Commercial Plans Medical Drugs Prior Authorization Criteria 2026

This prior authorization document was updated on 12/16/2025. To determine if your drug has a prior authorization requirement, or for information on how to request an authorization for any of these drugs, please contact Customer Care at 1-877-280-5600 toll free (TTY users should call 711), from 9 am to 5 pm, Monday – Friday.

Este documento de autorización previa fue actualizado el 12/16/2025. Para determinar si su medicamento tiene un requisito de autorización previa, o para obtener información sobre cómo solicitar una autorización para cualquiera de estos medicamentos, comuníquese con Atención al Cliente al 1-877-280-5600, 9 am a 5 pm, lunes a viernes.

Pharmacy Utilization Management Policy

GlobalHealth	**ENTITY** GlobalHealth Holdings, LLC	**NUMBER** GH-PT-001-C-V-2	
	TITLE Oncology Drug Commercial Prior Authorization Approval Criteria	**EFFECTIVE DATE** 4/14/2016	**LAST REVISED** 8/1/2023

Criteria for initial approval:

1. Conforms to guideline recommendations from National Comprehensive Cancer Network (NCCN)
2. For advanced metastatic cancer and associated conditions: no step therapy requirements apply when the requested treatment is consistent with best practices, supported by peer-reviewed, evidence-based literature; and the drug is approved by the United States Food and Drug Administration

Criteria for renewal:

1. Conforms to guideline recommendations from National Comprehensive Cancer Network (NCCN)

P&T Committee review dates: 4/14/16, 8/1/2018, 7/31/2019, 7/22/2020, 7/28/2021, 8/3/2022, 8/1/2023, 11/26/2024, 12/16/2025

Pharmacy Utilization Management Policy

	ENTITY GlobalHealth Holdings, LLC	NUMBER GH-PT-002-C-V-2	
GlobalHealth	TITLE Zilretta Commercial Prior Authorization Approval Criteria	EFFECTIVE DATE 7/31/2019	LAST REVISED 5/27/2020

HCPCS code: J3304 Inj triamcinolone ace xr 1mg

Therapeutic class: Intra-articular Corticosteroid

Available dosage forms: Triamcinolone acetonide extended-release injectable suspension single-dose kit

Criteria for initial approval (3 months: one injection per knee):

1. FDA-approved diagnosis: Osteoarthritis of the Knee
2. Age 18 years or older
3. Member has had treatment failure with or had clinically significant adverse effects to one of the following treatments.
   - 3.1. Oral nonsteroidal antiinflammatory drug (NSAID) at continuous therapeutic dosing (prescription strength); OR
   - 3.2. Topical NSAID if member an oral NSAID is contraindicated;
4. History of a positive but inadequate response to at least one other intraarticular glucocorticoid injection for the knee (e.g., inadequate pain relief, frequent need of rescue medications such as NSAIDs or opioids, need to decrease or inability to increase activity levels, adequate pain relief but with steroid-induced hyperglycemia);

Renewal: Zilretta is not eligible for renewal as the efficacy and safety of repeat administration of Zilretta have not been established.

References:

1. DRUGDEX® System [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically
2. Zilretta Prescribing Information. Burlington, MA: Flexion Therapeutics, Inc.; May 2024.
3. Bodick N, Lufkin J, Willwerth C, et al. An intra-articular, extended-release formulation of triamcinolone acetonide prolongs and amplifies analgesic effect in patients with osteoarthritis of the knee: A randomized clinical trial. J Bone Joint Surg Am. 2015; 97: 877-88. http://dx.doi.org/10.2106/JBJS.N.00918
4. Krause VB, Conaghan PG, Aazami HA, et al. Synovial and systemic pharmacokinetics (PK) of triamcinolone acetonide (TA) following intra-articular (IA) injection of an extended release microsphere-based formulation (FX006) or standard crystalline suspension in patients with knee osteoarthritis (OA). Osteoarthritis and Cartilage. 2018; 26: 34-42.
5. Russell SJ, Sala R, Conaghan PG, et al. In type 2 diabetes mellitus patients with knee osteoarthritis intra-articular injection of FX006 (Extended Release Triamcinolone) is associated with reduced blood glucose elevation vs. standard triamcinolone; a randomized, blinded, parallel group study. Diabetes 2017; 66(Suppl 1): A289.
6. Conaghan PG, Hunter DJ, Cohen SB, et al. Effects of a single intra-articular injection of a microsphere formulation of triamcinolone acetonide on knee osteoarthritis pain. A double-blind, randomized, placebo controlled, multinational study. J Bone Joint Surg Am. April 18, 2018; 100(8): 666-677.

7. Brown GA. American Academy of Orthopaedic Surgeons clinical practice guidelines: Treatment of osteoarthritis of the knee: Evidence-based guideline, 2nd edition. J Am Acad Orthop Surg. September 2013;21(9):577-9. doi: 10.5435/JAAOS-21-09-577.
8. Hochberg MC, Altman RD, April KT, et al. American College of Rheumatology 2012 recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee. Arthritis Care & Research. April 2012; 64(4): 465-474.
9. Rannou F, Peletier JP, Martel-Pelletier J. Efficacy and safety of topical NSAIDs in the management of osteoarthritis: Evidence from real-life setting trials and surveys. Semin Arthritis Rheum. 2016; 45:S18-S21.
10. McAlindon TE, Bannuru RR, Sullivan MC, at al. OARSI guidelines for the non-surgical management of knee osteoarthritis. Osteoarthritis Cartilage. 2014; 22:363-388.
11. Nelson AE, Allen KD, Golightly YM, et al. A systematic review of recommendations and guidelines for the management of osteoarthritis: The chronic osteoarthritis management initiative of the U.S. Bone and Joint Initiative. Semin Arthritis Rheum. 2014; 43:701-712.

P&T Committee review dates: 7/31/2019, 5/27/2020, 4/28/2021, 8/3/2022, 8/1/2023, 11/26/2024, 12/16/2025

Pharmacy Utilization Management Policy

	ENTITY GlobalHealth Holdings, LLC	NUMBER GH-PT-003-C-V-1	
GlobalHealth	TITLE Qutenza Commercial Prior Authorization Approval Criteria	EFFECTIVE DATE 11/26/2024	LAST REVISED

HCPCS Code: J7336 Capsaicin 8% patch

Therapeutic class: Analgesic | Central Nervous System Agent

Available dosage forms: Single-use 8% topical system

Criteria for initial approval:

1. FDA-approved indication/diagnosis: treatment of neuropathic pain associated with postherpetic neuralgia (PHN) and neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet.

