

## Clinical Policy: Step Therapy

Reference Number: MCPB.ST.00

Effective Date: 01.01.21

Last Review Date: 06.26

Line of Business: Medicare Part B

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

This policy provides a list of drugs that require step therapy. Step therapy is when we require the trial of a preferred therapeutic alternative prior to coverage of a non-preferred drug for a specific indication.

### FDA Approved Indication(s)

Various.

### Policy/Criteria

*This policy does not replace existing Medicare rules and regulations for the applicable agent(s).*

## I. Approval Criteria (NEW STARTS ONLY – member has not received the drug for the past 365 days)

### A. Step Therapy:

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
Abatacept (Orencia®)	PART B STEP: <ul style="list-style-type: none"> <li>• <b>All indications, except prophylaxis for acute graft-versus-host disease:</b> a tumor necrosis factor (TNF) inhibitor (e.g., infliximab)* (<i>note credit may be given if another TNF inhibitor was tried</i>)</li> </ul>
Ado-trastuzumab emtansine (Kadcyla®)	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Breast cancer:</b> trastuzumab-based therapy* and a taxane*, UNLESS prescribed as adjuvant treatment (<i>note some IV chemo may not require prior authorization</i>)</li> <li>• <b>Non-small cell lung cancer:</b> one prior systemic therapy*</li> </ul>
Afamitresgene autoleucel (Tecelra®)	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Synovial sarcoma:</b> prior systemic chemotherapy* (<i>note some IV chemo may not require prior authorization</i>)</li> </ul>
Aflibercept (Eylea®), Eylea® HD, Ahzantive™, Enzeevu™, Eydenzelt®, Opuviz™, Pavblu™, Yesafili™)	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Neovascular (wet) age-related macular degeneration (AMD), macular edema following retinal vein occlusion (RVO), diabetic macular</b></li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<p><b>edema (DME), or diabetic retinopathy (DR):</b> intravitreal bevacizumab solution</p>
<p>Atezolizumab (Tecentriq<sup>®</sup>), atezolizumab/hyaluronidase-tqjs (Tecentriq Hybreza<sup>™</sup>)</p>	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Urothelial carcinoma:</b> member is ineligible for platinum-containing chemotherapy as first-line systemic therapy* (<i>note some IV chemo may not require prior authorization</i>)</li> <li>• <b>Mesothelioma:</b> one prior systemic therapy*</li> <li>• <b>Non-small cell lung cancer that is stage IB to IIIB with programmed death-ligand 1 (PD-L1) expression <math>\geq 1\%</math> OR is recurrent, advanced, or metastatic and anaplastic lymphoma kinase (ALK) or epidermal growth factor receptor (EGFR) mutation negative or unknown:</b> prior platinum-containing chemotherapy (<i>note some IV chemo may not require prior authorization</i>), UNLESS one of the following is met: <ul style="list-style-type: none"> <li>○ Request is for use as a single agent as first-line therapy for tumors that have high PD-L1 expression, defined as PD-L1 <math>\geq 50\%</math> (tumor cells [TC] <math>\geq 50\%</math>) or tumor-infiltrating immune cells (IC) covering <math>\geq 10\%</math> of the tumor area [IC <math>\geq 10\%</math>]</li> <li>○ Disease is non-squamous, and Tecentriq/ Tecentriq Hybreza is prescribed as combination therapy</li> <li>○ No prior progression on a programmed death receptor-1 (PD-1) or PD-L1 inhibitor (e.g., atezolizumab, nivolumab, pembrolizumab, durvalumab), and Tecentriq/Tecentriq Hybreza is prescribed as single agent as subsequent therapy</li> <li>○ Member has a performance score of 3, and Tecentriq/Tecentriq Hybreza is prescribed as a single agent</li> </ul> </li> </ul>
<p>Axicabtagene ciloleucel (Yescarta<sup>®</sup>)</p>	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Large B-cell lymphoma:</b> one of the following: <ul style="list-style-type: none"> <li>○ 2 lines of systemic therapy that includes rituximab* and one anthracycline-containing regimen (e.g., doxorubicin)</li> <li>○ First-line chemoimmunotherapy that includes an anti-CD20 monoclonal antibody (e.g., rituximab*) and anthracycline-containing regimen (e.g., doxorubicin), if disease was refractory (defined as no complete remission) to</li> </ul> </li> </ul>

