

MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

iCCHP STATUS	Drug Name	CRITERIA
PA	Alprostadil (Caverject)	<p>For diagnosis of erectile dysfunction: -For BHC members: NOT A COVERED BENEFIT -For Commercial members: -Provider attests to no major drug/drug interactions (phosphodiesterase 5 inhibitors etc.) – approve for #3/30days for 12 months.</p> <p>Last review 3/2025</p>
	Amtagvi (lifileucel) IV	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescriber must be an oncologist • Diagnosis of unresectable or metastatic melanoma (Stage IIIc or Stage IV) • Member must have progressed through at least one prior systemic therapy including a PD-1/PD-L1 blocking antibody and, if BRAF V600 mutation–positive, a BRAF inhibitor or BRAF inhibitor in combination with a MEK inhibitor • Member must have at least one resectable lesion (or aggregate of lesions resected) of a minimum 1.5 cm in diameter post-resection • Eastern Cooperative Oncology Group (ECOG) score of 0 or 1 • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • The safety and effectiveness of repeat administration of Amtagvi has not been evaluated and will not be approved. <p><u>Exclusion:</u></p> <ul style="list-style-type: none"> • Uncontrolled brain metastases • Melanoma of uveal or ocular origin • Systemic steroid therapy for any reason <p><u>Coverage Duration:</u></p> <ul style="list-style-type: none"> • If all of the criteria are met, the initial request will be approved for a one-time treatment. <p>Last review: 6/2025</p>

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C1: CODE 1 RESTRICTION, REFERRING TO A NON-PREFERRED DRUG REQUIRING A CERTAIN CRITERIA WHICH COULD BE CITED ON THE PRESCRIPTION OR COMMUNICATED TO THE PHARMACIST. A PHARMACIST COULD ALSO OBTAIN THIS INFORMATION. NO PA FORM IS NECESSARY TO BE FILLED FOR THIS CONDITION.

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	<p>Beyfortus (nirsevimab-alip)</p>	<ul style="list-style-type: none"> • If member is less than 1 year old, request will be approved • If member is less than 2 years old AND entering their second respiratory syncytial virus (RSV) season, request will be approved with BOTH of the following: <ul style="list-style-type: none"> o The member remains at increased risk for severe respiratory syncytial virus (RSV) disease due to one of the following: <ul style="list-style-type: none"> ▪ Severely immunocompromised ▪ Chronic lung disease of prematurity requiring medical support (e.g., chronic steroid therapy, diuretic therapy, supplemental oxygen) in the 6 months before the start of RSV season ▪ Congenital heart disease ▪ Cystic Fibrosis with manifestations of severe lung disease or weight-for-length <10th percentile ▪ American Indian or Alaska Native ethnicity o Request is for an FDA-approved dose • If member is undergoing cardiac surgery with cardiopulmonary bypass, requests for additional doses will be approved with ALL of the following: <ul style="list-style-type: none"> o Date of scheduled surgery o Date of last Beyfortus dose o Member's weight o Request is for an FDA-approved dose <p>Coverage Duration: If all the criteria are met, the request will be approved for one dose.</p> <p>Last reviewed: 9/2025</p>
	<p>Botulinum Toxins A&B</p> <p>Pharmacy Benefit: Preferred Agents for FDA approved indications: IncobotulinumtoxinA (Xeomin) AbobotulinumtoxinA (Dysport)</p> <p>Non-preferred Agents: OnabotulinumtoxinA (Botox) RimabotulinumtoxinB (Myobloc) DaxibotulinumtoxinA (Daxxify)</p> <p>Or any newly marketed agent</p> <p>Medical Benefit: IncobotulinumtoxinA (Xeomin) AbobotulinumtoxinA (Dysport) OnabotulinumtoxinA (Botox) RimabotulinumtoxinB (Myobloc) DaxibotulinumtoxinA (Daxxify)</p>	<p>**The use of these medications for cosmetic purposes is NOT a covered benefit **</p> <p>For Initial Approval:</p> <ul style="list-style-type: none"> • The drug is being used for a medically accepted indication and dose • The member has tried and failed standard first line therapy for their disease state and/or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not using first line therapy • If the diagnosis is Chronic Migraines (≥15 days per month with headache lasting 4 hours a day or longer), the member has tried and failed, or has a medical reason for not using one drug from two of the following categories for at least 4 weeks each at a minimum effective dose: <ul style="list-style-type: none"> o e.g., Beta blockers (e.g. propranolol, timolol, metoprolol, nadolol or atenolol) or candesartan o Amitriptyline or venlafaxine o Topiramate, divalproex ER or DR, or valproic acid • If the diagnosis is Overactive Bladder, the member has tried and failed 2 formulary drugs (e.g., oxybutynin) • If the diagnosis is Hyperhidrosis, the member has tried and failed a prescription strength antiperspirant (e.g., 20% aluminum chloride hexahydrate [Drysol, Xerac]) • If the diagnosis is Chronic Sialorrhea, <ul style="list-style-type: none"> o Documentation is provided that the member has had sialorrhea lasting at least 3 months o The member has tried and failed, or has a medical reason for not using, an anticholinergic medication (e.g., glycopyrrolate, hyoscyamine, benztropine) • For requests under the pharmacy benefit: if the request is for a non-preferred agent, the member tried and failed a preferred agent if appropriate for the requested indication • For requests under the medical benefit, all botulinum toxins are co-preferred <p>For Reauthorization:</p> <ul style="list-style-type: none"> • Documentation of provider attestation that demonstrates a clinical benefit • The requested drug is for a medically accepted indication and dose <p>If all of the conditions are met, the request will be approved for 12 month duration.</p> <p>Last Review: 12/2025</p>

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	<p>Cortrophin (corticotropin)</p> <p><u>Formulary:</u> Cortrophin (corticotropin)</p> <p><u>Non-formulary:</u> Acthar Gel (corticotropin)</p>	<p>Criteria for Use</p> <ul style="list-style-type: none"> • Medication is being requested for an FDA approved indication • Member has a documented trial and failure of corticosteroids, or a documented medical reason for why the member cannot use corticosteroids for treatment • Prescriber is a specialist in the condition they are treating • If the request is for a non-formulary product, trial and failure of, contraindication to or medical reason for not using the preferred product is required <p>Coverage Duration</p> <ul style="list-style-type: none"> • If all of the criteria are met, the initial request will be approved for 4 weeks. For continuation of therapy, the request will be approved for 4 weeks. <p>Last review: 6/2025</p>
<p>PA</p>	<p>Daptomycin (Cubicin RF)</p>	<p>Criteria for use:</p> <ol style="list-style-type: none"> 1. Prescribed dosing is within FDA approved indications and/or supported by medical compendium. <ol style="list-style-type: none"> a. The indicated diagnosis must be supported by documentation from medical records and include any applicable labs including culture and sensitivities 2. Tried and failed or contraindications to an alternative antibiotic that the organism is susceptible to (examples of alternative antibiotics may include, but are not limited to vancomycin, cefazolin, nafcillin, TMP/SMX, doxycycline, cephalexin, clindamycin) or documented reason why a trial and failure of a preferred antibiotic is clinically inappropriate <ol style="list-style-type: none"> a. Demonstration of failure must include a culture and sensitivity test identifying an organism that exhibits resistance to other possible antimicrobial agents. <p>Last review 9/2025</p>