Criteria for renewal:

1. The member is currently receiving therapy with Qutenza.
2. Initial approval criteria are still met.
3. The member is receiving benefit from therapy.

Summary of evidence:

The contents of this policy were created after examining the following resources:

1. The prescribing information for Qutenza.
2. The available compendium
   a. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
   b. Micromedex DrugDex
   c. American Hospital Formulary Service- Drug Information (AHFS-DI)
   d. Lexi-Drugs
   e. Clinical Pharmacology

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Qutenza are covered.

Explanation of rationale:

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

References:

1. QUTENZA® [package insert]. Ardsley, NY; Acorda Therapeutics, Inc.; July 2024.

P&T Committee review dates: 11/26/2024, 12/16/2025

Commercial Plans Medical Drug Step Therapy Exception Criteria

January 2026

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Acromegaly Long-Acting Products	• Lanreotide injection	Preferred Product: • Somatuline Depot (lanreotide acetate) Coverage for the non-preferred product is provided when **either** of the following criteria is met: • Member has received treatment with the requested non-preferred product in the past 365 days; OR • The member has had a documented intolerable adverse event to Somatuline Depot, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
Acromegaly Long-Acting Products	• Sandostatin LAR Depot • Signifor LAR	Preferred Product: • Somatuline Depot (lanreotide acetate) Coverage for a non-preferred product is provided when **either** of the following criteria is met: • Member has received treatment with the requested non-preferred product in the past 365 days; OR • Member has a documented inadequate response or intolerable adverse event with the preferred product.

References

1. Somatuline Depot [package insert]. Cambridge, NJ: Ipsen Biopharmaceuticals, Inc.; July 2024.
2. Sandostatin LAR Depot [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2024.
3. Signifor LAR [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Company; July 2024.

4. Lanreotide Injection [package insert]. Warren, NJ: Cipla USA, Inc.; May 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Alpha1-Proteinase Inhibitors	• Aralast NP (alpha1-proteinase inhibitor [human]) • Glassia (alpha1-proteinase inhibitor [human])	Preferred products: • Prolastin-C (alpha1-proteinase inhibitor [human]) • Zemaira (alpha1-proteinase inhibitor [human]) Coverage for a non-preferred product is provided when **either** of the following criteria are met: • Member has received treatment with the non-preferred product in the past 365 days; OR • Member has had a documented intolerable adverse event to both of the preferred products (Prolastin-C and Zemaira), and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

References

1. Aralast NP [package insert]. Westlake Village, CA: Baxalta US Inc.; October 2024.
2. Glassia [package insert]. Westlake Village, CA: Baxalta US Inc.; February 2025.
3. Prolastin-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; January 2022.
4. Zemaira [package insert]. Kankakee, IL: CSL Behring LLC; January 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Antimetabolites	• Alimta (pemetrexed) • Pemfexy (pemetrexed)	Preferred products: • pemetrexed (generic) Coverage for a non-preferred product is provided when **either** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days; OR

		• Member has had a documented intolerable adverse event to the preferred product, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

References
1. Alimta [package insert]. Indianapolis, IN: Lilly USA, LLC; May 2023.
2. Pemetrexed [package insert]. Lake Forest, IL: Hospira, Inc.; February 2023.
3. Pemfexy [package insert]. Woodcliff Lake, NJ: Eagle Pharmaceuticals, Inc.; December 2022.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**

Asthma	• Cinqair	Preferred Products:
		• Fasenra (benralizumab)
		• Tezspire (tezepelumab-ekko)
		• Xolair (omalizumab)
		
		Coverage for Cinqair is provided when **either** of the following criteria is met:
		• Member has received treatment with Cinqair in the past 365 days; OR
		• Member has **both** of the following:
		  ○ Member has a documented inadequate response or intolerable adverse event with both of the preferred products, Fasenra and Tezspire; AND
		  ○ Member has either of the following:
		  ▪ A pretreatment serum IgE level of at least 30 IU/mL and has had a documented inadequate response or an intolerable adverse event with

		the preferred product Xolair; OR ▪ A pretreatment serum IgE level of less than 30 IU/mL.
Asthma	• Nucala	Preferred Products: • Fasenra (benralizumab) • Tezspire (tezepelumab-ekko) • Xolair (omalizumab) Coverage for Nucala is provided when **either** of the following criteria is met: • Member has received treatment with Nucala in the past 365 days; OR • Member meets **any** of the following: ○ Member has a comorbidity of nasal polyps and meets either of the following: ▪ A pretreatment serum IgE level of at least 30 IU/mL and has had a documented inadequate response or an intolerable adverse event with the preferred product Xolair; OR ▪ A pretreatment serum IgE level of less than 30 IU/mL. ○ Member meets **both** of the following: ▪ Member is 12 years of age and older and has a documented inadequate response or an intolerable adverse event with both of the preferred products, Fasenra and Tezspire; OR Member is less than

		12 years of age and has a documented inadequate response or an intolerable adverse event with the preferred product Fasenra; AND ▪ Member has pretreatment serum IgE level of at least 30 IU/mL and has had adocumented inadequate response or an intolerable adverse event with the preferred product Xolair; OR Member has a pretreatment serum IgE level of less than 30 IU/mL. ○ Member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) and has a documented inadequate response or intolerable adverse event with the preferred product Fasenra.

