Medicare Advantage Part B Step Therapy Program

Updated: August 27, 2024
Effective: December 15, 2024

Step Therapy is a program that uses a "step" approach and requires a trial of preferred drugs in the same class that are as effective before the plan covers non-preferred drugs. For example, if Drug A and Drug B are in the same drug class or category and both drugs treat your medical condition, we may prefer Drug A and require a trial of it first. If Drug A is determined to be ineffective for the member, Drug B may be approved for coverage upon request and subject to medical necessity.

The following list of Preferred Drug Products are included in the Medicare Advantage Part B Step Therapy Program and the listed preferred products should be used first. Coverage will be provided for Step Therapy Part B drugs when it is determined to be medically necessary, in accordance with CMS guidelines. This list of medical drugs (Part B) does not include drugs that process under the Medicare Part D pharmacy benefit, such as self-administered drugs or oral medications.

- This program applies to Medicare Part B drugs for members who are "new" to the drug(s) listed below or members who are currently and actively receiving medications (members with a paid claim within the past 365 days) on the list.
- The ***preferred*** drug products listed below must be used before a ***non-preferred*** drug product can be covered.
- Certain drugs may require prior authorization to ensure safe and effective use, consistent with Medicare rules defined in CMS National Coverage Determination (NCDs) and relevant Local Coverage Determination (LCD) guidelines.
- The drug dose, frequency, and duration of use may not exceed the safety and efficacy data supporting the medical condition.
- A request for an exception from the step therapy requirement to access a Part B covered drug may be submitted and is reviewed through Aspire Health's organization determination process.

This list is subject to change. Please review this list periodically for updates. Aspire Health reserves the right to revise, update, and/or add/remove drugs as new drugs are FDA-approved and become available for use. Notifications will be issued as appropriate.

Bone Density Agents (Osteoporosis)			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Bisphosphonates (IV): • Zoledronic acid (Reclast) • Ibandronate (Boniva)	J3489 J1740	**Preferred** FIRST: Zoledronic acid (Reclast) **Preferred** SECOND: Ibandronate (Boniva)	NO PA / ST REQUIRED
Prolia (denosumab)	J0897	**Preferred** FIRST: Zoledronic acid (Reclast) **Preferred** SECOND: Ibandronate (Boniva)	PA + ST REQUIRED
Jubbonti (denosumab-bbdz) *Biosimilar to Prolia*	J3590	**Preferred** FIRST: Zoledronic acid (Reclast) **Preferred** SECOND: Ibandronate (Boniva	PA + ST REQUIRED
Xgeva (denosumab)	J0897	**Preferred** FIRST: Zoledronic acid (Reclast) **Preferred** SECOND: Ibandronate (Boniva) **Exclude patients with metastatic breast and metastatic prostate per clinical data*	PA + ST REQUIRED
Wyost (denosumab-bbdz) *Biosimilar to Xgeva*	C9399 J3490 J3590 J9999	**Preferred** FIRST: Zoledronic acid (Reclast) **Preferred** SECOND: Ibandronate (Boniva) **Exclude patients with metastatic breast and metastatic prostate per clinical data*	PA + ST REQUIRED

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Intra-articular Corticosteroids (Osteoarthritis)			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Methylprednisolone acetate injection Methylprednisolone sodium succinate injection	**J1010 J2919**	**PREFERRED**	**NO PA / ST REQUIRED**
Triamcinolone acetonide injection Triamcinolone diacetate injection Triamcinolone hexacetonide injection	**J3301 J3302 J3303**	**PREFERRED**	**NO PA / ST REQUIRED**
Zilretta (triamcinolone acetonide ER)	J3304	NON-PREFERRED	PA + ST REQUIRED

Hyaluronic Acids / Viscosupplements (Osteoarthritis)			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Single Injection			
Durolane	**J7318**	**PREFERRED (FIRST)**	**PA REQUIRED**
Gel-One	J7326	NONPREFERRED	PA + ST REQUIRED
Monovisc	J7327	NONPREFERRED	PA + ST REQUIRED
Synvisc-One	J7325	NONPREFERRED	PA + ST REQUIRED
Multiple Injections			
VISCO-3	**J7321**	**PREFERRED (FIRST)**	**PA REQUIRED**
Euflexxa	**J7323**	**PREFERRED (SECOND)**	**PA REQUIRED**
GelSyn-3	**J7328**	**PREFERRED (SECOND)**	**PA REQUIRED**
Hyalgan, Supartz, Supartz FX,	J7321	NONPREFERRED	PA + ST REQUIRED
GenVisc 850	J7320	NONPREFERRED	PA + ST REQUIRED
Hymovis	J7322	NONPREFERRED	PA + ST REQUIRED
Orthovisc	J7324	NONPREFERRED	PA + ST REQUIRED
Synojoynt	J7331	NONPREFERRED	PA + ST REQUIRED
Synvisc	J7325	NONPREFERRED	PA + ST REQUIRED
Triluron	J7332	NONPREFERRED	PA + ST REQUIRED

Note: Hyaluronic Acids constitute a single category. Use any preferred product prior to a non-preferred single or multiple injection viscosupplement.