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<p>PA</p>	<p>Erythropoiesis-Stimulating Agents</p> <p>Aranesp (darbepoetin alfa) Procrit (epoetin alfa) Epogen (epoetin alfa) Retacrit (epoetin alfa-epbx) Mircera (Methoxy polyethylene glycol-epoetin beta)</p>	<p>Criteria for authorization of Mircera:</p> <p>Must meet criteria below:</p> <ul style="list-style-type: none"> • Must have a diagnosis of anemia secondary to chronic kidney disease Hemoglobin <10g/dL and/or Hematocrit (Hct)<30% at first initiation (may not apply if another erythropoiesis stimulating agent has been used) <p>Criteria for authorization of existing epoetin and darbepoetin users who are NEW to the plan:</p> <ul style="list-style-type: none"> • Drug is being prescribed for an FDA-approved indication at an FDA-approved dose or is otherwise supported by the compendia or standard-of-care guidelines • Documentation of current dose • The member's HgB is within the following indication specific range: <ul style="list-style-type: none"> ○ Anemia of CKD: ≤ 11 g/dL ○ Anemia related to cancer: ≤ 12 g/dL ○ Zidovudine related anemia in members with HIV: HgB ≤ 12 g/dL ○ Ribavirin-induced anemia: HgB ≤ 12g/dL <p>Criteria for approval of ALL epoetin and darbepoetin REQUESTS:</p> <ul style="list-style-type: none"> • All lab results submitted must have been drawn within 30 days of request • The following lab results must be submitted: <ul style="list-style-type: none"> ○ Hemoglobin (HgB) ○ Hematocrit (HCT) • Normal lab results or, if abnormally low, appropriate supplementation as follows <ul style="list-style-type: none"> ○ serum ferritin level (normal is > 100 ng/mL) ○ transferrin saturation (TSAT) (normal is > 20%) ○ vitamin B12 level (> 223 pg/mL) ○ folate level (> 3.1 ng/mL) • The medication is being prescribed at an FDA appropriate dose and indication, as indicated in compendia or standard of care guidelines. • If approved, Procrit OR Epogen OR Retacrit must be used. Aranesp is non-preferred, and will only be approved if patient is intolerant to Procrit or Epogen or Retacrit. <p>Criteria for approval for anemia of chronic kidney disease:</p> <ul style="list-style-type: none"> • Hemoglobin less than or equal to 10 g/dl <p>Initial approval for anemia due to cancer:</p> <ul style="list-style-type: none"> • Member must have a documented cancer diagnosis for which they are receiving myelosuppressive therapy for palliative treatment (members receiving myelosuppressive therapy with curative intent should not receive ESAs) AND documented symptomatic anemia with Hb <10 g/dl • OR Member must have symptomatic anemia related to myelodysplastic syndrome AND documented serum erythropoietin level < 500 mU/ml <p>Initial approval for anemia due to zidovudine-treated HIV infected patients:</p> <ul style="list-style-type: none"> • Patient has been receiving a highly reactive antiretroviral therapy (HAART) regimen for the past 35 days. • erythropoietin level ≤500 units/mL <p>Initial approval for ribavirin-induced anemia:</p> <p>Initial approval for ribavirin-induced anemia:</p>
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	(Continued) ESA agents	<p>Requests for members undergoing surgery to reduce the need for allogenic blood transfusion:</p> <ul style="list-style-type: none"> • Perioperative HgB < 13g/dL and > 10 g/dL. • The member is scheduled for an elective, non-cardiac, nonvascular surgery <p>Reauthorization:</p> <ul style="list-style-type: none"> • All submitted lab results have been drawn within 30 days of the reauthorization request. • The following lab results must be submitted: <ul style="list-style-type: none"> • Hemoglobin (HgB) • Repeat normal labs, or appropriate supplementation as follows: <ul style="list-style-type: none"> • serum ferritin (> 100 ng/mL) • TSAT (> 20%) • vitamin B12 level (>223 pg/mL) • folate level (>3.1 ng/mL) • For anemia of CKD: HgB ≤ 11g/dL • For anemia related to cancer: HgB ≤ 12 g/dL • For zidovudine-related anemia in members with HIV: HgB ≤ 12 g/dL • For ribavirin-induced anemia: HgB ≤ 12 g/dL • An increase in dose has not occurred more than once every 4 weeks • The medication is being recommended and/or prescribed at an FDA appropriate dose for indication, or as indicated in compendia or standard of care guidelines <p>Last review 3/2025</p>
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<p>PA</p>	<p>Denosumab (Prolia) and Biosimilars:</p> <ul style="list-style-type: none"> • Bildyos • Jubbonti • Conexence • Stoboclo • Ospomyv 	<p>For all requests:</p> <ul style="list-style-type: none"> • The member is taking calcium and vitamin D (not required for oncology diagnoses) • The member has a documented (consistent with pharmacy claims) adequate trial of an oral bisphosphonate or has a medical reason (e.g. intolerance, hypersensitivity, contraindication, very high risk status or prior fracture etc.) for not using an oral bisphosphonate • The member has a documented trial and failure with the biosimilar Bildyos (denosumab-nxxp), or has a medical reason (intolerance, hypersensitivity, contraindication, etc.) for not utilizing this agent to manage their medical condition <p><u>If the diagnosis is Androgen deprivation-induced bone loss in males with prostate cancer:</u></p> <ul style="list-style-type: none"> • Approve request <p><u>If the diagnosis is Aromatase inhibitor- induced bone loss in females with breast cancer</u></p> <ul style="list-style-type: none"> • Trial and failure, intolerance, or medical reason (i.e. renal insufficiency) not to use zoledronic acid <p><u>If the diagnosis is osteoporosis:</u></p> <ul style="list-style-type: none"> • Documentation was submitted indicating member is a postmenopausal woman or a male member over 50 years of age with a bone mineral density (BMD) value consistent with osteoporosis (T-score equal to or less than -2.5) OR has had an osteoporotic fracture OR member has a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability >3% or a 10 year major osteoporosis-related fracture probability >20%, based on the US-adapted WHO absolute fracture risk model • Trial and failure, intolerance, or medical reason not to use zoledronic acid infusion <p><u>If the diagnosis is glucocorticoid-induced osteoporosis:</u></p> <ul style="list-style-type: none"> ▪ For members ≥ 40 years of age on long-term glucocorticoid therapy: <ul style="list-style-type: none"> • Dosage of the glucocorticoid therapy is greater than 2.5 mg of prednisone daily or its equivalent for a minimum of 3 months • Member has a moderate to very high risk of fracture based on ONE of the following: <ul style="list-style-type: none"> • History of osteoporotic fracture (very high risk) • BMD less than or equal to -1 at the hip or spine (moderate to very high risk) • FRAX® (GC-Adjusted) 10-year risk of major osteoporotic fracture (MOF) ≥30% or hip ≥4.5% (very high risk) • FRAX® (GC-Adjusted) 10-year risk of MOF ≥20% but <30% or hip ≥3% but <4.5% (high risk) • FRAX® (GC-Adjusted) 10-year risk of MOF ≥10 and <20%, hip >1 and <3% (moderate risk) • Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate or zoledronic acid infusion ▪ For adult members (all ages) receiving HIGH dose glucocorticoid therapy: <ul style="list-style-type: none"> • Member has a moderate to very high risk of fracture based on ONE of the following: <ul style="list-style-type: none"> • Has a history of prior fracture(s) (very high risk) • Glucocorticoid ≥30mg/day or cumulative ≥5grams/year (very high risk) • Continuing glucocorticoid treatment ≥7.5mg/day for ≥6 months AND BMD Z score < -3 OR significant BMD loss (> least significant change of DXA) (moderate risk) • Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate or zoledronic acid infusion <p>Last reviewed: 12/2025</p>
<p>PA</p>	<p>Denosumab (Xgeva) and Biosimilars:</p>	<p>CCHP Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • The indicated diagnosis is bone metastases from solid tumors, multiple myeloma

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	<ul style="list-style-type: none"> • Bilprevda • Wyost • Bomynta • Osenvelt • Xbryk 	<p>osteolytic lesions, or hypercalcemia of malignancy (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient’s medical records.</p> <ul style="list-style-type: none"> • Must have tried, failed, not tolerated or contraindications (i.e. renal insufficiency) to pamidronate or zoledronic acid infusion • The member has a documented trial and failure with the biosimilar Bilprevda (denosumab-nxxp), or has a medical reason (intolerance, hypersensitivity, contraindication, renal insufficiency, etc.) for not utilizing this agent to manage their medical condition <p>*If the medication request is for treating Giant Cell Tumor of the bone, the patient must have documentation that the cancer is unresectable (e.g. denosumab is being used to aid in resection by shrinking the tumor) or that surgical resection is likely to result in morbidity or that disease has recurred</p> <p>Last review 12/2025</p>
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<p>PA</p>	<p>Gene Therapies for Regular Red Blood Cell (RBC) Transfusion Dependent Beta-Thalassemia</p> <p>Casgevy (exagamglogene autotemcel) Zynteglo (betibeglogene autotemcel)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> The prescriber must be a hematologist Medication is prescribed at an FDA approved dose Member has a diagnosis of transfusion dependent beta-thalassemia Member requires regular RBC transfusions defined as ONE of the following: <ul style="list-style-type: none"> History of ≥ 100 mL/kg/year of packed red blood cell (pRBCs) in the past 2 years History of ≥ 8 transfusions of pRBCs per year in the past 2 years Patient has not had a prior HSCT or gene therapy treatment If the request is for Zynteglo, a medical reason must be submitted why the patient is unable to use Casgevy Negative pregnancy test (if applicable) <p>The safety and effectiveness of repeat administration of Zynteglo or Casgevy have not been evaluated and will not be approved.</p> <p>Exclusion: Repeat use of same gene therapy agent Trial of a different gene therapy agent after another has been used</p> <p>Coverage Duration: If all the criteria are met, the initial request will be approved for a one-time treatment for one gene therapy agent.</p> <p>Last review: 3/2025</p>
<p>PA</p>	<p>Gene therapies for sickle cell disease</p> <p>Casgevy (exagamglogene autotemcel) Lyfgenia (lovotibeglogene autotemcel)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> The prescriber must be a hematologist or specialist in the treatment of sickle cell disease Medication is prescribed at an FDA approved dose Member has a diagnosis of sickle cell disease Member has experienced at least 2 severe vaso-occlusive crises/events (VOE) per year in the past 2 years defined as either: <ul style="list-style-type: none"> VOE requiring a hospitalization or multiple visits to an emergency department/urgent care over 72 hours and receiving intravenous medications at each visit priapism lasting > 2 hours and requiring a visit to a medical facility acute chest syndrome splenic sequestration hepatic sequestration Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose and has been compliant within the last 6 months (or a medical reason was provided why the patient is unable to use hydroxyurea) Documentation was provided that the member had a trial and failure of, or a medical reason was provided why the patient is unable to trial two of the following agents <ul style="list-style-type: none"> L-glutamine (Endari) Adakveo Prescriber attests pregnancy has been ruled out prior to initiation of treatment (if applicable) Patient has not had a prior HSCT or gene therapy treatment

