



Coverage of any drug intervention discussed in a Medica prior authorization guideline is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and applicable state and/or federal laws.

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- Commercial (Small & Large Group) ASO Exchange/ACA
 Medicare Advantage (MAPD)
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Medica Central Health Plan Step Therapy requirements for Medicare outpatient (Part B) medications

Covered Service: Yes

Prior Authorization Required: Yes

Additional Information: Must be prescribed by specialists with prior authorization through Utilization Management committee.

1.0 Step Therapy will be required for the medications listed in the table below effective 1/1/2025, 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 patient is considered a new start to the non-preferred product (defined as no use in the previous 365 days); AND
- The requested product is necessary for treating the enrollee's condition as the preferred drug(s) has(have) been or is(are) to be less effective or have adverse effects AND
- When there are multiple preferred drugs, unless otherwise specified, only one is required prior to approval of the non-preferred drug; AND
- Step therapy does not apply to patients using a non-preferred product if an indication is not shared by the preferred product or is not supported by treatment guidelines or clinical literature



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Category	Preferred drug(s) Drug A	Non-Preferred drug(s) Drug B
Visco supplements	Synvisc-one, Synvisc, Hyalagan, Hymovis and triluron	durolane, glesyn-3, supartz FX, Synvisc, Euflexxa, Gel-one, Genvisc 850, Mono-visc, Sodium Hyaluronate, TriVisc, Visco-3
Osteoporosis	Oral bisphosphonate trial (alendronate, ibandronate, or risedronate)	Prolia Jubbonti, Wyost (for a diagnosis of osteoporosis with high risk of fracture) and Evenity
Prevention of skeletal related events in patients with multiple	Reclast, zoledronic acid	Xgeva
Treatment of hypercalcemia of malignancy myeloma	Reclast, zoledronic acid	Xgeva
Colony Stimulating Factors Short Acting	Zarxio or Nivestym	Neupogen/Granix/Neupogen
Pegfilgrastim	Fulphila or Nyvepria	Neulasta, Udenyca, Ziextenzo, Rolvedron, Ryzneuta
Filgrastim	Zarxio or Nivestym	Leukine
Avastin	Zirabev	Avastin, Mvasi, Alymsys, Vegzelma, Avzivi
HER 2 Expression	Herumza, or Trazimera	Herceptin, Kanjinti, Ogivri
Rituximab	Truxima or Ruxience	Rituxan hycela, Rituxan
Infliximab	Avsola	Remicade, Renflexis, Inflectra
Migraine	Emgality and Aimovig	Vyepti
Crohn's	Infliximab, adalimumab product or Humira	Entyvio
Rheumatoid Arthritis	Enbrel, adalimumab product or Humira, infliximab	Orencia (Rheumatoid Arthritis)
Rheumatoid Arthritis	Enbrel, adalimumab product or Humira, infliximab	Simponi Aria (Rheumatoid Arthritis)
Rheumatoid Arthritis	Tyenne, Enbrel, adalimumab product or Humira, infliximab	Actemra (Rheumatoid Arthritis)
Polyarticular juvenile idiopathic arthritis (PJIA)	Enbrel, adalimumab product or Humira and Methotrexate inj	Orencia (Polyarticular juvenile idiopathic arthritis (PJIA))



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Polyarticular juvenile idiopathic arthritis (PJIA)	Tyenne, Enbrel, adalimumab product or Humira and Methotrexate inj	Actemra (Polyarticular juvenile idiopathic arthritis (PJIA))
Psoriatic Arthritis	Enbrel, adalimumab product or Humira, Cosentyx, Taltz, Stelara	Orencia (Psoriatic Arthritis)
Psoriatic Arthritis	Enbrel, adalimumab product or Humira, Cosentyx, Taltz, Stelara	Simponi Aria (Psoriatic Arthritis)
ankylosing spondylitis	Enbrel, adalimumab product or Humira, Cosentyx	Simponi Aria (ankylosing spondylitis)
Crohn's Disease	adalimumab product or Humira and infliximab	Tysabri
Crohn's Disease	adalimumab product or Humira, infliximab	Entyvio (Crohn's disease)
Unable to meet LDL goal + heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD)	Lipitor or Crestor	Leqvio (inclisiran)
Unable to tolerate statin therapy + heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD)	Two attempts with statin therapy	Leqvio (inclisiran)
Iron Replacement	Venofer/Infed/Ferrecit/Fereheme	Triferic/Injectafer/Monoferric/Triferic AVNU
High Cholesterol	Repatha or Praluent	Eveeka
Erythropoietic Agents	Retacrit	Procrit
VEGF (intraocular vascular endothelial growth factor inhibitor class)	Bevacizumab	Byooviz, Cimerli, Lucentis (ranibizumab), Eylea, Eyea HD, Vabysmo (patient must try 3 months or 3 injections into same affected eye with min improvement)



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	Committee/Source	Date
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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. 10002, 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 > InternetOnly 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/>

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