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	<p>or relapsed (defined as complete remission followed by biopsy-proven disease relapse) no more than 12 months after chemoimmunotherapy</p> <ul style="list-style-type: none"> <li>○ Disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy</li> <li>● <b>Relapsed or refractory follicular lymphoma:</b> 2 lines of systemic therapy that includes a combination of an anti-CD20 monoclonal antibody* (e.g., rituximab or Gazyva) and an alkylating agent (e.g., bendamustine, cyclophosphamide, chlorambucil)</li> <li>● <b>Relapsed or refractory marginal zone lymphoma:</b> 2 lines of systemic therapy that includes an anti-CD20 therapy* (e.g., rituximab) and an alkylating agent (e.g., bendamustine, chlorambucil, and cyclophosphamide)</li> <li>● <b>Relapsed or refractory primary mediastinal large B-cell lymphoma:</b> 2 prior chemoimmunotherapy regimens with partial response</li> <li>● <b>Richter transformation:</b> 1 prior systemic therapy regimen</li> </ul> <p><i>Only for initial treatment dose; subsequent doses will not be covered</i></p>
Bevacizumab (Avastin <sup>®</sup> , Alymsys <sup>®</sup> , Mvasi <sup>®</sup> , Jobevne <sup>™</sup> , Vegzelma <sup>™</sup> , Zirabev <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Oncology indications</b>, if request is for Avastin, Alymsys, Jobevne, or Vegzelma: Mvasi and Zirabev</li> </ul>
Brentuximab vedotin (Adcetris <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Lymphomatoid papulosis, B-cell lymphomas:</b> prior systemic therapy* (<i>note some IV chemo may not require prior authorization</i>)</li> </ul>
Brexucabtagene autoleucel (Tecartus <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Mantle cell lymphoma:</b> 2 to 5 prior regimens that included all of the following: anthracycline (e.g., doxorubicin*) or bendamustine*-containing chemotherapy; anti-CD20 monoclonal antibody therapy (e.g., rituximab*)</li> <li>● <b>B-cell precursor acute lymphoblastic leukemia:</b> at least two prior systemic therapies*</li> </ul> <p><i>Only for initial treatment dose; subsequent doses will not be covered</i></p>
Brolucizumab-dbl (Beovu <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Neovascular (wet) AMD, DME:</b> intravitreal bevacizumab solution</li> </ul>

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Cemiplimab-rwlc (Libtayo <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Cutaneous squamous cell carcinoma:</b> cisplatin*, UNLESS one of the following is met: <ul style="list-style-type: none"> <li>○ Curative radiation therapy or surgery is not feasible, or</li> </ul> </li> <li>• Prescribed as neoadjuvant treatment</li> </ul>
Certolizumab (Cimzia <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications:</b> a different TNF inhibitor (e.g., infliximab)* (<i>note credit may be given if another TNF inhibitor was tried</i>)</li> </ul>
Ciltacabtagene autoleucel (Carvykti <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Lenalidomide-refractory multiple myeloma:</b> at least 1 prior line of therapy* that include both of the following: immunomodulatory agent (e.g., lenalidomide, Pomalyst, Thalomid) and proteasome inhibitor (e.g., bortezomib, Kyprolis)</li> <li>• <b>Multiple myeloma:</b> 3 prior lines of therapy* that include all of the following: immunomodulatory agent (e.g., lenalidomide, Pomalyst, Thalomid), proteasome inhibitor (e.g., bortezomib, Kyprolis, Ninlaro), and anti-CD38 antibody (e.g., Darzalex/Darzalex Faspro, Sarclisa)</li> </ul> <p><i>Only for initial treatment dose; subsequent doses will not be covered</i></p>
Corticosteroid intravitreal implants: dexamethasone (Ozurdex <sup>®</sup> ), fluocinolone acetonide (Iluvien <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Macular edema following branch or central RVO (Ozurdex only):</b> bevacizumab intravitreal solution</li> <li>• <b>DME (Ozurdex or Iluvien):</b> bevacizumab intravitreal solution</li> </ul>
Corticotropin (H.P. Acthar <sup>®</sup> , Purified Cortrophin <sup>™</sup> Gel)	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications, except infantile spasms,</b> if request is for H.P. Acthar: Purified Cortrophin Gel</li> </ul> <p><u>IN ADDITION:</u></p> <ul style="list-style-type: none"> <li>• <b>Multiple sclerosis:</b> corticosteroid</li> </ul>
Daratumumab (Darzalex <sup>®</sup> ), daratumumab/hyaluronidase-fihj (Darzalex Faspro <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Multiple myeloma:</b> 1 prior systemic therapy (e.g., ixazomib*, bortezomib*, carfilzomib*) (<i>note some IV chemo may not require prior authorization</i>) if prescribed in combination with dexamethasone and either lenalidomide, pomalidomide, bortezomib, carfilzomib, Venclexta, or Xpovio; OR 3 prior lines of systemic therapies (e.g., ixazomib*, bortezomib*, carfilzomib*) if prescribed as monotherapy; UNLESS</li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<p>the requested agent is prescribed as primary therapy in one of the following ways:</p> <ul style="list-style-type: none"> <li>○ Member is ineligible for autologous stem cell transplant (ASCT), and prescribed in combination with lenalidomide/dexamethasone, bortezomib/lenalidomide/dexamethasone, or bortezomib/melphalan/prednisone; or</li> <li>○ Member is eligible for ASCT, and prescribed in combination with one of the following: bortezomib/thalidomide/dexamethasone, bortezomib/lenalidomide/dexamethasone, bortezomib/cyclophosphamide/dexamethasone, carfilzomib/lenalidomide/dexamethasone; or</li> <li>○ Maintenance therapy as a single agent or in combination with lenalidomide for transplant candidates</li> </ul> <ul style="list-style-type: none"> <li>● <b>Systemic light chain amyloidosis:</b> 1 prior systemic therapy (e.g., bortezomib*) (<i>note some IV chemo may not require prior authorization</i>), UNLESS one of the following is met: <ul style="list-style-type: none"> <li>○ Member has significant neuropathy or has Mayo stage IIIb disease, and the requested agent is prescribed as a single agent for newly diagnosed disease; or</li> <li>○ Prescribed in combination with bortezomib, cyclophosphamide, and dexamethasone; or</li> <li>○ Prescribed in combination with lenalidomide and dexamethasone</li> </ul> </li> </ul>
Darbepoetin alfa (Aranesp <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>All indications:</b> Retacrit <ul style="list-style-type: none"> <li>○ If Retacrit is unavailable due to shortage: Epogen</li> </ul> </li> </ul>
Denosumab (Prolia <sup>®</sup> , Xgeva <sup>®</sup> , Aukelso <sup>™</sup> , Boncresta <sup>®</sup> , Bosaya <sup>™</sup> , Enoby <sup>™</sup> , Jubbonti <sup>®</sup> , Jubereq <sup>®</sup> , Osponyv <sup>™</sup> , Osvyrti <sup>®</sup> , Oziltus <sup>®</sup> , Wyost <sup>®</sup> , Xbryk <sup>™</sup> , Xtrenbo <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>Prolia, Boncresta, Bosava, Enoby, Jubbonti, Osponyv, Osvyrti – All indications:</b> BILDYOS, Conexence, and Stoboclo</li> <li>● <b>Xgeva, Aukelso, Jubereq, Oziltus, Wyost, Xbryk, Xtrenbo – All indications:</b> Bilprevda, Bomynta, and Osenvelt</li> </ul>
Eculizumab (Soliris <sup>®</sup> , Bkerv <sup>™</sup> , Epysqli <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>All indications:</b> Ultomiris</li> </ul>
Efbemalenograstim alfa-vuxw (Ryzneuta <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>All indications:</b> Udenyca<sup>^</sup> or Fulphila</li> </ul>