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		<ul style="list-style-type: none"> If the request is for Lyfgenia, a medical reason must be submitted why the patient is unable to use Casgevy. <p>The safety and effectiveness of repeat administration of Casgevy or Lyfgenia have not been evaluated and will not be approved.</p> <p>Exclusion: Repeat use of same gene therapy agent Trial of a different gene therapy agent after another has been used</p> <p>Coverage Duration: If all the criteria are met, the initial request will be approved for a one-time treatment for one gene therapy agent.</p> <p>Last review: 12/2025</p>
PA	Etelcalcetide (Parsabiv)	<p>Criteria for use (bullet points below are all inclusive unless otherwise noted): The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records</p> <p>Serum calcium level must be ≥ 8.4 mg/dL</p> <ul style="list-style-type: none"> Secondary Hyperparathyroidism (HPT) in patients with chronic kidney disease (CKD) on dialysis- <p>For this indication, the member must also meet all of the following conditions:</p> <ul style="list-style-type: none"> Patient must have tried and failed or been intolerant to, or have a medical reason not to use at least one phosphate binder Patient must have tried and failed or been intolerant to, or have a medical reason not to use calcitriol or paricalcitol iPTH level must be at least $< 2-9x$ the ULN for the PTH assay Patient must have tried and failed or found to be intolerant to Sensipar tablets as defined by the following criteria: <ul style="list-style-type: none"> An adequate trial would be defined as at least 90 consecutive days of Sensipar fills (as seen in claims data) within the past 120 days. A Sensipar failure would be defined as an inability to control sx/labs with adequate titration and adherence to Sensipar. A Sensipar intolerance would be defined as an adverse event related to Sensipar that makes continued use of the medication relatively or absolutely contraindicated. <p>last review 3/2025</p>

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

	<p>*MEDICAL BENEFIT POLICY*</p> <p>Gene Therapy for Hemophilia B</p> <p>Hemgenix (etranacogene dezaparvovec)</p> <p>Beqvez (fidanacogene elaparvovec-dzkt)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> The prescriber must be a hematologist Diagnosis of Hemophilia B (congenital Factor IX deficiency) with ONE of the following: <ul style="list-style-type: none"> Currently using Factor IX prophylaxis therapy Has current or historical life-threatening hemorrhage Has repeated, serious spontaneous bleeding episodes Documentation that patient has $\leq 2\%$ of normal circulating Factor IX Prescriber attests they have performed liver health assessments, including enzyme testing and hepatic ultrasound and elastography Documented Factor IX inhibitor titer test showing the patient is negative for Factor IX inhibitors For Beqvez: Patient does not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test Patient's weight Medication is prescribed at an FDA approved dose <p>The safety and effectiveness of repeat administration of Hemgenix or Beqvez have not been evaluated and will not be approved.</p> <p>Last review: 9/2025</p>
<p>PA</p>	<p>Fosaprepitant (Emend IV)</p>	<p>FDA Approved indications:</p> <p>1. In combination with other anti-emetics for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly or moderately emetogenic cancer chemotherapy</p> <p>Duration of therapy: Days 1-3 of each chemotherapy cycle</p> <p>Criteria for use for highly emetogenic chemotherapy:</p> <ul style="list-style-type: none"> Concurrent use of dexamethasone, (+/- olanzapine), and a 5HT3 antagonist (if the member is of pediatric age, dexamethasone is not required) <p>Criteria for use for moderately emetogenic chemotherapy:</p> <ul style="list-style-type: none"> Concurrent use of 5HT3 antagonist and dexamethasone antiemetic therapy (if the member is of pediatric age, dexamethasone is not required) <p>Not approved if:</p> <ul style="list-style-type: none"> Use beyond days 1-4 of chemotherapy cycle Without concomitant dexamethasone therapy (does not apply for pediatric members) <p>Breakthrough nausea and vomiting</p> <p>Last review: 9/2025</p>
<p>PA</p>	<p><u>Hyaluronic acid derivatives</u></p> <p>Preferred: Hyaluronic acid (Hyalgan®, Supartz®,) Hyaluronic acid (Durolane®)</p> <p>Non-Preferred: Gel-One®, Gelsyn-3 Orthovisc®, Synvisc®, Euflexxa®)</p>	<p>Criteria for use:</p> <ul style="list-style-type: none"> Diagnosis by an orthopedic specialist Non-preferred hyaluronic acid products must have tried and failed J7321 (Supartz, Hyalgan) Non-preferred agents may be authorized if it is re-authorization for continuation of therapy <p>Last review: 6/2025</p>
<p>PA</p>	<p>*MEDICAL BENEFIT POLICY*</p> <p>Preferred</p> <p>Infliximab (Janssen) 57894-0160-01</p> <p>Avsola (infliximab-axxq) Q5121</p>	<p>Axial Spondyloarthritis/ Ankylosing Spondylitis/ Nonradiographic Axial Spondyloarthritis</p> <ul style="list-style-type: none"> Diagnosed axial spondyloarthritis/ ankylosing spondylitis/ nonradiographic axial spondyloarthritis by a rheumatologist Trial and failure, intolerance, or reason not to use two nonsteroidal anti-inflammatory drugs (NSAIDs), one of which must be a COX-2 selective inhibitor <p>Crohn's Disease/Fistulizing Crohn's Disease</p> <ul style="list-style-type: none"> Diagnosis of Crohn's disease by a gastroenterologist If the member has a diagnosis of severe-fulminant, moderate-severe, or perianal/fistulizing Crohn's disease – approve If the member has a diagnosis of mild-to-moderate/low-risk Crohn's disease, the

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

	<p><u>Non-preferred</u></p> <p>Renflexis (infliximab-abda) Q5104</p> <p>Inflectra (infliximab-dyyb) Q5103</p> <p>Zymfentra (infliximab-dyyb)</p>	<p>following is required: an adequate trial or a documented medical reason for not using conventional therapy to manage the condition (e.g. sulfasalazine, budesonide ER (Uceris), azathioprine, 6-mercaptopurine, or methotrexate)</p> <p><u>Psoriatic arthritis</u></p> <ul style="list-style-type: none"> • Diagnosed with psoriatic arthritis by a rheumatologist • Failed/intolerant to at least one NSAID (members with axial disease or enthesitis, do not have to try and fail a conventional DMARD) AND • Failed/intolerant to at least one conventional DMARD, such as: <ul style="list-style-type: none"> ○ Methotrexate, hydroxychloroquine, sulfasalazine, azathioprine, and/or leflunomide <p><u>Plaque Psoriasis</u></p> <ul style="list-style-type: none"> • Diagnosed plaque psoriasis by a dermatologist • Failed/Intolerant to at least 3 of the following, at least one of which must be either systemic therapy or phototherapy: <ul style="list-style-type: none"> ○ Topical steroids ○ Topical tacrolimus or pimecrolimus ○ Dovonex (calcipotriene) Tazorac (tazarotene), anthralin or a coal tar preparation that is indicated ○ Methotrexate ○ Cyclosporine ○ Soriatane (acitretin) ○ UVB phototherapy or PUVA (psoralen-oral or topical methoxsalen plus UVA therapy) <p><u>Rheumatoid Arthritis:</u></p> <ul style="list-style-type: none"> • Diagnosed rheumatoid arthritis by a rheumatologist • Failed/Intolerant to methotrexate (or another conventional DMARD, such as hydroxychloroquine, sulfasalazine, or leflunomide) <p><u>Ulcerative Colitis:</u></p> <ul style="list-style-type: none"> • Diagnosed ulcerative colitis by a gastroenterologist • If the member has a diagnosis of moderate-severe ulcerative colitis – approve. • If the member has a diagnosis of mild-moderate ulcerative colitis, the following is required: an adequate trial of, or medical reason for not using, conventional therapy to manage the condition (e.g. oral aminosalicylates, azathioprine, 6-mercaptopurine, or oral corticosteroids) <p>For all requests: Trial and failure, intolerance, or inability to use Avsola or Infliximab (branded Janssen product) required for approval of Remicade, Renflexis, or Inflectra</p> <p>Last review: 6/2025</p>
<p>PA</p>	<p>Iron Sucrose IV (Venofer)</p> <p>Iron Dextran (Infed)</p> <p>Sodium ferric gluconate (Ferrlecit)</p> <p>Ferumoxytol (Feraheme)</p> <p>Ferric derisomaltose (Monoferric)</p>	<p>Must meet criteria below:</p> <ul style="list-style-type: none"> • Laboratory evidence of iron deficiency anemia <ul style="list-style-type: none"> ○ Iron <40mcg/dL, TIBC>410 mcg/dL, SI/TIBC <10%, ferritin <10ng/mL, Hgb<10 • Trial and failure, intolerance, or relative contraindication to oral iron supplementation <p>OR</p> <ul style="list-style-type: none"> • Continued blood loss <ul style="list-style-type: none"> ○ If patient has CKD with Hemodialysis and is on ESA therapy, Serum iron/TIBC must be <30% <p>**Preferred agents are listed – all other agents are non-preferred**</p> <p>Last review 6/2025</p>