References

1. Cinqair [package insert]. West Chester, PA: Teva Respiratory, LLC; June 2020.
2. Fasenra [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; April 2024.
3. Nucala [package insert]. Research Triangle Park, NC: GlaxoSmithKline; March 2023.
4. Tezspire [package insert]. Thousand Oaks, CA: Amgen Inc.; May 2023.
5. Xolair [package insert]. South San Francisco, CA: Genentech, Inc.; February 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Autoimmune Conditions	• Cimzia lyophilized powder (certolizumab pegol)	Preferred Products: • Entyvio (IV) (vedolizumab) • Simponi Aria (golimumab) • Tremfya (IV) (guselkumab)

		Coverage for Cimzia lyophilized powder is provided when **any** of the following criteria is met: • Member has received treatment with Cimzia lyophilized powder in the past 365 days; OR • Member has a documented inadequate response or intolerable adverse event with all of the preferred products (Entyvio IV, Simponi Aria, and Tremfya IV), where the products' indications overlap. If the member is a documented primary non-responder to an interleukin-23 (IL-23) inhibitor, then the member would not need to use the corresponding preferred product(s) from the respective class; OR • Member is currently breastfeeding, pregnant, or planning pregnancy.
Autoimmune Conditions	• Actemra (IV) (tocilizumab) • Ilumya (tildrakizumab-asmn) • Orencia (IV) (abatacept) • Stelara (IV) (ustekinumab)	Preferred Products: • Entyvio (IV) (vedolizumab) • Simponi Aria (golimumab) • Tremfya (IV) (guselkumab) Coverage for all other non-preferred products is provided when **either** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days; OR • Member has a documented inadequate response or intolerable adverse event with all of the preferred products (Entyvio IV, Simponi Aria, and Tremfya IV) where the products' indications overlap, unless there is a documented clinical reason to avoid tumor necrosis factor (TNF) inhibitors ○ History of demyelinating disorder

		○ History of congestive heart failure ○ History of hepatitis B virus infection ○ Autoantibody formation/lupus-like syndrome ○ History or risk of lymphoma or other malignancy ○ History of being a primary non-responder to a TNF inhibitor

References
1. Actemra [package insert]. South San Francisco, CA: Genentech, Inc.; September 2024.
2. Cimzia [package insert]. Smyrna, GA: UCB, Inc.; September 2024.
3. Entyvio [package insert]. Cambridge, MA: Takeda Pharmaceuticals U.S.A., Inc.; May 2024.
4. Ilumya [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; April 2024.
5. Orencia [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; May 2024.
6. Simponi Aria [package insert]. Horsham, PA: Janssen Biotech, Inc.; April 2025.
7. Stelara [package insert]. Horsham, PA: Janssen Biotech, Inc.; November 2024.
8. Tremfya [package insert]. Horsham, PA: Janssen Biotech, Inc.; March 2025.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Infliximab	• Avsola (infliximab-axxq) • infliximab • Remicade (infliximab)	Preferred products: • Inflectra (infliximab-dyyb) • Renflexis (infliximab-abda) Coverage for a non-preferred product is provided when **either** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has had a documented intolerable adverse event to both of the preferred infliximab products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both

		the reference product and biosimilar products).

References
1. Avsola [package insert]. Thousand Oaks, CA: Amgen, Inc.; September 2021.
2. Inflectra [package insert]. New York, NY: Pfizer Inc.; April 2023.
3. infliximab [package insert]. Horsham, PA: Janssen Biotech, Inc.; March 2025.
4. Remicade [package insert]. Horsham, PA: Janssen Biotech, Inc.; February 2025.
5. Renflexis [package insert]. Jersey City, NJ: Organon & Co.; December 2023.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Bevacizumab-Oncology Products	• Alymsys (bevacizumab-maly) • Avastin (bevacizumab) • Vegzelma (bevacizumab-adcd)	Preferred products: • Mvasi (bevacizumab-awwb) • Zirabev (bevacizumab-bvzr) Coverage for a non-preferred product is provided when **either** of the following criteria is met: • Member has received treatment with the requested non-preferred product in the past 365 days**; OR** • Member has had a documented intolerable adverse event to both of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

References
1. Alymsys [package insert]. Bridgewater, NJ: Amneal Pharmaceuticals LLC; April 2022.
2. Avastin [package insert]. South San Francisco, CA: Genentech, Inc.; September 2022.
3. Mvasi [package insert]. Thousand Oaks, CA: Amgen, Inc.; February 2023.
4. Vegzelma [package insert]. Incheon, Republic of Korea: Celltrion, Inc.; February 2023.
5. Zirabev [package insert]. New York, NY: Pfizer, Inc.; August 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements

Botulinum Toxins	• Botox (onabotulinumtoxinA)
	• Myobloc (rimabotulinumtoxinB)
		Preferred products:
		• Dysport (abobotulinumtoxinA)
		• Xeomin (incobotulinumtoxinA)
		
		Coverage for a non-preferred product is provided when **any** of the following criteria is met:
		• Member has received treatment with the non-preferred product in the past 365 days**; OR**
		• Member has a documented inadequate response or intolerable adverse event to both of the preferred products**; OR**
		• Member is requesting Botox for the treatment of blepharospasm and **either** of the following criteria is met:
		  ○ Member is 18 years of age and older and the member has had a documented inadequate response or intolerable adverse event with Xeomin**; OR**
		  ○ Member is 12 years of age or older but less than 18 years of age**; OR**
		• Member is requesting Botox for the treatment of lower limb spasticity and has had a documented inadequate response or adverse event to Dysport**; OR**
		• Member is requesting Botox for the treatment of upper limb spasticity and both of the following criteria are met:
		  ○ Member is a pediatric patient 2 years of age to 17 years of age and the

		upper limb spasticity is caused by cerebral palsy**; AND** ○ Member has had a documented inadequate response or adverse event with Dysport**; OR** • Member is requesting Myobloc for the treatment of chronic sialorrhea and has had a documented inadequate response or an intolerable adverse event with Xeomin.

References
1. Botox [package insert]. North Chicago, IL: Allergan, Inc., an AbbVie company; November 2023.
2. Dysport [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, LLC; September 2023.
3. Myobloc [package insert]. Rockville, MD: Solstice Neurosciences, Inc.; March 2021.
4. Xeomin [package insert]. Raleigh, NC: Merz Pharmaceuticals, LLC; July 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Breast Cancer	• Perjeta (pertuzumab)	Preferred products: • Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)) Coverage for a non-preferred product is provided when **any** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has had a documented intolerable adverse event to the preferred product, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

References
1. Perjeta [package insert]. South San Francisco, CA: Genentech, Inc.; February 2021.

