Banner Medicare Advantage Prime HMO and Banner Medicare Advantage Dual HMO D-SNP Plans

Step Therapy Requirements for Medicare Outpatient (Part B) Medications

Medications requiring Step Therapy first go through trial and failure of formulary preferred agents prior to approval. Step Therapy will be required for the medications listed in the table below effective **1/1/2025 – 5/31/2025**, provided the following are met:

- The requested product meets the definition of a Medicare outpatient (Part B) 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 dose, frequency, and duration of use may not exceed the safety and efficacy data supporting the medically accepted indication; **AND**
- The proposed use of the preferred alternative agent will be limited to new starts. (For the purposes of this program, an existing utilizer means the member has a paid claim in the 365-day lookback period); **OR**
- Trial and failure of preferred product has been determined for any member utilizing a preferred alternative agent when switch to requested product is proposed

Class	Requested Product	Preferred Alternative Agent(s)[1]
Erythropoiesis-Stimulating Agents	Aranesp (J0881) Epogen/Procrit (J0885) Mircera (J0888)	Retacrit (Q5106)
Bone resorption inhibitors	Denosumab (Xgeva) (J0897) **[Step therapy only applies to bone metastases, multiple myeloma, hypercalcemia (excluding prostate cancer)]**	Pamidronate (J2430) or Zoledronic Acid (J3489)

	(Osteoporosis does not require ST)	
Colony-stimulating factors – leukocyte growth factors (short-acting)	Granix (J1447) Neupogen (J1442) Leukine (J2820) Nivestym (Q5110) Releuko (Q5125)	Zarxio (Q5101)
Colony Stimulating Factors -Leukocyte Growth Factors (long-acting)	Rolvedon (J1449) Nyvepria (Q5122) Udenyca (Q5111) Ziextenzo (Q5120) Fylnetra (Q5130) Stimufend (Q5127)	Fulphila (Q5108) or Neulasta (J2506)
Immunologic drugs – autoimmune disorders (arthritis, psoriasis, inflammatory bowel disease)	Avsola (Q5121) Ilumya (J3245) Orencia IV (J0129) Renflexis (Q5104)	Inflectra (Q5103) or Remicade and Infliximab (J1745)
Immunologic drugs – rheumatoid arthritis	Actemra IV (J3262) **[Step therapy only applies to rheumatoid arthritis]**	Inflectra (Q5103) or Remicade and Infliximab (J1745) Or Tyenne (Q5135) or Tofidence (Q5133)
Oncology (Abraxane)	Abraxane (J9264) **[Step therapy only applies to breast cancer (excluding triple negative breast cancer) & non-small cell lung cancer]**	Docetaxel (J9171) or Paclitaxel (J9267)
Vincristine (liposomal)	Marqibo (J9371)	Vincristine sulfate (J9370)
Viscosupplements	Durolane (J7318) Gel-One (J7326) Gelsyn3 (J7328) Genvisc 850 (J7320) Hyalgan (J7321) Hymovis (J7322) Monovisc (J7327)	Euflexxa (J7323)

	Orthovisc (J7324) Supartz & Supartz FX (J7321) Synvisc & Synvisc- One (J7325) Synojoynt (J3490) Triluron (J7332) TriVisc (J7329) Visco-3 (J7321)	
Doxorubicin (liposomal)	Doxil (Q2050)	Doxorubicin, conventional (J9000)
Trastuzumab / Trastuzumab and hyaluronidase-oysk	Herceptin (J9355) Herceptin Hylecta (J9356) Ontruzant (Q5112) or Herzuma (Q5113) Ogivri (Q5114) or	Kanjinti (Q5117) or Trazimera (Q5116)
Rituximab / Rituximab and hyaluronidase	Rituxan (J9312) Rituxan Hyclea (J9311) Riabni (Q5123)	Ruxience (Q5119) or Truxima (Q5115)
Ophthalmic disorders	Eylea HD (J0177) Eylea (J0178) Beovu (J0179) Vabysmo (J2777) Lucentis (J2778) Susvimo (J2779) Macugen (J2503) Visudyne (J3396) Byooviz(Q5124) Cimerli (Q5128) Vegzelma (Q5129)	Avastin (J9035 or J7999) **NAN**[2] or Mvasi (Q5107) or Zirabev (Q5118)
Zilretta	Zilretta (J3304)	Kenalog (J3301) **NAN**[2]
Leucovorin/levoleucovorin	Fusilev (J0641) Khapzory (J0642)	Leucovorin (J0640)
Oncology (Avastin)	Avastin (J9035) (oncology) Alysys (Q5126)	Mvasi (Q5107) or Zirabev (Q5118)
Trastuzumab	Trastuzumab-dkst (Ontruzant) (Q5112) Trastuzumab-pkrb (Herzuma)	Trastuzumab-qyyp (Trazimera) (Q5116) Trastuzumab-anns (Kanjinti) (Q5117)

	(Q5113) Trastuzumab-dkst (Ogivri) (Q5114)	
Soliris	Soliris (J1300) **[Step therapy only applies for Atypical hemolytic uremic syndrome (aHUS) and Paroxysmal nocturnal hemoglobinuria (PNH)]**	Ultomiris (J1303)

1. **Prior Authorization is required for all medications listed except for Kenalog**
2. **NAN – No Prior Authorization is needed**

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/