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	<p>Lenmeldy (atidarsagene autotemcel)</p>	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescriber must be a neurologist, hematologist/oncologist, or geneticist • Member has diagnosis of one of the following metachromatic leukodystrophies (MLD): <ul style="list-style-type: none"> ○ Pre-symptomatic late infantile (PSLI) MLD ○ Pre-symptomatic early juvenile (PSEJ) MLD ○ Early symptomatic early juvenile (ESEJ) MLD • Documentation patient has both of the following: <ul style="list-style-type: none"> ○ Arylsulfatase A (ARSA) activity below the normal range (normal range 31-198 nmol/mg/h) ○ Identification of two disease-causing ARSA alleles • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • The safety and effectiveness of repeat administration of Lenmeldy has not been evaluated and will not be approved. <p><u>Coverage Duration:</u></p> <ul style="list-style-type: none"> • If all the criteria are met, the initial request will be approved for a one-time treatment.. <p>Last Review 6/2025</p>
<p>PA</p>	<p>Linezolid (Zyvox®)</p>	<p><u>PA CRITERIA FOR APPROVAL</u></p> <ul style="list-style-type: none"> • Documented history of treatment with linezolid IV (continuation of therapy, IV to PO conversion). OR <p>Both of the following:</p> <ul style="list-style-type: none"> • Prescribed dosing is within FDA approved indications and/or supported by medical compendium <ul style="list-style-type: none"> • The indicated diagnosis must be supported by documentation from medical records and include any applicable labs • Documentation that the infection is susceptible to Zyvox AND the patient has failed treatment or is contraindicated to treatment with preferred antibiotics to which the organism is susceptible. <p>If the above conditions are met, the request will be approved with up to a 1 month duration depending on the type of infection</p> <p>Last review 9/2025</p>

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

	<p style="text-align: center;">Nemluvio (nemolizumab-ilto)</p>	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Patient must be 18 years of age or older • Prescriber must be an allergist, immunologist, or a dermatologist • Diagnosis of severe prurigo nodularis (PN) with ≥ 6 weeks of pruritus • Member has ≥ 20 PN lesions • Documentation of patient’s weight • Member has a ≥ 2-week trial of one of the following: <ul style="list-style-type: none"> ▪ Moderate potency or higher topical corticosteroid (TCS) ▪ Topical calcineurin inhibitor (TCI) • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (reduced nodular lesion count, decreased pruritis, etc.) • Documentation of patient’s weight • Medication is prescribed at an FDA approved dose <p><u>Coverage Duration:</u> If the criteria are met, the initial request will be approved for a 6 month duration and reauthorization request for a 12 month duration.</p> <p>Last review: 12/2025</p>
<p>PA</p>	<p>Neulasta (pegfilgrastim) Neulasta Onpro (pegfilgrastim) Fulphila (pegfilgrastim-jmdb) Udenyca (pegfilgrastim-cbqv) /Udenyca Onbody Ziextenzo (pegfligtastim-bmez) Nyvepria (pegfilgrastim-apgf) Stimufend (pegfilgrastim-fpgk) Fylnetra (pegfilgrastim-pbbk)</p>	<p>Drug is being used for an FDA-approved indication at an FDA-approved dose and duration</p> <p>Duration of therapy: once each chemotherapy cycle</p> <p>Criteria for use:</p> <ul style="list-style-type: none"> • For ALL requests for treatment or prophylaxis of febrile neutropenia: Documentation of the patient’s absolute neutrophil count (ANC) within the last 30 day has been provided. <p>Not approved if:</p> <ul style="list-style-type: none"> • Given 14 days before administration of chemotherapy. • Chemotherapy regimens with under a two week cycle. • ANC greater than $1 \times 10^9/L$ ($1000/mm^3$). <p>Febrile neutropenia defined as (all inclusive):</p> <ul style="list-style-type: none"> • An ANC of less than $0.5 \times 10^9/L$ ($500/mm^3$) or less than $1 \times 10^9/L$ ($1000/mm^3$) and predicted to fall below $0.5 \times 10^9/L$ ($500/mm^3$) within 48 hours. • Fever or other clinical signs/symptoms of sepsis. <p>All pegfilgrastim and biosimilar pegfilgrastim products are co-preferred</p> <p>Last review 9/2025</p>