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Multiple Sclerosis (Infusion)			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Tysabri (natalizumab)	J2323	PREFERRED	PA REQUIRED
Ocrevus (ocrelizumab)	J2350	PREFERRED	PA REQUIRED
Lemtrada (alemtuzumab)	J0202	NONPREFERRED	PA + ST REQUIRED

BIOSIMILARS			
Infliximab Products			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Inflectra (infliximab-dyyb)	Q5103	PREFERRED	PA REQUIRED
Remicade (infliximab)	J1745	NONPREFERRED	PA + ST REQUIRED
Infliximab	J1745	NONPREFERRED	PA + ST REQUIRED
Avsola (infliximab-axxq)	Q5121	NONPREFERRED	PA + ST REQUIRED
Renflexis (infliximab-abda)	Q5104	NONPREFERRED	PA + ST REQUIRED
Zymfentra (infliximab-dyyb)	J3590; Q5136	NONPREFERRED	PA + ST REQUIRED
Rituximab Products			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Ruxience (rituximab-pvvr)	Q5119	PREFERRED	PA REQUIRED
Truxima (rituximab-abbs)	Q5115	NONPREFERRED	PA + ST REQUIRED
Riabni (rituximab-arrx)	Q5123	NONPREFERRED	PA + ST REQUIRED
Rituxan (rituximab)	J9312	NONPREFERRED	PA + ST REQUIRED
Rituxan Hycela (rituximab and hyaluronidase)	J9311	NONPREFERRED	PA + ST REQUIRED

ONCOLOGY BIOSIMILARS			
BEVACIZUMAB PRODUCTS (ONCOLOGY ONLY; NOT APPLICABLE TO OPTHALMOLOGY) *For Colorectal diagnosis: Refer to NCD 110.17: Anti-Cancer Chemotherapy for Colorectal Cancer*			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Avastin (bevacizumab)	J9035	NONPREFERRED	PA + ST REQUIRED
Alymsys (bevacizumab-maly), biosimilar	Q5126	NONPREFERRED	PA + ST REQUIRED
Mvasi (bevacizumab-awwb), biosimilar	**Q5107**	**PREFERRED**	**PA REQUIRED**
Vegzelma (bevacizumab-adcd), biosimilar)	Q5129	NONPREFERRED	PA + ST REQUIRED

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Zirabev (bevacizumab-bvzr), biosimilar	**Q5118**	**PREFERRED**	**PA REQUIRED**
Avzivi (bevacizumab-tnjn)	J3490, J3590	NONPREFERRED *FDA approved December 2023; anticipated availability is currently unknown.	PA + ST REQUIRED
TRASTUZUMAB PRODUCTS			
Herceptin (trastuzumab) *excludes biosimilars*	J9355	NONPREFERRED	PA + ST REQUIRED
Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)	J9356	NONPREFERRED	PA + ST REQUIRED
Enhertu (fam-trastuzumab deruxtecan-nxki)	J9358	NONPREFERRED	PA + ST REQUIRED
Ontruzant (trastuzumab-dttb), biosimilar	Q5112	NONPREFERRED	PA + ST REQUIRED
Herzuma (trastuzumab-pkrb), biosimilar	Q5113	NONPREFERRED	PA + ST REQUIRED
Ogivri (trastuzumab-dkst), biosimilar	**Q5114**	**PREFERRED**	**PA REQUIRED**
Trazimera (trastuzumab-qyyp), biosimilar	**Q5116**	**PREFERRED**	**PA REQUIRED**
Kanjinti (trastuzumab-anns), biosimilar	Q5117	NONPREFERRED	PA + ST REQUIRED
Phesgo (pertuzumab, trastuzumab, hyaluronidase-zzxf)	J9316	NONPREFERRED	PA + ST REQUIRED

Vascular Endothelial Growth Factor (VEGF) Inhibitor (Retinal Disorders Agents)			
Drug Name	**HCPCS**	**Preferred/NonPreferred**	**Requirements**
Avastin (bevacizumab), intravitreal	**C9257 / J7999**	**PREFERRED**	**NO PA / ST REQUIRED**
Eylea (aflibercept)	J0178	NON-PREFERRED	PA + ST REQUIRED
Eylea HD (aflibercept)	J0177	NON-PREFERRED	PA + ST REQUIRED
Lucentis (ranibizumab)	J2778	NON-PREFERRED	PA + ST REQUIRED
Byooviz (ranibizumab-nuna)	Q5124	NON-PREFERRED	PA + ST REQUIRED
Cimerli (ranibizumab-eqrn)	J3590	NON-PREFERRED	PA + ST REQUIRED
Susvimo (ranibizumab implant)	J2779	NON-PREFERRED	PA + ST REQUIRED
Beovu (brolucizumab-dbll)	J0179	NON-PREFERRED	PA + ST REQUIRED
Vabysmo (faricimab)	J2777	NON-PREFERRED	PA + ST REQUIRED

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Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self- administered by the patients who take them. See the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals at: http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf.

This Medicare Part B Step Therapy Drug List is provided for informational purposes only and neither constitutes nor replaces professional medical advice. Physicians, hospitals, and other providers are expected to administer or use drugs/biologicals in the most effective and clinically appropriate manner. Treating physicians and other health care providers is solely responsible for all medical care decisions. In accordance with the member's Evidence of Coverage (EOC), every benefit plan has its own coverage provisions, limitations, and exclusions. In the event of a conflict between this policy and the member's EOC, the member's EOC provisions will take precedence.

The inclusion of a code in this policy does not imply that the health service it describes is covered or not covered. Benefit coverage for health services is determined by the member-specific plan document and applicable laws that may mandate coverage for a particular service. Inclusion of a code does not imply or guarantee reimbursement or payment of a claim. Other Policies and Standards may also apply. Providers are expected to retain or have access to the necessary documentation when requested to support coverage.

References:

- Centers for Medicare and Medicaid Services, Medicare Advantage Prior Authorization and Step Therapy for Part B Drugs. August 7, 2018. Available online at: http://cms.gov.
- Centers for Medicare and Medicaid Services, Internet-Only Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sec. 50. Available online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

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