2. Phesgo [package insert]. South San Francisco, CA: Genentech, Inc.; November 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Complement Inhibitor Products - Atypical Hemolytic Uremic Syndrome (aHUS), Paroxysmal Nocturnal Hemoglobinuria (PNH)	• Soliris (eculizumab) • Ultomiris (ravulizumab-cwvz)	Preferred products: • Bkemv (eculizumab-aeeb) Coverage for a non-preferred product is provided when **any** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • The request is for Soliris and the member has a documented intolerable adverse event to Bkemv, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)**; OR** • The request is for Ultomiris and the member has a documented inadequate response or intolerable adverse event with the preferred product.
Complement Inhibitor Products - Myasthenia Gravis	• Soliris (eculizumab) • Ultomiris (ravulizumab-cwvz)	Preferred products: • Bkemv (eculizumab-aeeb) • Vvygart (efgartigimod alfa) • Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Coverage for a non-preferred product is provided when **any** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR**

		• The request is for Soliris and both of the following are met:
		  ○ Member has a documented intolerable adverse event to Bkemv, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)**; AND**
		  ○ Member has a documented inadequate response or intolerable adverse event with either Vyvgart or Vyvgart Hytrulo**; OR**
		• The request is for Ultomiris and the member has a documented inadequate response or intolerable adverse event with Bkemv, and either Vyvgart or Vyvart Hytrulo.

Complement Inhibitor Products - Neuromyelitis Optica Spectrum Disorder (NMOSD)	• Soliris (eculizumab)	Preferred products: • Bkemv (eculizumab-aeeb) Coverage for a non-preferred product is provided when **any** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has a documented intolerable adverse event to Bkemv, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse

		reaction for both the reference product and biosimilar products).

References
1. Bkemv [package insert]. Thousand Oaks, CA: Amgen Inc.; October 2024.
2. Soliris [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; March 2025.
3. Ultomiris [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; September 2024.
4. Vyvgart [package insert]. Boston, MA: Argenx US, Inc.; August 2024.
5. Vyvgart Hytrulo [package insert]. Boston, MA: Argenx US. Inc.; August 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Colony Stimulating Factors-Long Acting	• Neulasta (including Onpro kit) (pegfilgrastim) • Nyvepria (pegfilgrastim-apgf) • Rolvedon (eflapegrastim-xnst) • Stimufend (pegfilgrastim-fpgk) • Udenyca (pegfilgrastim-cbqv) • Ziextenzo (pegfilgrastim-bmez)	Preferred products: • Fulphila (pegfilgrastim-jmdb) • Fylnetra (pegfilgrastim-pbbk) Coverage for a non-preferred product is provided when **one** of the following criteria is met: • Member has had a documented intolerable adverse event to both of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference products and biosimilar products)**; OR** • Member has received treatment with the requested non-preferred product in the past 365 days.

References
1. Neulasta [package insert]. Thousand Oaks, CA: Amgen, Inc.; February 2021.
2. Fulphila [package insert]. Cambridge, MA: Biocon Biologics Inc.; June 2023.
3. Fylnetra [package insert]. Piscataway, NJ: Kashiv BioSciences, LLC; May 2022.
4. Nyvepria [package insert]. Lake Forest, IL: Hospira, Inc.; March 2023.
5. Rolvedon [package insert]. Lake Forest, IL: Spectrum Pharmaceuticals, Inc.; November 2023.
6. Stimufend [package insert]. Lake Zurich, IL: Fresenius Kabi USA, LLC; September 2023.
7. Udenyca [package insert]. Redwood City, CA: Coherus BioSciences, Inc.; December 2023.
8. Ziextenzo [package insert]. Princeton, NJ: Sandoz Inc.; February 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Colony Stimulating Factors – Short Acting	• Granix (TBO-filgrastim) • Neupogen (filgrastim) • Nivestym (filgrastim-aafi) • Releuko (filgrastim-ayow)	Preferred products: • Zarxio (filgrastim-sndz) Coverage for the non-preferred products, Granix, Neupogen, Nivestym or Releuko, is provided when the member meets **one** of the following criteria: • Member has had a documented intolerable adverse event to the preferred product, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)**; OR** • Member is requesting Granix, Neupogen vials or Nivestym and has a documented latex allergy that the prescriber states the member must use latex-free products. Neupogen pre-filled syringes contain latex and are not covered under this criterion**; OR** • Neupogen, Nivestym, or Granix are requested for doses less than 180 mcg**; OR** • Member has received treatment with the requested non-preferred product in the past 365 days.
Colony Stimulating Factors – Short Acting	• Leukine (sargramostim)	Preferred Product: • Zarxio (filgrastim-sndz) Coverage for the non-preferred product, Leukine, is provided when the member meets **one** of the following criteria:

		• Member has had a documented inadequate response or an intolerable adverse event to the preferred product**; OR** • Leukine is being requested for an indication that is not FDA-approved for the preferred product**; OR** • Member has received treatment with the requested non-preferred product in the past 365 days.

References
1. Granix [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; November 2023.
2. Leukine [package insert]. Lexington, MA: Partner Therapeutics, Inc.; August 2023.
3. Neupogen [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2023.
4. Nivestym [package insert]. Lake Forest, IL: Hospira, Inc., a Pfizer Company: February 2024.
5. Releuko [package insert]. Piscataway, NJ: Kashiv BioSciences, LLC; September 2023.
6. Zarxio [package insert]. Princeton, NJ: Sandoz, Inc.; October 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Erythropoiesis Stimulating Agents - Anemia Due to Chronic Kidney Disease (CKD)	• Epogen (epoetin alfa) • Mircera (methoxy polyethylene glycol-epoetin beta) • Procrit (epoetin alfa)	Preferred products: • Aranesp (darbepoetin alfa) • Retacrit (epoetin alfa-epbx) Coverage for **Epogen or Procrit** is provided when **either** of the following criteria is met: • Member has received treatment with Epogen or Procrit in the past 365 days**; OR** • Member meets **both** of the following criteria: o Member has had a documented intolerable adverse event with Retacrit, and the adverse event was not an expected adverse event attributed to the active

		ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; AND** ○ Member has a documented inadequate response or intolerable adverse event with the preferred product Aranesp. Coverage for **Mircera** is provided when **either** of the following criteria is met: • Member has received treatment with Mircera in the past 365 days**; OR** • Member has a documented inadequate response or intolerable adverse event with both of the preferred products, Aranesp and Retacrit.
Erythropoiesis Stimulating Agents - Anemia Due to Myelosuppressive Chemotherapy in Cancer	• Epogen (epoetin alfa) • Procrit (epoetin alfa)	Preferred products: • Aranesp (darbepoetin alfa) • Retacrit (epoetin alfa-epbx) Coverage for Epogen or Procrit is provided when **either** of the following criteria is met: • Member has received treatment with Epogen or Procrit in the past 365 days**; OR** • Member meets **both** of the following criteria: ○ Member has had a documented intolerable adverse event with Retacrit, and the adverse event was

		not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; AND** ○ Member has a documented inadequate response or intolerable adverse event with the preferred product Aranesp.
Erythropoiesis Stimulating Agents – Anemia Due to Zidovudine in Patients with Human Immunodeficiency Virus (HIV) Infection and To Reduce Need for Allogeneic Red Blood Cell (RBC) Transfusions	• Epogen (epoetin alfa) • Procrit (epoetin alfa)	Preferred products: • Retacrit (epoetin alfa-epbx) Coverage for Epogen or Procrit is provided when **either** of the following criteria is met: • Member has received treatment with Epogen or Procrit in the past 365 days**; OR** • Member has had a documented intolerable adverse event with Retacrit, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product).

References

1. Aranesp [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.
2. Epogen [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.
3. Mircera [package insert]. St. Gallen, Switzerland: Vifor (International) Inc.; June 2024.
4. Procrit [package insert]. Horsham, PA: Janssen Products, LP; April 2024.
5. Retacrit [package insert]. Lake Forest, IL: Hospira Inc.; June 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Factor VIII Products	• Advate (antihemophilic factor [recombinant]) • Kogenate FS (antihemophilic factor [recombinant]) • Novoeight (antihemophilic factor [recombinant]) • Recombinate (antihemophilic factor [recombinant]) • Xyntha (antihemophilic factor [recombinant]) • Xyntha Solofuse (antihemophilic factor [recombinant])	Preferred products: • Afstyla (antihemophilic factor [recombinant]) • Kovaltry (antihemophilic factor [recombinant]) • Nuwig (antihemophilic factor [recombinant]) Coverage for the non-preferred product is provided when **either** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has a documented inadequate response or intolerable adverse event with all of the preferred products.

References
1. Advate [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; March 2023.
2. Afstyla [package insert]. Kankakee, IL: CSL Behring LLC; June 2023.
3. Kogenate FS [package insert]. Whippany, NJ: Bayer HealthCare LLC; December 2019.
4. Kogenate FS with BIO-SET [package insert]. Whippany, NJ: Bayer HealthCare LLC; December 2019.
5. Kogenate FS with Vial Adapter [package insert]. Whippany, NJ: Bayer HealthCare LLC; December 2019.
6. Kovaltry [package insert]. Whippany, NJ: Bayer Healthcare LLC; December 2022.
7. Novoeight [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; July 2020.
8. Nuwiq [package insert]. Paramus, NJ: Octapharma USA, Inc., June 2021.
9. Recombinate [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; March 2023.
10. Xyntha [package insert]. Philadelphia, PA; Wyeth Pharmaceuticals LLC; July 2022.
11. Xyntha Solufuse [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals LLC; July 2022.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Gaucher Disease Agents	• VPRIV (velaglucerase alfa)	Preferred products: • Cerezyme (imiglucerase) • Elelyso (taliglucerase alfa) Coverage for the non-preferred product is provided when **ANY** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • The member has had a documented inadequate response or an intolerable adverse event with Cerezyme AND is between 2 and 4 years of age**; OR** • Member has had a documented inadequate response or an intolerable adverse event with both of the preferred products, Cerezyme and Elelyso.

References

1. Elelyso [package insert]. New York, NY: Pfizer, Inc; January 2025.
2. Cerezyme [package insert]. Cambridge, MA: Genzyme Corporation; December 2024.
3. VPRIV [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; September 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Gonadotropin Releasing Hormone Agonists (Prostate Cancer Only)	• Camcevi (leuprolide mesylate) • Lupron Depot (leuprolide acetate for depot suspension) • Trelstar (triptorelin) • Zoladex (goserelin acetate))	Preferred products: • Eligard (leuprolide acetate)) Coverage for the non-preferred product is provided when **EITHER** of the following criteria is met: • Member has received treatment with a non-preferred product in the past 365 days**; OR** • Member has a documented hypersensitivity to the preferred product.

References
1. Camcevi [package insert]. Durham, NC: Accord BioPharma Inc.; February 2025.
2. Eligard [package insert]. Fort Collins, CO: Tolmar Pharmaceuticals, Inc.; February 2025.
3. Lupron Depot [package insert]. North Chicago, IL: AbbVie Inc.; March 2024.
4. Trelstar [package insert]. Ewing, NJ: Verity Pharmaceuticals, Inc.; March 2025.
5. Zoladex [package insert]. Deerfield, IL: TerSera Therapeutics LLC; December 2020.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Hyaluronates (Osteoarthritis-Multi)	• Gelsyn-3 (sodium hyaluronate) • GenVisc 850 (sodium hyaluronate) • Hyalgan (sodium hyaluronate) • Hymovis (high molecular weight viscoelastic hyaluronan) • Orthovisc (high molecular weight hyaluronan) • Supartz FX (sodium hyaluronate) • Triluron (sodium hyaluronate) • Trivisc (sodium hyaluronate) • Visco-3 (sodium hyaluronate)	Preferred products: • Euflexxa (1% sodium hyaluronate) • Synvisc (hylan G-F 20) Coverage for a non-preferred product is provided when **EITHER** of the following criteria is met: • Member has received treatment with the requested non-preferred product in the past 365 days**; OR** • Member has a documented intolerable adverse event to both of the preferred products, Euflexxa and Synvisc.
Hyaluronates (Osteoarthritis-Single)	• Gel-One (cross-linked hyaluronate) • Monovisc (high molecular weight hyaluronan)	Preferred Product: • Durolane (hyaluronic acid) • Synvisc-One (hylan G-F 20) Coverage for a non-preferred product is provided when **EITHER** of the following criteria is met: • Member has received treatment with the requested non-preferred product in the past 365 days**; OR** • Member has a documented intolerable adverse event to both

		of the preferred products, Durolane and Synvisc-One.