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<p>PA</p>	<p>Neupogen (filgrastim) Zarxio (filgrastim-sndz) Q5101 Nivestym (filgrastim-aafi) Q5110 Granix (tbo-filgrastim) J1447 Releuko (filgrastim-ayow) J3590 Nypozi (filgrastim-txid)</p>	<p>Drug is being used for an FDA-approved indication at an FDA-approved dose and duration.</p> <p>Criteria for use:</p> <ul style="list-style-type: none"> For ALL requests for treatment or prophylaxis of febrile neutropenia: Documentation of the patient's absolute neutrophil count (ANC) within the last 30 day has been provided. <p>Not approved if:</p> <ul style="list-style-type: none"> ANC greater than $1 \times 10^9/L$ ($1000/mm^3$) <p>For all requests: Trial and failure, intolerance, or inability to use a Nivestym or Releuko is required for approval of Granix, Zarxio, Nypozi, or Neupogen</p> <p>Last review 6/2025</p>
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<p>PA</p>	<p>Non-Preferred/ Prior Authorization Required Medications</p> <p>Non-preferred, Non-Formulary and/or specialty drugs without drug or class specific prior authorization criteria</p> <p>Brand drugs and reference biologics when a therapeutic equivalent generic drug or biosimilar/interchangeable biologic is available</p>	<p>Authorization:</p> <ul style="list-style-type: none"> • The drug is requested for an appropriate use (per the references outlined in “Covered Uses”) • The dose requested is appropriate for the requested use (per the references outlined in “Covered Uses”) • Patient meets one of the following criteria: <ul style="list-style-type: none"> ○ Documented trial and failure or intolerance with up to two formulary/preferred medications appropriate for the requested use (per the references outlined in “Covered Uses” or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication). For medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. ○ Documented trial and failure or intolerance with the two separate formulary components of the combination medication OR two separate therapeutic equivalents to the components of the combination medication, if available on formulary OR the provider has submitted a medical reason why the requested combination medication would be superior to the required prerequisite trial(s) with formulary drug(s) [e.g. Yosprala (aspirin/omeprazole), the two separate components would need to be tried and failed] ○ No other preferred medication has a medically accepted use for the patient’s specific diagnosis as referenced in the medical compendia. ○ All other preferred medications are contraindicated based on the patient’s diagnosis, other medical conditions, or other medication therapy. • If the request is for a brand drug with a therapeutically equivalent (A-rated) generic drug currently available, documentation of the following: <ul style="list-style-type: none"> ○ The provider either verbally or in writing has submitted a medical or member specific reason why the brand name drug is required based on the member’s condition or treatment history; AND if the member had side effects or a reaction to the generic drug, the provider has completed and submitted an FDA MedWatch form to justify the member’s need to avoid these drugs. The MedWatch form must be included with the prior authorization request • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available, documentation of one of the following: <ul style="list-style-type: none"> ○ The prescriber has verbally or in writing submitted a medical or member specific reason why the reference biologic is required based on the member’s condition or treatment history; AND if the member had side effects or a reaction to all biosimilar or interchangeable biologics, the provider has completed and submitted an FDA MedWatch form to justify the member’s need to avoid these drugs. The MedWatch form must be included with the prior authorization ○ The currently available biosimilar product(s) does not have the same appropriate use (per the references outlined in “Covered Uses”) as the reference biologic drug being requested <p>COVERED USES: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines</p> <p>If the above conditions are met, the request will be approved with up to a 12 month duration depending upon the diagnosis and usual treatment therapies</p> <p>Last Review 12/2025</p>
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<p>PA</p>	<p>Non-formulary and prior authorization required medication oral liquid formulations</p>	<p>Non-formulary and prior authorization-required oral liquid formulations, where solid oral dosage forms exist, are approved when the following criteria are met:</p> <ul style="list-style-type: none"> • For members ≤ 12 years of age <ul style="list-style-type: none"> ○ Approve • For members > 12 years of age <ul style="list-style-type: none"> ○ Documentation of difficulty swallowing, inability to swallow, or unable to use oral tablet formulation. <p>Last review: 9/2025</p>
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	<p>Spevigo (spesolimab-abzo)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Prescriber must be a dermatologist or geneticist • Member has a diagnosis of generalized pustular psoriasis(GPP) • The drug is being prescribed for an FDA approved age at an FDA approved dose • For an acute GPP flare (IV vial), member must be experiencing an acute flare of GPP of moderate to severe intensity as defined by having all of the following: <ul style="list-style-type: none"> ○ Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of 3 or greater ○ Presence of fresh pustules (new appearance or worsening of pustules) ○ GPPPGA pustulation sub score of 2 or greater ○ At least 5% of body surface area covered with erythema and the presence of pustules • For maintenance treatment (SQ syringe), member must have all of the following: <ul style="list-style-type: none"> ○ History of at least two GPP flares in the past year of moderate to severe intensity ○ GPPPGA score of 0 or 1 ○ Documented trial and failure, intolerance, or contraindication to TWO of the following: oral retinoids, methotrexate, and cyclosporine <p>Reauthorization:</p> <ul style="list-style-type: none"> • If request is for an acute GPP flare (IV vial), member must have achieved a clinical response, defined as achieving a GPPPGA score of 0 or 1, to previous treatment and is now experiencing a new flare • If request is for maintenance treatment of GPP (SQ syringe), member must have documentation of positive clinical response to therapy (i.e., reduction in GPP flares) • Medication is prescribed at an FDA approved dose <p>Acute Flares (IV vial): If all of the criteria are met, the request will be approved for up to 2 doses.</p> <p>Maintenance Treatment (SQ syringe): If all criteria are met, the initial request will be approved for 12 months. Reauthorization requests will be approved for 12 months.</p> <p>Last review: 6/2025</p>
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<p>PA</p>	<p>Synagis (palivizumab)</p>	<p><u>Infants less than 1 year of age at the onset of the RSV season (which typically starts November 1st, but may vary seasonally) must have a documented medical reason for not being able to use Beyfortus (nirsevimab-alip) AND have one of the following indications:</u></p> <ul style="list-style-type: none"> • Born at less than 29 weeks, 0 days gestation • Born at less than 32 weeks, 0 days gestation AND had chronic lung disease of prematurity defined as greater than 21% oxygen for at least 28 days after birth • Born at any gestational age with hemodynamically significant heart disease including: <ul style="list-style-type: none"> o Cyanotic heart disease in consultation with a pediatric cardiologist o Acyanotic Heart disease with one of the following: <ul style="list-style-type: none"> ▪ On heart failure medication and expected to require cardiac surgical procedure ▪ Moderate to severe pulmonary hypertension • Cystic fibrosis with clinical evidence of chronic lung disease (CLD) and/or nutritional compromise in the first year of life • Born at any gestational age with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the lower airway <p><u>Infants less than 2 years of age at the onset of the RSV season (which typically starts November 1st, but may vary seasonally) must have a documented medical reason for not being able to use Beyfortus (nirsevimab-alip) AND have one of the following indications:</u></p> <ul style="list-style-type: none"> • Born at less than 32 weeks, 0 days AND had a diagnosis of chronic lung disease of prematurity at birth as defined above AND had continued need for one of the following respiratory interventions in the 6 months preceding RSV season: Chronic steroids, chronic diuretics, supplemental oxygen • Cystic fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length less than the 10th percentile • Born at any gestational age and will be profoundly immunocompromised during the RSV season, including: <ul style="list-style-type: none"> o Solid organ or hematopoietic stem cell transplant recipient o Chemotherapy recipient • Born at any gestational age and receiving a cardiac transplant <p>Coverage Duration: A maximum of 5 doses may be approved within the Respiratory Syncytial Virus (RSV) season. Requests for additional doses will be reviewed on a case-by case basis based on CDC surveillance reports, state/local health department recommendations, and other current medical literature.</p> <p>Exclusion: Members who have received Beyfortus (nirsevimab-alip) for the current respiratory syncytial virus (RSV) season</p> <p>Last review 9/2025</p>
<p>PA</p>	<p>Vaccines</p>	<ul style="list-style-type: none"> • Must match CDC recommendations <p>Last review 2/2025</p>

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

	<p>*MEDICAL BENEFIT POLICY*</p> <p>Vascular Endothelial Growth Factor (VEGF) Inhibitors for Ophthalmic Conditions</p> <p><u>Preferred:</u> Avastin (bevacizumab) Byooviz (ranibizumab-nuna) Lucentis (ranibizumab) Eylea (afibercept)</p> <p><u>Non-Preferred:</u> Beovu (brolucizumab) Cimerli (ranibizumab-eqrn) Eylea HD (afibercept) Pavblu (afibercept-ayyh) Susvimo (ranibizumab) Vabysmo (faricimab)</p>	<p><u>Initial Authorization:</u></p> <p>Avastin:</p> <ul style="list-style-type: none"> Request is for compendia supported dosing for an ophthalmic indication <p>Byooviz, Lucentis, Eylea:</p> <ul style="list-style-type: none"> Request is for an FDA-approved dosing regimen <p>Non-Preferred VEGF Inhibitor:</p> <ul style="list-style-type: none"> Request is for an FDA-approved dosing regimen; AND Documented trial and failure with a preferred VEGF inhibitor for all FDA-approved indications OR a medical justification for not using a preferred VEGF inhibitor (e.g. experienced a severe ADR such as hypersensitivity, arterial thromboembolism, cerebrovascular accident, raised intraocular pressure, retinal detachment). <p><u>Reauthorization:</u></p> <ul style="list-style-type: none"> Prescriber attests that member has obtained a clinical benefit from medication Request is for FDA-approved dosing regimen <p>If all of the criteria are met, the initial request will be approved for 3 months. For continuation of therapy, the request will be approved for 12 months.</p> <p>Last review: 6/2025</p>
<p>PA</p>	<p>*MEDICAL BENEFIT POLICY*</p> <p>Vedolizumab (Entyvio)</p>	<p>Criteria for use (ALL of the following must be met):</p> <ul style="list-style-type: none"> Must be prescribed by a GI specialist The member is 18 years of age <p><u>Ulcerative Colitis</u></p> <ul style="list-style-type: none"> Diagnosed with moderate to severe ulcerative colitis Failed/intolerant to any two of the following: 5-aminosalicylates (mesalamine, sulfasalazine), corticosteroids, 6-mercaptopurine, azathiopurine, and/or methotrexate <p><u>Crohn's Disease</u></p> <p>The member has a diagnosis of severe/fulminant Crohn's disease</p> <p>OR</p> <ul style="list-style-type: none"> The member has moderate-to-severe/moderate-to-high risk Crohn's disease AND has had an adequate trial of one of the following: azathioprine, 6-mercaptopurine or methotrexate <p>OR</p> <ul style="list-style-type: none"> The member has a diagnosis or moderate-to-severe/moderate-to-high risk Crohn's disease AND has evidence of active disease despite treatment with oral or intravenous corticosteroids <p>OR</p> <ul style="list-style-type: none"> The member has a diagnosis of perianal/fistulizing Crohn's disease AND has had an adequate trial of azathioprine, 6-mercaptopurine, or tacrolimus <p>• Approval for 16 weeks</p> <p>Continuation of therapy: Documentation of therapeutic benefit by 14 weeks must be met for continuation of therapy based on FDA and vedolizumab manufacturer recommendations</p> <p>Last review: 3/2025</p>

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

<p>PA</p>	<p>Voriconazole (Vfend®)</p>	<p>Maximum BID dosing. MD = Infectious Disease: Approve as requested.</p> <p>DX Invasive Aspergillosis, Serious Fungal infection from Scedosporium or Fusarium: Approve as requested.</p> <p>For Transplant patients: Approve x 1 month (up to #60/30 days) and fax back "For additional therapy, fluconazole is available without a PA for transplant patients. If patient needs additional voriconazole, please provide justification for why other antifungals such as fluconazole or itraconazole cannot be used.</p> <p>For candidemia and other candida infections or esophageal candidiasis Documented trial and failure, contraindication, culture and sensitivity resistance, or inability to use at least one formulary antifungal medication</p> <p>For any diagnosis, if the liquid formulation is requested, inability to swallow or other reason not to use the tablet formulation must be provided.</p> <p>Last review: 9/2025</p>
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