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	<ul style="list-style-type: none"> <li>○ If member is unable to use Udenyca<sup>^</sup> or Fulphila: biosimilar pegfilgrastim product (e.g., Fylnetra, Nyvepria, Stimufend, Ziextenzo)</li> </ul> <p><sup>^</sup> Udenyca refers to all formulations (prefilled syringe, autoinjector, and on-body injector)</p>
Eflapegrastim-xnst (Rolvedon <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>All indications:</b> Udenyca<sup>^</sup> or Fulphila               <ul style="list-style-type: none"> <li>○ If member is unable to use Udenyca<sup>^</sup> or Fulphila: biosimilar pegfilgrastim product (e.g., Fylnetra, Nyvepria, Stimufend, Ziextenzo)</li> </ul> </li> </ul> <p><sup>^</sup> Udenyca refers to all formulations (prefilled syringe, autoinjector, and on-body injector)</p>
Elranatamab-bcmm (Elrexio <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>Multiple myeloma:</b> 4 prior lines of therapy* that include all of the following: immunomodulatory agent (e.g., lenalidomide, Pomalyst, Thalomid), proteasome inhibitor (e.g., bortezomib, Kyprolis), and anti-CD38 antibody (e.g., Darzalex/Darzalex Faspro, Sarclisa)</li> </ul>
Elotuzumab (Empliciti <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>Multiple myeloma:</b> prior line of systemic therapy (e.g., bortezomib*) (<i>note some IV chemo may not require prior authorization</i>)</li> </ul>
Emapalumab-lzsg (Gamifant <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>Primary hemophagocytic lymphohistiocytosis (HLH):</b> conventional HLH therapy* (<i>note some IV chemo may not require prior authorization</i>)</li> <li>● <b>HLH/macrophage activation syndrome in Still's disease:</b> IV corticosteroid</li> </ul>
Epoetin alfa (Epogen <sup>®</sup> , Procrit <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>All indications:</b> Retacrit               <ul style="list-style-type: none"> <li>○ If Retacrit is unavailable due to shortage: Epogen</li> </ul> </li> </ul>
Faricimab-svoa (Vabysmo <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>Neovascular (wet) AMD, DME, macular edema following RVO:</b> bevacizumab intravitreal solution</li> </ul>
Ferric carboxymaltose (Injectafer <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>● <b>Iron deficiency anemia (IDA) with chronic kidney disease (CKD), unless member has heart failure:</b> Ferrlecit and iron sucrose (generic Venofer)               <ul style="list-style-type: none"> <li>○ If unable to use or failure of Ferrlecit and iron sucrose (generic Venofer): ferumoxytol (generic Feraheme)</li> </ul> </li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<ul style="list-style-type: none"> <li>• <b>IDA without CKD, unless member has heart failure:</b> two of the following: Ferrlecit, Infed, iron sucrose (generic Venofer)               <ul style="list-style-type: none"> <li>○ If unable to use or failure of Ferrlecit, Infed, and iron sucrose (generic Venofer): ferumoxytol (generic Feraheme)</li> </ul> </li> <li>• <b>Management of cancer- and chemotherapy-induced anemia:</b> two of the following: Ferrlecit, Infed, iron sucrose (generic Venofer)               <ul style="list-style-type: none"> <li>○ If unable to use or failure of Ferrlecit, Infed, and iron sucrose (generic Venofer): ferumoxytol (generic Feraheme)</li> </ul> </li> </ul>
Ferric derisomaltose (Monoferric <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>IDA with CKD:</b> Ferrlecit and iron sucrose (generic Venofer)               <ul style="list-style-type: none"> <li>○ If unable to use or failure of Ferrlecit and iron sucrose (generic Venofer): ferumoxytol (generic Feraheme)</li> </ul> </li> <li>• <b>IDA without CKD:</b> two of the following: Ferrlecit, Infed, iron sucrose (generic Venofer)               <ul style="list-style-type: none"> <li>○ If unable to use or failure of Ferrlecit, Infed, and iron sucrose (generic Venofer): ferumoxytol (generic Feraheme)</li> </ul> </li> <li>• <b>Management of cancer- and chemotherapy-induced anemia:</b> two of the following: Ferrlecit, Infed, iron sucrose (generic Venofer)               <ul style="list-style-type: none"> <li>○ If unable to use or failure of Ferrlecit, Infed, and iron sucrose (generic Venofer): ferumoxytol (generic Feraheme)</li> </ul> </li> </ul>
Ferumoxytol (Feraheme <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications,</b> if request is for Feraheme: generic ferumoxytol</li> </ul> <p><u>IN ADDITION:</u></p> <ul style="list-style-type: none"> <li>• <b>IDA with CKD:</b> Ferrlecit and iron sucrose (generic Venofer)</li> <li>• <b>IDA without CKD:</b> two of the following: Ferrlecit, Infed, iron sucrose (generic Venofer)</li> <li>• <b>Management of cancer- and chemotherapy-induced anemia:</b> two of the following: Ferrlecit, Infed, iron sucrose (generic Venofer)</li> </ul>
Fidanacogene elaparvovec-dzkt (Beqvez <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Congenital hemophilia B:</b> factor IX product (e.g., Alprolix, Benefix, Idelvion, Ixinity, Rebinyn, Rixubis)</li> </ul>