References
1. Durolane [package insert]. Durham, NC: Bioventus, LLC; September 2017.
2. Euflexxa [package insert]. Parsippany, NJ: Ferring Pharmaceuticals, Inc.; July 2016.
3. Gel-One [package insert]. Warsaw, IN: Zimmer, Inc.; May 2011.
4. Gelsyn-3 [package insert]. Durham, NC: Bioventus LLC; December 2017.
5. GenVisc 850 [package insert]. Doylestown, PA: OrthogenRx, Inc.; November 2019.
6. Hyalgan [package insert]. Florham Park, NJ: Fidia Pharma USA Inc.; August 2017.
7. Hymovis [package insert]. Parsippany, NJ: Fidia Pharma USA Inc.; September 2017.
8. Monovisc [package insert]. Bedford, MA: Anika Therapeutics, Inc.; July 2020.
9. Orthovisc [package insert]. Bedford, MA: Anika Therapeutics, Inc.; November 2021.
10. Supartz FX [package insert]. Durham, NC: Bioventus LLC; April 2015.
11. Synvisc [package insert]. Ridgefield, NJ: Genzyme Biosurgery; May 2023.
12. Synvisc One [package insert]. Ridgefield, NJ: Genzyme Biosurgery; May 2023.
13. Triluron [package insert]. Florham Park, NJ: Fidia Pharma USA Inc.; July 2019.
14. Trivisc [package insert]. Doylestown, PA: OrthogenRX; September 2018.
15. Visco-3 [package insert]. Warsaw, IN: Zimmer Inc.; May 2017.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Immune Globulins	• Asceniv (intravenous) • Bivigam (intravenous) • Cutaquig (subcutaneous) • Cuvitru (subcutaneous) • Gammagard Liquid (subcutaneous/intravenous) • Gammaplex (intravenous) • HyQvia (subcutaneous) • Panzyga (intravenous) • Xembify (subcutaneous)	Preferred products: • Flebogamma (intravenous) • Gammaked (subcutaneous/intravenous) • Gamunex-C (subcutaneous/intravenous) • Hizentra (subcutaneous) • Octagam (intravenous) • Privigen (intravenous) Coverage for the non-preferred product is provided when **EITHER** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has a documented intolerable adverse event with at least 3 of the preferred products.

References
1. Asceniv [package insert]. Boca Raton, FL: ADMA Biologics; April 2019.
2. Bivigam [package insert]. Boca Raton, FL: ADMA Biologics; December 2023.
3. Cutaquig [package insert]. Paramus, NJ: Octapharma USA, Inc.; November 2021.
4. Flebogamma Dif [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; September 2019.
5. Gammagard Liquid [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; January 2024.
6. Gammaked [package insert]. Research Triangle Park, NC: Grifols Therapeutics LLC; January 2020.
7. Gammaplex 5% [package insert]. Hertfordshire, United Kingdom: Bio Products Laboratory; November 2021.
8. Gammaplex 10% [package insert]. Hertfordshire, United Kingdom: Bio Products Laboratory; November 2021.
9. Gamunex-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; January 2020.
10. Octagam 10% [package insert]. Paramus, NJ: Octapharma USA, Inc.; April 2022.
11. Octagam 5% [package insert]. Paramus, NJ: Octapharma USA, Inc.; April 2022.
12. Panzyga [package insert]. New York, NY; Pfizer; February 2021.
13. Privigen [package insert]. Kankakee, IL: CSL Behring LLC; March 2022.
14. Cuvitru [package insert]. Lexington, MA: Baxalta US Inc.; March 2023.
15. Hizentra [package insert]. Kankakee, IL: CSL Behring LLC; April 2023.
16. HyQvia [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; January 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Intravenous Iron	• Feraheme (ferumoxytol) • Injectafer (ferric carboxymaltose) • Monoferric (ferric derisomaltose)	Preferred products: • Ferrlecit (sodium ferric gluconate complex) • Infed (iron dextran) • Sodium ferric gluconate • Venofer (iron sucrose) Coverage for a non-preferred product is provided when **ANY** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • The requested product is Feraheme and the member meets any of the following: o Member has a diagnosis of iron deficiency anemia

		with intolerance or unsatisfactory response to oral iron and has had documented inadequate response or intolerable adverse event with Infed**; OR** ○ Member has a diagnosis of hemodialysis-dependent chronic kidney disease and is receiving supplemental epoetin therapy and has had a documented inadequate response or intolerable adverse event with both Ferrlecit and sodium ferric gluconate**; OR** ○ Member has a diagnosis of chronic kidney disease and has had a documented inadequate response or intolerable adverse event with Venofer**; OR** • The requested product is Injectafer and the member meets any of the following: ○ Member has a diagnosis of iron deficiency anemia with intolerance or unsatisfactory response to oral iron and has had documented inadequate response

		or intolerable adverse event with Infed**; OR** ○ Member has a diagnosis of non-hemodialysis dependent chronic kidney disease and has had a documented inadequate response or intolerable adverse event with Venofer**; OR** ○ Member has a diagnosis of iron deficiency with heart failure categorized as New York Heart Association class II/III. • The requested product is Monoferric and the member meets any of the following: ○ Member has a diagnosis of iron deficiency anemia with intolerance or unsatisfactory response to oral iron and has had documented inadequate response or intolerable adverse event with Infed**; OR** ○ Member has a diagnosis of non-hemodialysis dependent chronic kidney disease and has had a documented inadequate response or intolerable adverse event with Venofer.

References
1. Ferrlecit [package insert]. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; March 2022.
2. Infed [package insert]. Madison, NJ: Allergan USA, Inc.; August 2024.
3. Sodium Ferric Gluconate [package insert]. Berkley Heights, NJ: Hikma Pharmaceuticals USA, Inc.; January 2021
4. Venofer [package insert]. Shirley, NY: American Regent, Inc.; June 2022.
5. Feraheme [package insert]. Waltham, MA: AMAG Pharmaceuticals, Inc.; June 2022.
6. Injectafer [package insert]. Shirley, NY: American Regent, Inc.; January 2025.
7. Monoferric [package insert]. Morristown, NJ: Pharmacosmos Therapeutics, Inc.; February 2022

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Mitotic Inhibitors	• Abraxane (paclitaxel, albumin-bound)	Preferred products: • docetaxel (generic) • paclitaxel (generic) Coverage for the non-preferred product is provided when **ANY** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has a documented inadequate response or intolerable adverse event with either of the preferred products, docetaxel or paclitaxel**; OR** • Member has a documented clinical reason to avoid all of the preferred products.