	<p><u>Xolair for Asthma, Urticaria, and IgE-Mediated Food Allergy</u></p>	<p>**For nasal polyposis, please refer to the “Biologic Agents for Nasal Polyposis” policy**</p> <p>Prescriber must be an allergist, pulmonologist, immunologist, or dermatologist</p> <p><u>Initial Authorization for Xolair for asthma:</u></p> <ul style="list-style-type: none"> • Member has at least a 6 month history of moderate to severe asthma • The drug is being prescribed at an FDA approved dose and according to member’s weight and IgE level • Member is taking maximal tolerated dose of inhaled corticosteroid/long-acting beta agonist (ICS/LABA) combination WITH add-on therapy of a LAMA (e.g. tiotropium) for a minimum of 3 months; or there is a documented medical reason why the member is unable to take these medications • Member’s asthma is uncontrolled as defined by having at least ONE of the following: <ul style="list-style-type: none"> ○ Frequent severe exacerbations requiring two or more bursts of systemic glucocorticoids (more than three days each) in the previous year ○ History of serious exacerbation: at least one hospitalization, intensive care unit stay, or mechanical ventilation in the previous year ○ Airflow limitation defined as an FEV1 less than 80% of predicted ○ Poor symptom control including at least THREE of the following: <ul style="list-style-type: none"> ▪ Asthma Control Questionnaire (ACQ) consistently >1.5 or Asthma Control Test (ACT) <20 ▪ Daytime asthma symptoms more than twice per week ▪ Use of an inhaled short acting beta2 agonist to relieve asthma symptoms more than twice per week (not including use prior to exercise) ▪ Limited physical activity due to asthma symptoms ▪ Nighttime awakening due to asthma • The member has a positive documented immediate response on RAST test and/or skin prick test to at least 1 common allergen (e.g. dermatophagoides farinae, dermatop hagoides pteronyssinus, dog, cat, or cockroach) which is an asthma trigger (copy of results required). • Pre-treatment serum IgE levels must be greater than or equal to 30 IU/mL <p><u>Initial Authorization for Xolair for urticaria:</u></p> <ul style="list-style-type: none"> • The drug is being prescribed at an FDA approved dose • The member has a documented history of urticaria for at least 6 weeks • The member requires oral corticosteroids to control symptoms • The member remains symptomatic despite a minimum two week trial of a formulary second generation H1 antihistamine at the maximum tolerated dose; or has a medical reason for not utilizing a second generation antihistamine <p><u>Initial Authorization for Xolair for IgE-mediated food allergy:</u></p> <ul style="list-style-type: none"> • Diagnosis of IgE-mediated food allergy with documented allergy to one or more of the following foods: <ul style="list-style-type: none"> ○ Peanut, milk, egg, wheat, cashew, hazelnut, or walnut • Attestation Xolair will be used in conjunction with food allergen avoidance • The drug is being prescribed at an FDA approved dose according to the member’s weight and IgE level
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

		<p>Exclusion:</p> <ul style="list-style-type: none"> • Use of Xolair concomitantly with Palforzia • Use of Xolair for emergency treatment of allergic reactions, including anaphylaxis • When used in combination with another pulmonary biologic (e.g., Cinqair, Fasentra, Nucala, Dupixent, or Tezspire) <p>Reauthorization:</p> <ul style="list-style-type: none"> • The drug is being prescribed at an approved dose • The member has clinically benefited from medication (e.g. decreased exacerbations, reduction in use of oral steroids, decrease in skin manifestations or severe itching, improvement in pulmonary function tests, etc.) <p>If the above conditions are met, the initial request will be approved with a 4 month duration. All subsequent requests will be approved with a 12 month duration.</p> <p>Last review date: 9/2025</p>
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

<p>PA</p>	<p>Zoledronic acid (Reclast)</p>	<p>The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records.</p> <p>For all requests:</p> <ul style="list-style-type: none"> • The member is taking calcium and vitamin D • The member has a documented (consistent with pharmacy claims) adequate trial of an oral bisphosphonate or has a medical reason (e.g. intolerance, hypersensitivity, contraindication, very high risk status or prior fracture etc.) for not using an oral bisphosphonate • Patient's creatinine clearance must be greater than or equal to 35 mL/min <p>If the diagnosis is osteoporosis:</p> <ul style="list-style-type: none"> • Documentation was submitted indicating member is postmenopausal woman or a male member over 50 years of age with a bone mineral density (BMD) value consistent with osteoporosis (T-score equal to or less than -2.5) OR has had an osteoporotic fracture OR member has a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability >3% or a 10 year major osteoporosis-related fracture probability >20%, based on the US-adapted WHO absolute fracture risk model <p>If the diagnosis is Paget's disease:</p> <ul style="list-style-type: none"> • Documentation of ONE of the following: <ul style="list-style-type: none"> • Member's serum alkaline phosphatase level of ≥ two times the upper limit of normal (within 60 days of request) OR • The member is symptomatic OR • Documentation of biochemically active disease on bone scintigraphy <p>If the diagnosis is glucocorticoid-induced osteoporosis:</p> <ul style="list-style-type: none"> ▪ For members ≥ 40 years of age on long-term glucocorticoid therapy: <ul style="list-style-type: none"> • Dosage of the glucocorticoid therapy is greater than 2.5 mg of prednisone daily or its equivalent for a minimum of 3 months • Member has a moderate to very high risk of fracture based on ONE of the following: <ul style="list-style-type: none"> • History of osteoporotic fracture (very high risk) • BMD less than or equal to -1 at the hip or spine (moderate to very high risk) • FRAX® (GC-Adjusted) 10-year risk of major osteoporotic fracture (MOF) ≥30% or hip ≥4.5% (very high risk) • FRAX® (GC-Adjusted) 10-year risk of MOF ≥20% but <30% or hip ≥3% but <4.5% (high risk) • FRAX® (GC-Adjusted) 10-year risk of MOF ≥10 and <20%, hip >1 and <3% (moderate risk) • Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate ▪ For adult members (all ages) receiving HIGH dose glucocorticoid therapy: <ul style="list-style-type: none"> • Member has a moderate to very high risk of fracture based on ONE of the following: <ul style="list-style-type: none"> • Has a history of prior fracture(s) (very high risk) • Glucocorticoid ≥30mg/day or cumulative ≥5grams/year (very high risk) • Continuing glucocorticoid treatment ≥7.5mg/day for ≥6 months AND BMD Z score < -3 OR significant BMD loss (> least significant change of DXA) (moderate risk) • Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate <p>Last review: 12/2025</p>
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

<p>Step Therapy Exception Criteria</p> <p>Requests for drugs on the plan's formulary with a step therapy restriction which do not meet step therapy requirements</p>	<p>Requests for drugs on the plan's formulary with a step therapy restriction which do not meet step therapy requirements will be considered when the provider verbally or in writing has submitted a medical reason why:</p> <ul style="list-style-type: none"> • Required step therapy drug(s) have previously or have the potential to cause an adverse reaction, physical or mental harm, or deterioration of the member's condition, or; • Required step therapy drug(s) would be ineffective, or; • Required step therapy drug(s) have been previously discontinued due to lack of efficacy, diminished effect, or an adverse reaction, or; • Required step therapy drug(s) are not clinically appropriate (i.e., would worsen a comorbid condition, decrease the members ADLs, pose a significant barrier to adherence with the member's drug regimen, or the member is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid), or; • The requested drug would be superior to the required prerequisite trial(s) with preferred drug(s). <p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</p> <p>Last review: 3/2025</p>
<p>Off-label uses</p> <p>Formulary, Formulary PA required, Formulary, ST required, or Non-formulary medications with off-label uses</p>	<p>Initial criteria for approval:</p> <ul style="list-style-type: none"> • One of the following: <ul style="list-style-type: none"> • Patient has had a documented trial and or intolerance with up to two preferred medications used to treat the documented diagnosis, or for medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. • No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia <p>AND</p> <ul style="list-style-type: none"> • One of the following: <ul style="list-style-type: none"> • Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Covered Uses section) • Requested use can be supported by at least two published peer reviewed clinical studies <p>AND</p> <ul style="list-style-type: none"> • Medication is being requested at an appropriate dose per literature <p>Reauthorization criteria for approval:</p> <ul style="list-style-type: none"> • Patient is stable and continuing the medication AND • Medication is used for appropriate indication and at appropriate dose