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Filgrastim (Neupogen <sup>®</sup> , Zarxio <sup>®</sup> , Nivestym <sup>™</sup> , Granix <sup>®</sup> , Releuko <sup>®</sup> , Nypozi <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications</b>, if request is for an agent other than Zarxio: Zarxio               <ul style="list-style-type: none"> <li>○ If unable to use Zarxio: Nivestym                   <ul style="list-style-type: none"> <li>▪ If unable to use Zarxio and Nivestym and request is for Neupogen: biosimilar filgrastim product (e.g., Granix, Releuko, Nypozi)</li> </ul> </li> </ul> </li> </ul>
Golimumab (Simponi <sup>®</sup> , Simponi Aria <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications</b>: a different TNF inhibitor (e.g., infliximab)* (<i>note credit may be given if another TNF inhibitor was tried</i>)</li> </ul>
Hyaluronate derivatives: sodium hyaluronate (Euflexxa <sup>®</sup> , Gelsyn-3 <sup>™</sup> , GenVisc <sup>®</sup> 850, Hyalgan <sup>®</sup> , Supartz FX <sup>™</sup> , Synjojoynt <sup>™</sup> , Triluron <sup>™</sup> , TriVisc <sup>™</sup> , VISCO-3 <sup>™</sup> ), hyaluronic acid (Durolane <sup>®</sup> ), cross-linked hyaluronate (Gel-One <sup>®</sup> ), hyaluronan (Hymovis <sup>®</sup> , Orthovisc <sup>®</sup> , Monovisc <sup>®</sup> ), hylan polymers A and B (Synvisc <sup>®</sup> , Synvisc One <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Osteoarthritis of the knee</b>: intra-articular glucocorticoid injection*, and:               <ul style="list-style-type: none"> <li>○ If request is for a product other than Synvisc/Synvisc One or Euflexxa: Synvisc*/Synvisc One* or Euflexxa*</li> </ul> </li> </ul>
Idecabtagene vicleucel (Abecma <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Multiple myeloma</b>: 2 prior lines of therapy* that include all of the following: immunomodulatory agent (e.g., lenalidomide, Pomalyst, Thalomid), proteasome inhibitor (e.g., bortezomib, Kyprolis), and anti-CD38 antibody (e.g., Darzalex/Darzalex Faspro, Sarclisa) <i>Only for initial treatment dose; subsequent doses will not be covered</i></li> </ul>
Imetelstat (Rytelo <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications</b>: Retacrit, unless member is ineligible for erythropoietin-stimulating agent (ESA) therapy or member has had inadequate response to another ESA therapy               <ul style="list-style-type: none"> <li>○ If Retacrit is unavailable due to shortage: Epogen, unless member is ineligible for ESA therapy or member has had inadequate response to another ESA therapy</li> </ul> </li> </ul>
Immune globulins	PART B STEP:

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<p>(Alyglo<sup>™</sup>, Asceniv<sup>™</sup>, Bivigam<sup>®</sup>, Cutaquig<sup>®</sup>, Cuvitru<sup>™</sup>, Flebogamma<sup>®</sup> DIF, GamaSTAN<sup>®</sup>, GamaSTAN<sup>®</sup> S/D, Gammagard<sup>®</sup> liquid, Gammagard<sup>®</sup> S/D, Gammaked<sup>™</sup>, Gammaplex<sup>®</sup>, Gamunex<sup>®</sup>-C, Hizentra<sup>®</sup>, HyQvia<sup>®</sup>, Octagam<sup>®</sup>, Panzyga<sup>®</sup>, Qivigy<sup>®</sup>, Privigen<sup>®</sup>, Yimmugo<sup>®</sup>, Xembify<sup>®</sup>)</p>	<ul style="list-style-type: none"> <li>• <b>All indications</b>, if request is for an agent other than Gammagard and Gamunex-C: Gammagard and Gamunex-C, UNLESS one of the following applies:               <ul style="list-style-type: none"> <li>○ Request is for Octagam for dermatomyositis</li> <li>○ Request is for GamaSTAN or GamaSTAN S/D for viral prophylaxis for hepatitis A, measles, varicella, or rubella viruses</li> </ul> </li> </ul> <p><b>IN ADDITION:</b></p> <ul style="list-style-type: none"> <li>• <b>Chronic idiopathic demyelinating polyneuropathy:</b> a systemic corticosteroid, unless the member has pure motor symptoms</li> <li>• <b>Polymyositis, myasthenia gravis, bullous pemphigoid, mucous membrane pemphigoid (a.k.a. cicatricial pemphigoid), epidermolysis bullosa acquisita:</b> a systemic corticosteroid</li> <li>• <b>Dermatomyositis:</b> rituximab*</li> <li>• <b>Idiopathic thrombocytopenic purpura:</b> a systemic corticosteroid or Rho(D) immune globulin*</li> <li>• <b>Pemphigus vulgaris, pemphigus foliaceus,:</b> one corticosteroid and rituximab*</li> <li>• <b>Adenosine deaminase (ADA)-severe combined immunodeficiency disorders (SCID):</b> Revcovi*</li> <li>• <b>Cytokine release syndrome:</b> high-dose systemic corticosteroids and anti-IL-6 therapy*</li> </ul>
<p>IncobotulinumtoxinA (Xeomin<sup>®</sup>)</p>	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Upper and lower limb spasticity, cervical dystonia, blepharospasm, overactive bladder and urinary incontinence, chronic migraine, primary axillary hyperhidrosis, focal dystonia, essential tremor:</b> Botox and Dysport</li> </ul>
<p>Infliximab-ayyb (Zymfentra<sup>®</sup>)</p>	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Crohn's disease, ulcerative colitis:</b> IV infliximab product (e.g., Avsola, Inflectra, Renflexis)</li> </ul>
<p>Lanreotide (Somatuline<sup>®</sup> Depot)</p>	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications:</b> Sandostatin LAR Depot</li> </ul>
<p>Lisocabtagene maraleucel (Breyanzi<sup>®</sup>)</p>	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Large B-cell lymphoma:</b> one of the following:               <ul style="list-style-type: none"> <li>○ 2 lines of systemic therapy that includes an anti-CD20 therapy (e.g., rituximab)* and one anthracycline-containing regimen (e.g., doxorubicin)</li> <li>○ First-line chemoimmunotherapy that includes an anti-CD20 monoclonal antibody (e.g., rituximab*)</li> </ul> </li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<p>and anthracycline-containing regimen (e.g., doxorubicin), if disease was refractory (defined as no complete remission) to or relapsed (defined as complete remission followed by biopsy-proven disease relapse) no more than 12 months after chemoimmunotherapy</p> <ul style="list-style-type: none"> <li>• <b>Relapsed or refractory follicular lymphoma:</b> 2 lines of systemic therapy that includes a combination of an anti-CD20 monoclonal antibody* (e.g., rituximab or Gazyva) and an alkylating agent (e.g., bendamustine, cyclophosphamide, chlorambucil)</li> <li>• <b>Mantle cell lymphoma:</b> 2 lines of systemic therapy that includes an anti-CD20 monoclonal antibody therapy (e.g., rituximab)* and an alkylating agent (e.g., bendamustine, cyclophosphamide, platinum [carboplatin, cisplatin, or oxaliplatin])</li> <li>• <b>Relapsed or refractory marginal zone lymphoma:</b> 2 lines of systemic therapy that includes an anti-CD20 therapy (e.g., rituximab*) and an alkylating agent (e.g., bendamustine, chlorambucil, and cyclophosphamide)</li> </ul> <p><i>Only for initial treatment dose; subsequent doses will not be covered</i></p>
Lurbinectedin (Zepzelca <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Small cell lung cancer:</b> platinum-containing regimen (e.g., cisplatin, carboplatin)* <i>(note some IV chemo may not require prior authorization)</i></li> </ul>
Luspatercept-aamt (Reblozyl <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Myelodysplastic syndrome with ring sideroblasts &lt; 15% (or ring sideroblasts &lt; 5% with SFB3B1 mutation):</b> Retacrit, unless serum erythropoietin &gt; 200 mU/mL <ul style="list-style-type: none"> <li>○ If Retacrit is unavailable due to shortage: Epogen</li> </ul> </li> </ul>
Lutetium Lu 177 dotatate (Lutathera <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Neuroendocrine tumor (NET):</b> somatostatin analog (e.g., octreotide, lanreotide), unless member has a well-differentiated grade 3 NET or gastrointestinal or pancreas NET with Ki-67 ≥ 10% and clinically significant tumor burden</li> </ul>
Mirikizumab-mrkz (Omvoh <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Crohn's disease, ulcerative colitis:</b> a TNF inhibitor (e.g., infliximab)* <i>(note credit may be given if another TNF inhibitor was tried)</i></li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
Motixafortide (Aphexda <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Multiple myeloma:</b> plerixafor</li> </ul>
Nadofaragene firadenovec-vnccg (Adstiladrin <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Non-muscle invasive bladder cancer:</b> Bacillus Calmette-Guerin (BCG) treatment*</li> </ul>
Natalizumab (Tysabri <sup>®</sup> , Tyruko <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Crohn's disease:</b> a TNF inhibitor (e.g., infliximab*) <i>(note credit may be given if another TNF inhibitor was tried)</i></li> </ul>