References
1. Abraxane [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; October 2022.
2. docetaxel [package insert]. Lake Forest, IL: Hospira, Inc.; May 2023.
3. paclitaxel [package insert]. Bedminster, NJ: Alembic Pharmaceutical, Inc.; November 2022.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Multiple Myeloma	• Empliciti (elotuzumab) • Kyprolis (carfilzomib) • Sarclisa (isatuximab)	Preferred products: • bortezomib (generic) J9046, NDC 43598-0865-60 • bortezomib (generic) J9048, NDC 63323-0721-10

	• Velcade (J9041) (bortezomib)	• bortezomib (generic) J9049, NDC 00409-1703-01 Coverage for the non-preferred product is provided when **ANY** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • The request is for Empliciti, Kyprolis or Sarclisa and the member has a documented inadequate response or intolerable adverse event with a preferred product**; OR** • The request is for Velcade and the member has had a documented intolerable adverse event to a preferred product, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

References
1. bortezomib [package insert]. Lake Zurich, IL: Fresenius Kabi; April 2022.
2. Empliciti [package insert]. Princeton, NJ: Bristol-Myers Squibb; March 2022.
3. Kyprolis [package insert]. Thousand Oaks, CA: Onyx Pharmaceuticals, Inc.; June 2022.
4. Sarclisa [package insert]. Bridgewater, NJ: sanofi-aventis U.S. LLC; October 2024.
5. Velcade [package insert]. Lexington, MA: Takeda Pharmaceuticals America; August 2022.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Multiple Sclerosis	• Briumvi (ublituximab-xiiy) • Lemtrada (alemtuzumab) • Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)	Preferred products: • Ocrevus (ocrelizumab) Tyruko (natalizumab-sztn) **Briumvi and Lemtrada:** Coverage for Briumvi or Lemtrada is provided when either of the following criteria is met:

	• Tysabri (natalizumab)	• Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has a documented inadequate response, intolerable adverse event, or contraindication to therapy with both of the preferred products or any of their components. **Ocrevus Zunovo:** Coverage for Ocrevus Zunovo is provided when either of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member meets both of the following criteria: ○ Member has had a documented intolerable adverse event with the preferred product, Ocrevus, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information**; AND** ○ Member has a documented inadequate response, intolerable adverse event, or contraindication to therapy with the preferred product, Tyruko, or any of its components.

		Tysabri: Coverage for Tysabri is provided when either of the following criteria is met: Member has received treatment with the non-preferred product in the past 365 days. • Member meets both of the following criteria: ○ Member has had a documented intolerable adverse event to the preferred product, Tyruko, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)**; AND** ○ Member has a documented inadequate response, intolerable adverse event, or contraindication to therapy with the preferred product, Ocrevus, or any of its components.

References
1. Briumvi [package insert]. Morrisville, NC: TG Therapeutics, Inc.; November 2024.
2. Lemtrada [package insert]. Cambridge, MA: Genzyme Corporation; May 2024.
3. Ocrevus [package insert]. South San Francisco, CA: Genentech, Inc.; June 2024.
4. Ocrevus Zunovo [package insert]. South San Francisco, CA: Genentech, Inc.; September 2024.
5. Tyruko [package insert]. Princeton, NJ: Sandoz Inc.; August 2023.
6. Tysabri [package insert]. Cambridge, MA: Biogen Inc.; March 2025.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements

Osteoporosis-Bone Density	• Evenity (romosozumab-aqqg)
	• Prolia (denosumab)
		Preferred products:
		• Jubbonti (denosumab-bbdz)
		• zoledronic acid
		
		Evenity:
		Coverage for Evenity is provided when **ANY** of the following criteria are met:
		• Member has received treatment with the non-preferred product in the past 365 days**; OR**
		• Member meets both of the following criteria:
		  ○ Member has had a documented inadequate response, intolerable adverse event, contraindication, or clinical reason to avoid Jubbonti**; AND**
		  ○ Member has had a documented inadequate response, intolerable adverse event, or contraindication to zoledronic acid (e.g., creatinine clearance less than 35 mL/min).
		
		Prolia:
		Coverage for Prolia is provided when **ANY** of the following criteria are met:
		• Member has received treatment with the non-preferred product in the past 365 days**; OR**
		• Member has both of the following:
		  ○ Member has had a documented intolerable adverse event to the preferred products, and the adverse event was not an expected adverse event

		attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; AND** ○ Member has had a documented inadequate response, intolerable adverse event, or a contraindication to zoledronic acid (e.g., creatinine clearance less than 35 mL/min).

References
1. Evenity [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.
2. Jubbonti [package insert]. Princeton, NJ: Sandoz Inc.; October 2024.
3. Prolia [package insert]. Thousand Oaks, CA: Amgen Inc.; March 2024.
4. Zoledronic acid [package insert]. Princeton, NJ: Fosun Pharma USA Inc.; February 2023.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Osteoporosis–Hypercalcemia of Malignancy	• Xgeva (denosumab)	Preferred products: • pamidronate • Wyost (denosumab-bbdz) • zoledronic acid Coverage for the non-preferred product is provided when the member meets **EITHER** of the following criteria: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member meets both of the following criteria: ○ Member meets either of the following criteria: ▪ Member has a documented inadequate response to

		pamidronate or zoledronic acid**; OR** ▪ Member has had a documented intolerable adverse event or contraindication to therapy with both pamidronate and zoledronic acid (i.e., severe renal impairment [creatinine clearance less than 35 mL/min])**; AND** ○ Member has had a documented intolerable adverse event to Wyost, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product).

References
1. Pamidronate [package insert]. Morgantown, WV: Mylan Institutional LLC; July 2022.
2. Wyost [package insert]. Princeton, NJ: Sandoz Inc.; March 2024.
3. Xgeva [package insert]. Thousand Oaks, CA: Amgen Inc.; June 2020.
4. Zoledronic acid [package insert]. Raleigh, NC: Accord Healthcare, Inc.; September 2023.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
PD1/PDL1 Products: Basal Cell Carcinoma and Squamous Cell Carcinoma	• Keytruda (pembrolizumab)	Preferred products: • Libtayo (cemiplimab) Coverage for the non-preferred product is provided when **EITHER** of the following criteria is met:

		• Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has a documented intolerable adverse event with the preferred product.

