Banner
University Health Plans

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 **1/1/23**, 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	Epogen/Procrit (J0885)	Retacrit (Q5106)
Bone resorption inhibitors	Xgeva (J0897) (Only oncology indications)	Zoledronic Acid (J3489) **NAN**[2]
Colony-stimulating factors – leukocyte growth factors (short-acting)	Granix (J1447) Zarxio (Q5101) Releuko (Q5125)	Neupogen (J1442) or Nivestym (Q5110)
Colony Stimulating Factors -Leukocyte Growth Factors (long-acting)	Neulasta (J2506) Ziextenzo (Q5120) Fylnetra (TBD)	Fulphila (Q5108) or Nyvepria (Q5122) or Udenyca (Q5111)
Immunomodulators	Inflectra (Q5103) Remicade and Infliximab (J1745) Renflexis (Q5104)	Avsola (Q5121)

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)
Trastuzumab / Trastuzumab and hyaluronidase-oysk	Herceptin (J9355) Herceptin Hylecta (J9356) Ontruzant (Q5112)	Herzuma (Q5113) Kanjinti (Q5117) Ogivri (Q5114) Trazimera (Q5116)
Rituximab / Rituximab and hyaluronidase	Rituxan (J9312)	Riabni (Q5123) Ruxience (Q5119) Truxima (Q5115)
Immunological Agents	Immune Globulin (asceniv) (J1554) Immune Globulin SQ (Cuvitru) (J1555) Immune Globulin (Gammaplex) (J1557) Gamma Globulin (GamaStan) (J1460) Immune Globulin NOS powder (J1566) Immune Globulin NOS non-lyophilized (J1599) Immune Globulin (Octagam) (J1568) Immune Globulin (Vivaglobin) (J1562) Immune Globulin (Xembify) (J1558)	Immune Globulin (Bivigam) (J1556) or 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)
Oncology (Avastin)	Mvasi (Q5107) or Zirabev (Q5118)	Avastin (J9035) **NAN**[2]
Iron Supplements	Feraheme (Q0138) Injectafer (J1439)	Ferrlecit (J2916) **NAN**[2] or Infed (J1750) **NAN**[2] or Venofer (J1756) **NAN**[2]

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, 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/