



Banner
University Family Care

Banner – University Family Care (ACC and ALTCS Plans) Step Therapy Requirements for Medications

Step Therapy will be required for the medications listed in the table below effective **11/01/2024**, provided the following are met:

- The requested product meets the definition of a step therapy drug; **AND**
- The proposed use of the requested product has been determined to be a medically accepted indication; **AND**
- The proposed use of the preferred alternative agent has been determined to be a medically accepted indication; **AND**
- The proposed use of the preferred alternative agent will be limited to new starts (365-day lookback period); **AND**
- The dose, frequency, and duration of use may not exceed the safety and efficacy data supporting the medically accepted indication

| Class | Requested Product | Preferred Alternative Agent(s) ¹ |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| Erythropoiesis-Stimulating Agents | Mircera (J0887) Aranesp (J0881) Procrit (J0885) Epoeten beta (J0888) | Retacrit (Q5106) Epogen (J0885) |
| Bone resorption inhibitors | Xgeva (J0897) (Only oncology indications) | Zoledronic Acid (J3489) NAN ² |
| Colony-stimulating factors – leukocyte growth factors (short-acting) | Granix (J1447) Leukine (J2820) Zarxio (Q5101) Releuko (Q5125) | Nivestym (Q5110) Neupogen (J1442) |
| Colony Stimulating Factors -Leukocyte Growth Factors (long-acting) | Rolvedon (J1449) Neulasta and Neulasta Onpro(J2506) Stimufend (Q5127) Fulphila (Q5108) | Ziextenzo (Q5120) Fylnetra (Q5130) Nivestym (Q5110) Nyvepria (Q5122) Udenyca or Udenyca Onbody(J2506 or Q5111) |

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|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Immunomodulators | Avsola (Q5121) Inflectra (Q5103) Remicade (J1745) Renflexis (Q5104) | Infliximab -Janssen Manufacturer (J1745) |
| Viscosupplements | Durolane (J7318) Gel-One (J7326) Gelsyn3 (J7328) Genvisc 850 (J7320) Hyalgan (J7321) Hymovis (J7322) Monovisc (J7327) Orthovisc (J7324) Supartz & Supartz FX (J7321) Synojoynt (J3490) Synvisc & Synvisc- One (J7325) Triluron (J7332) TriVisc (J7329) Visco-3 (J7321) | Euflexxa (J7323) |
| Rituximab / Rituximab and hyaluronidase | Riabni (Q5123) Rituxan (J9312) | Ruxience (Q5119) Truxima (Q5115) |
| Oncology (Avastin) | Zirabev (Q5118) or Almysys (Q5126) or Vegzelma (Q5129) | Avastin (J9035) NAN ² Mvasi (Q5107) |
| Ophthalmic (Avastin) | Beovu (J0179) Byooviz (Q5124) Cimerli (Q5128) Eylea (J0178) Lucentis (J2778) Susvimo (J2779) Vabysmo (J2777) | Avastin (J7999 or J9035) NAN ² |
| Immunological Agents | Immune Globulin (asceniv) (J1554) Immune Globulin SQ (Cuvitru) (J1555) Immune Globulin (Gammaplex) (J1557) Gamma Globulin (GamaStan) (J1460) Immune Globulin NOS non-lyophilized (J1599) Immune Globulin NOS powder (J1566) Immune Globulin (Vivaglobin) (J1562) | Immune Globulin (Flebogamma/Flebogamma Dif) (J1572) or Gamma Globulin (Gammunex, Gammaked) (J1560) or Immune Globulin (Gamunex/Gamunex-C/Gammaked) (J1561) or Immune Globulin (Gammagard Liquid) (J1569) or Immune Globulin (Hizentra) (J1559) or Immune Globulin (Privigen) (J1459) or Immune Globulin (Bivigam) (J1556) or Immune Globulin (Octagam) (J1568) or Immune Globulin (Xembify) (J1558) |

1. Prior Authorization is required for all medications listed unless it states NAN

2. NAN = No Prior Authorization is needed

References

- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, CMS Pub. 100- 02, Chapter 15, Sec. 50 (Rev. 12684, June 13, 2024); available at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf>
- AHCCCS Fee-For-Service Prior Authorization Criteria <https://www.azahcccs.gov/PlansProviders/Pharmacy/> (accessed Sep 11, 2024)
- 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/>