Nivolumab (Opdivo <sup>®</sup> ), nivolumab/hyaluronidase-nvhy (Opdivo Qvantig <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Non-small cell lung cancer:</b> prior systemic therapy*, UNLESS one of the following is met: <ul style="list-style-type: none"> <li>○ Request is for Opdivo prescribed in combination with Yervoy for disease with RET rearrangement or unknown/negative mutation status for EGFR, ALK, ROS1, BRAF, MET exon 14 skipping, and NTRK gene fusion, or</li> <li>○ Prescribed as neoadjuvant treatment, or</li> <li>○ Prescribed as adjuvant treatment, following neoadjuvant treatment</li> </ul> </li> <li>• <b>Malignant pleural mesothelioma:</b> prior therapy*, unless request is for Opdivo prescribed in combination with Yervoy</li> <li>• <b>Classical Hodgkin lymphoma:</b> prior therapy*, UNLESS one of the following is met: <ul style="list-style-type: none"> <li>○ Prescribed in combination with doxorubicin, vinblastine, and dacarbazine</li> <li>○ Member is not a candidate for anthracycline therapy</li> <li>○ Prescribed as palliative therapy</li> <li>○ Prescribed as a single agent for post allogeneic hematopoietic cell transplant</li> </ul> </li> <li>• <b>Vulvar cancer, vaginal cancer, extranodal NK/T-cell lymphoma – nasal type, small cell lung cancer, cervical cancer, pediatric primary mediastinal large B-cell lymphoma, classic Kaposi sarcoma, pleomorphic rhabdomyosarcoma:</b> prior therapy*</li> <li>• <b>Squamous cell carcinoma of the head and neck:</b> <ul style="list-style-type: none"> <li>○ Platinum-containing regimen*, unless prescribed as combination therapy</li> <li>○ If member has nasopharyngeal carcinoma: Loqtorzi</li> </ul> </li> <li>• <b>Urothelial carcinoma:</b> platinum-containing regimen*, unless prescribed as adjuvant treatment and</li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<p>member is at high risk of recurrence after undergoing resection, or member is at high risk of recurrence and did not previously receive a platinum-containing regimen, or prescribed in combination with cisplatin and gemcitabine</p> <ul style="list-style-type: none"> <li>• <b>Esophageal squamous cell carcinoma:</b> both of the following: <ul style="list-style-type: none"> <li>○ Fluoropyrimidine-based (e.g., 5- fluorouracil, capecitabine) and platinum-based chemotherapy*, unless prescribed in combination with Yervoy (Opdivo only) or with fluoropyrimidine- and platinum-containing chemotherapy (Opdivo or Opdivo Qvantig)</li> <li>○ Tevimbra</li> </ul> </li> <li>• <b>Gastric and esophageal adenocarcinomas:</b> Tevimbra, unless for MSI-H or dMMR cancers</li> <li>• <b>Gestational trophoblastic neoplasia:</b> prior multi-agent chemotherapy*</li> <li>• <b>Anal carcinoma:</b> prior therapy*, unless prescribed prior to resection</li> </ul> <p><i>(note some IV chemo may not require prior authorization)</i></p>
Obecabtagene autoleucel (Aucatzyl <sup>®</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>B-cell precursor acute lymphoblastic leukemia:</b> prior systemic therapy*, unless disease has relapsed or is refractory following allogeneic stem cell transplantation <i>(note some IV chemo may not require prior authorization)</i></li> </ul>
Pasireotide (Signifor <sup>®</sup> LAR)	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Acromegaly:</b> Sandostatin LAR Depot</li> </ul>
Pegfilgrastim (Neulasta <sup>®</sup> , Armlupeg <sup>®</sup> , Fulphila <sup>™</sup> , Fylnetra <sup>®</sup> , Nyvepria <sup>™</sup> , Stimufend <sup>®</sup> , Udenyca <sup>™</sup> , Ziextenzo <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>All indications:</b> Udenyca<sup>^</sup> or Fulphila <ul style="list-style-type: none"> <li>○ If request is for Neulasta and member is unable to use Udenyca<sup>^</sup> or Fulphila: biosimilar pegfilgrastim product (e.g., Armlupeg, Fylnetra, Nyvepria, Stimufend, Ziextenzo)</li> </ul> </li> </ul> <p><i><sup>^</sup>Udenyca refers to all formulations (prefilled syringe, autoinjector, and on-body injector)</i></p>
Pembrolizumab (Keytruda <sup>®</sup> ), pembrolizumab/berahyaluronidase alfa-pmph (Keytruda Qlex <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Head and neck squamous cell carcinoma:</b> both of the following: <ul style="list-style-type: none"> <li>○ Platinum-containing chemotherapy*, unless prescribed as part of combination therapy or prescribed as a single agent for a tumor that</li> </ul> </li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<p>expresses PD-L1 with a combined positive score (CPS) <math>\geq 1</math></p> <ul style="list-style-type: none"> <li>○ If member has nasopharyngeal carcinoma: Loqtorzi</li> <li>● <b>Classical Hodgkin lymphoma (Keytruda only):</b> at least 1 prior therapy*, unless prescribed for palliative therapy, post allogenic hematopoietic cell transplant or post-autologous stem cell rescue, or member is not a candidate for anthracycline</li> <li>● <b>Primary mediastinal large B-cell lymphoma (Keytruda only), anal carcinoma (Keytruda only), gestational trophoblastic neoplasia (Keytruda only), extranodal NK/T-cell lymphoma (Keytruda only), vulvar carcinoma (Keytruda only), anaplastic large cell lymphoma (Keytruda only), small cell lung cancer, soft tissue sarcoma subtypes (myxofibrosarcoma, undifferentiated pleomorphic sarcoma, dedifferentiated liposarcoma, cutaneous angiosarcoma, and undifferentiated sarcomas) (Keytruda only), ovarian cancer, fallopian tube cancer, primary peritoneal cancer:</b> at least 1 prior therapy*</li> <li>● <b>Endometrial carcinoma:</b> at least 1 prior therapy*, unless prescribed in combination with carboplatin and paclitaxel and continued as a single agent for maintenance therapy for advanced, recurrent, or Stage III-IV tumor</li> <li>● <b>Tumor mutational burden-high cancer:</b> at least 1 prior therapy*, unless member has ampullary adenocarcinoma or pancreatic adenocarcinoma</li> <li>● <b>Cervical cancer:</b> at least 1 prior therapy*, unless prescribed in combination with chemotherapy (e.g., paclitaxel/cisplatin, paclitaxel/carboplatin) or chemoradiotherapy</li> <li>● <b>Microsatellite instability-high/mismatch repair deficient cancer:</b> at least 1 prior therapy*, unless member has colorectal cancer, ampullary adenocarcinoma, gallbladder cancer, gastric cancer, esophagogastric junction cancer, intrahepatic/extrahepatic cholangiocarcinoma, non-nasopharyngeal head, and neck cancer, occult primary tumor, pancreatic adenocarcinoma, or small bowel adenocarcinoma</li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<ul style="list-style-type: none"> <li>• <b>Urothelial carcinoma:</b> at least 1 prior therapy*, unless ineligible for platinum-containing chemotherapy, prescribed in combination with Padcev, Inlyta, or Lenvima, or used as adjuvant therapy</li> <li>• <b>Non-muscle invasive bladder cancer:</b> Bacillus Calmette-Guerin treatment*</li> <li>• <b>Gastric cancer, esophageal cancer, or gastroesophageal junction cancer:</b> Tevimbra, unless HER2-positive or prescribed as a single agent after at least 1 prior line of systemic therapy and PD-L1 (CPS <math>\geq 10</math>)</li> <li>• <b>Squamous cell esophagogastric junction cancer:</b> at least 1 prior therapy (if CPS <math>\geq 10</math>), unless prescribed in combination with fluoropyrimidine- and platinum-containing chemotherapy</li> <li>• <b>Stage IB, II, or IIIA non-small cell lung cancer:</b> platinum-containing chemotherapy*, unless one of the following is met:               <ul style="list-style-type: none"> <li>○ Disease is PD-L1 positive (tumor proportion score [TPS] <math>\geq 1\%</math>)</li> <li>○ Prescribed as part of combination therapy</li> <li>○ Prescribed as part of combination therapy as neoadjuvant treatment, followed by single-agent adjuvant treatment after surgery for patients with resectable (tumors <math>\geq 4</math> cm or node positive) disease</li> <li>○ Prescribed as single-agent continuation maintenance therapy if previously given first line as part of a chemotherapy regimen</li> </ul> </li> </ul> <p><i>(note some IV chemo may not require prior authorization)</i></p>
