lilly; May 2022
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12. Qulipta® tablets [prescribing information]. Madison, NJ: AbbVie; April 2023.
13. Nurtec® ODT [prescribing information]. New Haven, CT: Biohaven; April 2022.
14. Micromedex. Merative LP. Available at: <https://www.micromedexsolutions.com/>. Accessed on August 7, 2023. Search terms: lisinopril, verapamil.
15. Clinical Pharmacology. ClinicalKey. Available at: <https://www.clinicalkey.com/pharmacology/> Accessed on August 7, 2023. Search terms: lisinopril, verapamil.

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**

1. Praluent® subcutaneous injection [prescribing information]. Tarrytown, NY: Regeneron; April 2021.
2. Repatha® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; September 2021.
3. Leqvio® subcutaneous injection [prescribing information]. East Hanover, NJ: Novartis; July 2023.
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Systemic Lupus Erythematosus (SLE) Lupus**

1. Benlysta® injection [prescribing information]. Rockville, MD: Human Genome Sciences/GlaxoSmithKline; February 2023.
2. Saphnelo® injection [prescribing information]. Wilmington, DE: AstraZeneca; September 2022.
3. Hahn BH, McMahon MA, Wilkinson A, et al. American College of Rheumatology guidelines for screening, treatment, and management of lupus nephritis. *Arthritis Care Res (Hoboken)*. 2012;64(6):797-808.
4. Rovin BH, Adler SG, Barratt J, et al. Executive summary of the KDIGO 2021 guideline for the management of glomerular diseases. *Kidney Int*. 2021;100(4):753-779.
5. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus. *Ann Rheum Dis*. 2019;78(6):736-745.
6. Stohl W, Merrill JT, McKay JD, et al. Efficacy and safety of belimumab in patients with rheumatoid arthritis: a phase II, randomized, double-blind, placebo-controlled, dose-ranging study. *J Rheumatol*. 2013;40(5):579-589

Revision History

Date	Summary of Changes
1/1/2024	<p>Coverage Criteria</p> <ul style="list-style-type: none"> • Ophthalmic Disorders Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors medication list addition <ul style="list-style-type: none"> ○ Eylea HD (new medication) added as Non-Preferred • Trastuzumab medication list addition <ul style="list-style-type: none"> ○ Ogivri changed from a Non-Preferred medication to a Preferred • Systemic Lupus Erythematosus (SLE) Lupus <ul style="list-style-type: none"> ○ New step therapy class and criteria added for part B benefit • Calcitonin Gene-Related Peptide Inhibitors** <ul style="list-style-type: none"> ○ New step therapy class and criteria added

- **Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors****
 - New step therapy class and criteria added
- **Systemic Lupus Erythematosus (SLE)** Lupus**
 - New step therapy class and criteria added for part D benefit

Applicable Codes

- **Ophthalmic Disorders** Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors medication HCPC list addition
 - **J3490/J3590** added for Eylea HD until permanent code is assigned
- **Trastuzumab** medication HCPC list revision
 - **Q5114** changed from Non-Preferred to Preferred
- **Systemic Lupus Erythematosus (SLE)** Lupus for Part B new step therapy class HCPCs added
 - **J0490** Preferred
 - **J0491** Non-Preferred
- **Calcitonin Gene-Related Peptide Inhibitors**** new step therapy class HCPCs added
 - N/A Preferred
 - **J3032** Non-Preferred
- **Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors**** new step therapy class HCPCs added
 - N/A Preferred
 - **J1306** Non-Preferred
- **Systemic Lupus Erythematosus (SLE)**** Lupus for Part D new step therapy class HCPCs added
 - N/A Preferred
 - **J0491** Non-Preferred

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