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

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<p>Oncology Drugs/Therapies</p> <p>Oncology Medications and Oncology Gene Therapies (specialty or non-specialty) without product specific criteria when requested for an oncology diagnosis</p>	<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Prescriber is an oncologist, or specialist in type of cancer being treated • Requested use must be a labeled indication or be supported by NCCN Category 1 or 2A level of evidence. If the request is for an off-label use supported by NCCN as Category 2B recommendation then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication) • Documentation has been provided of the results of all required genetic testing where required per drug package insert • Documentation has been provided of the results of all required laboratory values and patient specific information (e.g. weight, ALT/AST, Creatine Kinase, etc.) necessary to ensure the patient has no contraindications to therapy per drug package insert • The product is being prescribed at a dose that is within FDA approved/NCCN guidelines. • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available, documentation of one of the following: <ul style="list-style-type: none"> ○ The provider has verbally or in writing submitted a member specific reason why the reference biologic is required based on the member’s condition or treatment history; AND if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member’s need to avoid these drugs. The MedWatch form must be included with the prior authorization request ○ The currently available biosimilar product does not have the same appropriate use (per the references outlined in “Covered Uses”) as the reference biologic drug being requested <p style="text-align: center;"><u>Form FDA 3500 – Voluntary Reporting</u></p> <ul style="list-style-type: none"> • If the request is for abiraterone (Zytiga) 500 mg tablet, a documented medical reason why two tablets of generic abiraterone acetate 250 mg cannot be used <p>If the criteria are met, the request will be approved for up to 6 month duration</p> <p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI) , and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)</p> <p>Last reviewed: 9/2025</p>

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

<p>Specialty Biologic Agents</p> <p><u>Step 1: Preferred (pays at point-of-sale)</u> Hadlima (adalimumab-bwwd) Adalimumab-fkjp (Hulio) Adalimumab-aaty (Yuflyma) Simlandi (adalimumab-ryvk)</p> <p><u>Step 2: Preferred (PA required)</u> Enbrel (etanercept) Simponi, Simponi Aria (golimumab) Infliximab Inflectra (infliximab-dyyb) Avsola (infliximab-axxq) Renflexis (infliximab-abda) Orencia (abatacept) Xeljanz, Xeljanz XR (tofacitinib) Kineret (anakinra) Otezla (Apremilast) Siliq (brodalumab) Kevzara (sarilumab) Tyenne (tocilizumab-aazg) Tofidence (tocilizumab-bavi) Avtozma (tocilizumab-anoh) Olumiant (baricitinib) Otulfi (ustekinumab-aaaz) Yesintek (ustekinumab-kfce) Selarsdi (ustekinumab-aekn) Imuldosa (ustekinumab-srlf)</p> <p><u>Step 3: Non-Preferred (PA required)</u> Humira (adalimumab) Stelara (ustekinumab) Skyrizi (risankizumab) Actemra (tocilizumab) Arcalyst (rilonacept) Ilaris (canakinumab) Tremfya (guselkumab) Remicade (infliximab) Cosentyx (secukinumab) Zeposia (ozanimod) Taltz (ixekizumab) Tysabri (natalizumab) Tyruko (natalizumab-sztn) Cimzia (certolizumab) Rinvoq (upadacitinib) Ilumya (tildrakizumab-asmn) Sotyktu (deucravacitinib) Bimzelx (bimekizumab) Omvoh (mirikizumab)</p>	<p>Note: ** For Non-FDA approved (i.e. off-label) uses; refer to the “Off-Label Use” policy**</p> <ul style="list-style-type: none"> The drug is being requested for an appropriate indication and dose (per the references outlined in covered uses) The prescriber is a specialist in the field to treat the member’s respective medical condition If the request is for a preferred Step 2 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use a preferred Step 1 agent appropriate for the requested use (per the references outlined in “Covered Uses”) If the request is for a non-preferred Step 3 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use one preferred step 1 agent and one preferred step 2 agent appropriate for the requested use (per the references outlined in covered uses) <p>AND:</p> <ul style="list-style-type: none"> If the request is for a reference biologic drug with a biosimilar or interchangeable biologic drug (ex. Humira, Remicade, Actemra, Stelara), documentation of one of the following: <ul style="list-style-type: none"> The provider has verbally, or in writing, submitted a member-specific reason why the reference biologic is required based on the member’s condition or treatment history; AND if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member’s need to avoid these drugs. MedWatch form must also be included with the prior authorization request. Form FDA 3500 – Voluntary Reporting The currently available biosimilar product does not have the same appropriate use (per the references outlined in “Covered Uses”) as the reference biologic drug being requested <p>*NOTE:</p> <ul style="list-style-type: none"> Requests for Humira 10 mg/0.1 mL in pediatric patients may be approved without a trial of a step 1 or step 2 agent, when requested for an appropriate use (per the references outlined in “Covered Uses”) <p>Reauthorization:</p> <ul style="list-style-type: none"> Documentation submitted indicates that the member has obtained clinical benefit from the medication. The drug is being requested for an appropriate use and dose <p>Initial approval and reauthorization: 12 months</p> <p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</p> <p>Last review: 12/2025</p>
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

<p>Zymfentra (infliximab) All adalimumab biosimilar agents not listed in step 1 (ex. Amjevita, Cyltezo, Hyrimoz, Yuflyma, etc.) Litfulo (ritilecitinib) All Stelara biosimilars not listed in step 2 (ex. Steqeyma, Wezlana, etc.) Or any newly marketed agent</p>	
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

<p>Specialty Biological Agents for Rheumatoid Arthritis</p> <p><u>Step 1: Preferred (pays at point-of-sale)</u> Hadlima (adalimumab-bwwd) Adalimumab-fkjp (Hulio) Adalimumab-aaty (Yuflyma) Simlandi (adalimumab-ryvk)</p> <p><u>Step 2: Preferred (PA required)</u> Enbrel (etanercept) Simponi, Simponi Aria (golimumab) Infliximab Inflextra (infliximab-dyyb) Avsola (infliximab-axxq) Renflexis (infliximab-abda) Orencia (abatacept) SQ, IV Xeljanz, Xeljanz XR (tofacitinib) PO Kineret (anakinra) SQ Kevzara (sarilumab) SQ Tyenne (tocilizumab-aazg) SQ Tofidence (tocilizumab-bavi) SQ Olumiant (baricitinib) PO</p> <p><u>Step 3: Non-Preferred (PA required)</u> Humira (adalimumab) Actemra (tocilizumab) Remicade (infliximab) Cimzia (certolizumab) Rinvoq (upadacitinib) Zymfentra (infliximab) All adalimumab biosimilar agents not listed in step 1(ex. Amjevita, Cyltezo, Hyrimoz, Yuflyma, etc.) Litfulo (ritlectinib) Or any newly marketed agent</p>	<p><u>PA CRITERIA FOR APPROVAL FOR RHEUMATOID ARTHRITIS:</u></p> <ul style="list-style-type: none"> • Prescriber is a rheumatologist • The member has a diagnosis of rheumatoid arthritis. • Member has documented (consistent with pharmacy claims/medical record data/chart notes/physician attestation) adequate trial of, or has a documented medical reason (e.g. allergy, intolerance, contraindication), for not taking one other disease modifying anti-rheumatic drug (DMARD) (e.g. methotrexate, leflunomide, sulfasalazine or hydroxychloroquine) to manage their condition. • The medication requested is being prescribed at an FDA-approved dosage for age and weight. • If the request is for a preferred Step 2 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use a preferred Step 1 agent appropriate for the requested use (per the references outlined in “Covered Uses”) • If the request is for a non-preferred Step 3 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use one preferred step 1 agent and one preferred step 2 agent appropriate for the requested use (per the references outlined in covered uses) <p><u>PA CRITERIA FOR RE-AUTHORIZATION FOR RHEUMATOID ARTHRITIS:</u></p> <ul style="list-style-type: none"> • The member has been receiving the medication and documentation was provided that a rheumatologist has evaluated the member and recommends continuation of therapy. • Documentation submitted indicates that the member has obtained clinical benefit from the medication. • For members who require dose increases to Humira 40 mg weekly or 80mg every other week, documentation must be submitted indicating that the member is not on concomitant methotrexate and has a medical reason (e.g. intolerance, hypersensitivity, contraindication) for not receiving concomitant methotrexate • The medication is being prescribed at an FDA-approved dosage. <p>Last review: 3/2025</p>
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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

Table of common chemotherapy agents associated with emesis risk and corresponding preferred anti-emetic agents