Polatuzumab vedotin-piiq (Polivy <sup>™</sup> )	<p>PART B STEP:</p> <ul style="list-style-type: none"> <li>• <b>Diffuse large B-cell lymphoma (including histologic transformation of indolent lymphoma), high-grade B-cell lymphoma:</b> 1 prior therapy*, unless all of the following are met:               <ul style="list-style-type: none"> <li>○ Prescribed for previously untreated disease</li> <li>○ Prescribed in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone</li> <li>○ Member has an International Prognostic Index (IPI) score or stage modified IPI score <math>\geq 2</math></li> </ul> </li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<ul style="list-style-type: none"> <li>• <b>Post-transplant lymphoproliferative disorder (B-cell type), HIV-related B-cell lymphoma:</b> 1 prior therapy* <i>(note some IV chemo may not require prior authorization)</i></li> </ul>
Ramucirumab (Cyramza <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Esophageal, esophagogastric junction, and gastric cancer:</b> prior lines of systemic therapy* <i>(note some IV chemo may not require prior authorization)</i></li> </ul>
Ranibizumab (Lucentis <sup>®</sup> , Byooviz <sup>®</sup> , Cimerli <sup>™</sup> , Nufymco <sup>™</sup> , Susvimo <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Neovascular (wet) AMD, macular edema following RVO, DME, DR, or myopic choroidal neovascularization (mCNV):</b> intravitreal bevacizumab solution</li> </ul>
Remestemcel-L-rknd (Ryoncil <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Acute graft versus host disease:</b> corticosteroid</li> </ul>
RimabotulinumtoxinB (Myobloc <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Cervical dystonia:</b> Botox and Dysport</li> <li>• <b>Chronic sialorrhea:</b> Xeomin</li> </ul>
Rituximab (Rituxan <sup>®</sup> , Riabni <sup>™</sup> , Ruxience <sup>™</sup> , Truxima <sup>®</sup> ), rituximab/hyaluronidase (Rituxan Hycela <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>All indications,</b> if request is for Rituxan: Ruxience, Truxima, and Riabni</li> <li>• <b>All indications,</b> if request is for Riabni: Ruxience* and Truxima*</li> <li>• <b>All oncology indications,</b> if request is for Rituxan Hycela: member has received at least one full dose of Rituxan, Riabni, Ruxience, or Truxima</li> </ul> IN ADDITION: <ul style="list-style-type: none"> <li>• <b>Rheumatoid arthritis,</b> if request is for Rituxan or Riabni: infliximab*, unless member has had a history of failure of two TNF inhibitors</li> </ul>
Romiplostim (Nplate <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Immune thrombocytopenia:</b> systemic corticosteroid <i>(credit may be given for prior use of intravenous immune globulin or intravenous anti-D [Rho(D) immune globulin])</i></li> <li>• <b>Myelodysplastic syndrome:</b> hypomethylating agent (e.g., azacitadine*, decitabine*) or immunosuppressive therapy (e.g., Atgam*)</li> <li>• <b>Chemotherapy-induced thrombocytopenia:</b> prior chemotherapy* <i>(note some IV chemo may not require prior authorization)</i></li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
Romosozumab-aqqg (Evenity <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Postmenopausal osteoporosis:</b> bisphosphonate, unless member is very high risk for fracture (recent osteoporotic fracture within the past 12 months, BMD T-score at hip or spine <math>\leq -3.0</math>, OR BMD T-score at hip or spine <math>\leq -2.5</math> and major osteoporotic fracture [i.e., hip, spine, forearm, wrist, humerus])</li> </ul>
Sargramostim (Leukine <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>All indications:</b> Zarxio</li> </ul>
Sipuleucel-T (Provenge <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Prostate cancer:</b> androgen deprivation therapy* (e.g., Zoladex, Vantas, leuprolide, Trelstar, Firmagon)</li> </ul>
Talquetamab-tgvs (Talvey <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Multiple myeloma:</b> one of the following:               <ul style="list-style-type: none"> <li>○ If prescribed as a single agent, 4 prior lines of therapy* that include all of the following: immunomodulatory agent (e.g., lenalidomide, Pomalyst, Thalomid), proteasome inhibitor (e.g., bortezomib, Kyprolis), and anti-CD38 antibody (e.g., Darzalex/Darzalex Faspro, Sarclisa)</li> <li>○ If prescribed in combination with Tecvayli, 3 prior lines of therapy*</li> </ul> </li> </ul>
Teclistamab-cqyv (Tecvayli <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Multiple myeloma:</b> one of the following:               <ul style="list-style-type: none"> <li>○ If prescribed as a single agent, 4 prior lines of therapy* that include all of the following: immunomodulatory agent (e.g., lenalidomide, Pomalyst, Thalomid), proteasome inhibitor (e.g., bortezomib, Kyprolis, Ninlaro), and anti-CD38 antibody (e.g., Darzalex/Darzalex Faspro, Sarclisa)</li> <li>○ If prescribed in combination with Talvey, 3 prior lines of therapy*</li> </ul> </li> </ul>
Teprotumumab-trbw (Tepezza <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>Thyroid eye disease:</b> a systemic corticosteroid, UNLESS member has significant proptosis or diplopia</li> </ul>
Tisagenlecleucel (Kymriah <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>• <b>B-cell precursor acute lymphoblastic leukemia:</b> at least two prior systemic therapies*</li> <li>• <b>Large B-cell lymphoma:</b> one of the following:               <ul style="list-style-type: none"> <li>○ 2 lines of systemic therapy that includes rituximab* and one anthracycline-containing regimen (e.g., doxorubicin*)</li> </ul> </li> </ul>

Drug Name	Part B Required Step-Through Agents* By Indication <i>*May require prior authorization</i>
	<ul style="list-style-type: none"> <li>○ Disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy</li> <li>● <b>Relapsed or refractory follicular lymphoma:</b> 2 lines of systemic therapy that includes a combination of an anti-CD20 monoclonal antibody (e.g., rituximab or Gazyva)* and an alkylating agent (e.g., bendamustine, cyclophosphamide, chlorambucil) <i>Only for initial treatment dose; subsequent doses will not be covered</i></li> </ul>
Tocilizumab (Actemra <sup>®</sup> , Avtozma <sup>®</sup> , Tofidence <sup>™</sup> , Tyenne <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Polyarticular juvenile idiopathic arthritis, rheumatoid arthritis:</b> a TNF inhibitor (e.g., infliximab)* <i>(note credit may be given if another TNF inhibitor was tried)</i></li> </ul>
Trastuzumab (Herceptin <sup>®</sup> , Ontruzant <sup>®</sup> , Herzuma <sup>®</sup> , Ogivri <sup>™</sup> , Trazimera <sup>™</sup> , Kanjinti <sup>™</sup> , Hercessi <sup>™</sup> ), trastuzumab/hyaluronidase (Herceptin Hylecta <sup>™</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>All indications</b>, if request is for an agent other than Trazimera or Kanjinti: Trazimera or Kanjinti               <ul style="list-style-type: none"> <li>○ If unable to use Trazimera or Kanjinti and request is for Herceptin or Herceptin Hylecta: biosimilar trastuzumab product (e.g., Hercessi, Ogivri, Ontruzant)</li> </ul> </li> </ul>
Triamcinolone ER injection (Zilretta <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Osteoarthritis of the knee:</b> intra-articular immediate-release glucocorticoid injection</li> </ul>
Vedolizumab (Entyvio <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>All indications:</b> a TNF inhibitor (e.g., infliximab)* <i>(note credit may be given if another TNF inhibitor was tried)</i></li> </ul>
Verteporfin (Visudyne <sup>®</sup> )	PART B STEP: <ul style="list-style-type: none"> <li>● <b>Classic subfoveal choroidal neovascularization (CNV) due to AMD or pathologic myopia:</b> intravitreal bevacizumab solution</li> </ul>

For questions, please reach out to your provider relations.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on FDA recommendation(s), peer-reviewed medical literature, and evidence-based clinical practice guidelines.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan or responsible business unit. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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