High Risk (>90% frequency without anti-emetics)		
<ul style="list-style-type: none"> • AC combination: Doxorubicin (Adriamycin) or Epirubicin (Elevance)+ Cyclophosphamide (Cytoxan, Neosar) • Altretamine (HMM, Hexalen) • Carmustine (BCNU, BICNU) >250mg/m² • Cisplatin (CDDP, Platinol, Platinol-AQ) >50mg/m² • Cyclophosphamide (CTX, Cytoxan, Neosar) >1,500mg/m² 	<ul style="list-style-type: none"> • Dacarbazine (DTIC, DTIC-Dome) • Doxorubicin (Adriamycin) >60mg/m² • Epirubicin (Elevance) >90mg/m² • Ifosfamide (Ifex) >10g/m² • Mechlorethamine (Mustargen) • Procarbazine (Matulane) oral • Streptozocin (Zanosar) 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Aprepitant PO 2. Dexamethasone PO 3. Ondansetron PO/IV 4. Prochlorperazine PO/PR and/or metoclopramide PO/IV
Moderate Risk (30–90% frequency without anti-emetics)		
<ul style="list-style-type: none"> • Aldesleukin (IL-2, Proleukin) >12–15 million units/m² • Amifostine (Ethylol) >300mg/m² • Arsenic trioxide (As₂O₃, Trisenox) • Azacitidine (Vidaza) • Bendamustine (Treanda) • Busulfan (Busulfex) IV, oral >4mg/d • Carboplatin (Paraplatin) • Carmustine (BCNU, BICNU) <250mg/m² • Cisplatin (CDDP, Platinol, Platinol-AQ) <50mg/m² • Clofarabine (Clolar) • Cyclophosphamide (CTX, Cytoxan, Neosar) <1,500mg/m² • Cyclophosphamide (CTX) oral >100mg/m²/day • Cytarabine (ARA-C, Cytosar-U) >200mg/m² 	<ul style="list-style-type: none"> • Dactinomycin (actinomycin D, Cosmegen) • Daunorubicin (Cerubidine, Daunomycin) • Doxorubicin (Adriamycin) <60mg/m² • Epirubicin (Elevance) <90mg/m² • Estramustine (Emcyt) • Etoposide (VP-16, VePesid) oral • Idarubicin (Idamycin) • Ifosfamide (Ifex) < 10g/m² • Interferon alpha (IFN-alfa, Intron A) >10 million units/m² • Irinotecan (CPT-11, Camptosar) • Lomustine (CCNU, CeeNU) • Melphalan (L-PAM, Alkeran) >50mg/m² IV • Methotrexate (MTX) >250mg/m² • Oxaliplatin (Eloxatin) >75mg/m² • Temozolomide (Temodar) oral >75mg/m²/day • Vinorelbine (Navelbine) oral 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Ondansetron PO/IV 2. Dexamethasone PO 3. Prochlorperazine PO/PR and/or metoclopramide PO/IV
Low Risk (10–30% frequency without anti-emetics)		
<ul style="list-style-type: none"> • Aldesleukin (IL-2, Proleukin) <12 million units/m² • Amifostine (Ethylol) <300mg • Bexarotene (Targretin) • Cabazitaxel (Jevtana) • Capecitabine (Xeloda) oral • Cetuximab (C225, Erbitux) • Cyclophosphamide (CTX) oral <100mg/m²/d 	<ul style="list-style-type: none"> • Cytarabine (ARA-C, Cytosar-U) 100–200mg/m² • Docetaxel (Taxotere) • Doxorubicin liposomal (Doxil) • Eribulin (Halaven) • Etoposide (VP-16, Etopophos, VePesid) IV • Floxuridine • Fludarabine (Fludara) oral • Fluorouracil (5-FU) 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Ondansetron PO/IV 2. Dexamethasone PO 3. Prochlorperazine PO/PR and/or metoclopramide PO/IV
Minimal Risk (<10% frequency without anti-emetics)		
<ul style="list-style-type: none"> • Alemtuzumab (Campath) • Asparaginase (Elspar) • Bevacizumab (Avastin) • Bleomycin (Blenoxane) • Bortezomib (Velcade) • Busulfan (Busulfex) oral 4mg/d • Cetuximab (Erbitux) • Chlorambucil (Leukeran) oral • Cladribine (2-CdA, Leustatin) • Cytarabine (ARA-C, Cytosar-U) <100mg/m² • Dasatinib (Sprycel) • Decitabine (Dacogen) • Denileukin diftitox (Ontak) • Dexrazoxane (Totect, Zinecard) • Erlotinib (Tarceva) • Everolimus (Afinitor, Zortress) • Fludarabine (Fludara) IV • Gefitinib (Iressa) • Hydroxyurea (Hydrea) oral • Imatinib (Gleevec) • Interferon alpha (IFN-alfa, Intron A) • Ipilimumab (Yervoy) • Lapatinib (Tykerb) • Lenalidomide (Revlimid) 	<ul style="list-style-type: none"> • Melphalan (L-PAM, Alkeran) low dose oral • Mercaptopurine (purinethol) • Methotrexate (MTX) <50mg/m² IV/oral • Nelarabine (Arranon) • Nilotinib (Tasigna) • Ofatumumab (Arzerra) • Panitumumab (Vectibix) • Pazopanib (Votrient) • Pegaspargase (Oncaspar) • Peginterferon • Rituximab (Rituxan) • Sorafenib (Nexavar) • Sunitinib (Sutent) • Temsirolimus (Torisel) • Temozolamide (Temodar) < 75mg/m²/day • Tretinoin (Vesanoid) • Thalidomide (Thalomid) • Thioguanine (6-TG, Tabloid) • Trastuzumab (Herceptin) • Valrubicin (Valstar) • Vandetanib (Caprelsa) • Vinblastine (VLB) • Vincristine (VCR) • Vinorelbine (Navelbine) IV • Vorinostat (Zolinza) 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Prochlorperazine PO/PR and/or metoclopramide PO/IV

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

Table of common chemotherapy regimens associated with risk of febrile neutropenia

Chemotherapy regimens associated with febrile neutropenia risk > 20%		
ABVD AC + docetaxel ACE BEACOPP BOP CEC (R-)CHOP-21 Capecitabine/docetaxel Cisplatin/vinorelbine/cetuximab Hyper CVAD + rituximab DCP DHAP Docetaxel Docetaxel/carboplatin	Docetaxel/cisplatin Docetaxel/irinotecan Docetaxel/doxorubicin Paclitaxel/doxorubicin ECF (R-)ESHAP Etoposide/cisplatin FC(R) (R-)ICE IGEV LVFU (-cisplatin/irinotecan) MAID MOPPED-VCAD MVAC	Paclitaxel Stanford V TAC TC(F) TIC Topotecan VICE VeIP Dose-dense FEC Dose-dense epirubicin/cyclophosphamide Dose-dense CAV -> PE Dose-dense VAPEC-B Dose-dense ACVBP
Chemotherapy regimens associated with febrile neutropenia risk 10-20%		
5-FU AC ACOD BEP Mega CHOP-R-Ara-C cyclophosphamide Cyclophosphamide/mitoxantrone CODE Doxorubicin/vinorelbine Epirubicin /cyclophosphamide	Etoposide/carboplatin Etoposide/cisplatin ECF ECX EOF EOX EPOCH Fludarabine/mitoxantrone GAV Gemcitabine/irinotecan	(R-)GemP (R-)GemOx FEC-D FEC-100 FOLFIRI Topotecan/cisplatin Tirapazamine/cisplatin/etoposide/irradiation VIG Vinorelbine/cisplatin
Chemotherapy regimens associated with febrile neutropenia risk < 10%		
Bevacizumab/paclitaxel/carboplatin CAV->PE CMF IV/oral Epirubicin/cyclophosphamide +/- lonidamine Gemcitabine/cisplatin	FEC-120 FAC-50 FOLFOX (-6) IFL	Irinotecan TAP TPF

Febrile neutropenia is defined as (bullet points below are all inclusive):

1. An absolute neutrophil count (ANC) of less than $0.5 \times 10^9/L$ (or less than $1 \times 10^9/L$ predicted to fall below $0.5 \times 10^9/L$ within 48 hours)
2. Fever or other clinical signs/symptoms of sepsis

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MEDICAL BENEFIT PHYSICIAN ADMINISTERED DRUG APPROVAL CRITERIA

Jcode Appendix- supportive and supplemental care

The following Jcodes are frequently used for supportive and supplemental care during infusion therapy. Jcodes are approved for the indications such as the ones specified below:

Jcodes	Indication
J0461 - PR ATROPINE SULFATE INJECTION	Chemotherapy supportive care to alleviate side effects from drugs such as irinotecan
J0640 - PR LEUCOVORIN CALCIUM INJECTION	Preventative support for chemotherapy, specifically for methotrexate
J2919 - INJ, METHYLPRED SOD SUCC 5MG	Supportive care for chemotherapy; Nausea and vomiting; Immune therapy pre-treatment
J3475 - PR INJ MAGNESIUM SULFATE	Supportive care for chemotherapy, protective against nephrotoxicity
J1100 - PR DEXAMETHASONE SODIUM PHOS	Supportive care for chemotherapy and other infusions; Nausea and vomiting prevention
J1200 - PR DIPHENHYDRAMINE HCL INJECTIO	Supportive care for chemotherapy and other infusions
J1720 - PR HYDROCORTISONE SODIUM SUCC I	Supportive care for infusions
J3420 - PR VITAMIN B12 INJECTION	Vitamin B12 deficiency
J7030 - PR NORMAL SALINE SOLUTION INFUS	Hydration
J2405 - PR ONDANSETRON HCL INJECTION	Nausea and vomiting prevention
J3480 - PR INJ POTASSIUM CHLORIDE	Potassium supplementation

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