References
1. Keytruda [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; March 2025.
2. Libtayo [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; March 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
PD1/PDL1 Products - Non-Small Cell Lung Cancer (NSCLC)	• Imfinzi (durvalumab) • Keytruda (pembrolizumab) • Opdivo (nivolumab) • Tecentriq (atezolizumab)	Preferred products: • Libtayo (cemiplimab) Coverage for a non-preferred product is provided when the member meets **ONE** of the following criteria: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has had a documented intolerable adverse event to the preferred product**; OR** • Keytruda is being used for advanced or metastatic NSCLC with adenocarcinoma or squamous cell histology and with PD-L1 expression of greater than or equal to 1-49%**; OR** • Keytruda, Imfinzi or Tecentriq is being used for the adjuvant treatment of NSCLC**; OR** • Imfinzi is being used following concurrent chemoradiation for NSCLC**; OR** • Keytruda, Imfinzi, or Opdivo is being used for the neoadjuvant treatment of NSCLC.

References
1. Imfinzi [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2025.
2. Libtayo [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; March 2024.

3. Keytruda [package insert]. Rathway, NJ: Merck & Co., Inc.; March 2025.
4. Opdivo [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; October 2024
5. Tecentriq [package insert]. South San Francisco, CA: Genentech, Inc.; April 2024.
6. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 15, 2024.

Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**

Retinal Disorders	• Beovu (brolucizumab-dbll)
	• Cimerli (ranibizumab-eqrn)
	• Eylea (aflibercept)
	• Eylea HD (aflibercept)
	• Lucentis (ranibizumab)
	• Susvimo (ranibizumab injection)
	• Vabysmo (faricimab-svoa)
		Primary Preferred product:
		• Avastin (bevacizumab)
		
		Secondary Preferred products:
		• Byooviz (ranibizumab-nuna)
		• Pavblu (aflibercept-ayyh)
		
		Coverage for a non-preferred product is provided when **ANY** of the following criteria are met:
		• Member has received treatment with the non-preferred product in the past 365 days**; OR**
		• The requested product is Byooviz or Pavblu and member has had a documented inadequate response or intolerable adverse event with the primary preferred product, Avastin**; OR**
		• The requested product is Eylea and either of the following criteria are met:
		  ○ Member meets both of the following:
		  ▪ Member has a documented inadequate response or intolerable adverse event with the primary preferred product, Avastin, and the secondary preferred product, Byooviz**; AND**

		▪ Member has a documented intolerable adverse event to the secondary preferred product, Pavblu, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; OR** ○ Member has a diagnosis of retinopathy of prematurity and has a documented intolerable adverse event to the secondary preferred product, Pavblu, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; OR** • The requested product is Eylea HD and both of the following criteria are met: ○ Member has a documented inadequate response or intolerable adverse event with the primary preferred product, Avastin, and the secondary preferred product, Byooviz**; AND**

		○ Member has a documented intolerable adverse event to the secondary preferred product, Pavblu, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; OR** • The requested product is Beovu or Vabysmo and both of the following criteria are met: ○ Member has had a documented inadequate response or intolerable adverse event with the primary preferred product, Avastin**; AND** ○ Member has had a documented inadequate response or intolerable adverse event with both of the secondary preferred products: Byooviz and Pavblu**; OR** • The requested product is Cimerli or Lucentis and either of the following criteria are met: ○ Member has a diagnosis of myopic choroidal neovascularization (mCNV) and all of the following criteria are met: ▪ Member has a documented inadequate response or intolerable adverse event with the primary preferred

		product, Avastin**; AND** ▪ Member has had a documented intolerable adverse event to the secondary preferred product, Byooviz, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; OR** ○ Member has a diagnosis other than myopic choroidal neovascularization (mCNV) and all of the following criteria are met: ▪ Member has had a documented inadequate response or intolerable adverse event with the primary preferred product, Avastin**; AND** ▪ Member has had a documented intolerable adverse event to the secondary preferred product, Byooviz, and the adverse event was not an

		expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; AND** ▪ Member has had a documented inadequate response or intolerable adverse event with the secondary preferred product, Pavblu**; OR** • The requested product is Susvimo and all of the following criteria are met: ○ Member has had a documented inadequate response or intolerable adverse event with the primary preferred product, Avastin**; AND** ○ Member has had a documented intolerable adverse event to the secondary preferred product, Byooviz and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar product)**; AND** ○ Member has had a documented inadequate

		response or intolerable adverse event with the secondary preferred product, Pavblu.

References
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Category/Criteria Name	**Non-Preferred Product(s)**	**Step Therapy Requirements**
Rituximab Products	• Riabni (rituximab-arrx) • Rituxan (rituximab) • Rituxan Hycela (rituximab and hyaluronidase human)	Preferred products: • Ruxience (rituximab-pvvr) • Truxima (rituximab-abbs) Coverage for a non-preferred product is provided when **EITHER** of the following criteria is met: • Member has received treatment with the non-preferred product in the past 365 days**; OR** • Member has had a documented intolerable adverse event to both of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

References
1. Riabni [package insert]. Thousand Oaks, CA: Amgen, Inc.; February 2023.
2. Rituxan [package insert]. South San Francisco, CA: Genentech, Inc.; December 2021.
3. Rituxan Hycela [package insert]. South San Francisco, CA: Genentech, Inc.; June 2021.

4. Ruxience [package insert]. New York, NY: Pfizer; October 2023.
5. Truxima [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc; December 2024.

Category/Criteria Name	Non-Preferred Product(s)	Step Therapy Requirements
Trastuzumab Products	• Herceptin (trastuzumab) • Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) • Hercessi (trastuzumab-strf) • Herzuma (trastuzumab-pkrb) • Trazimera (trastuzumab-qyyp)	Preferred products: • Kanjinti (trastuzumab-anns) • Ogivri (trastuzumab-dkst) • Ontruzant (trastuzumab-dttb) Coverage for a non-preferred product is provided when **EITHER** of the following criteria is met: • Member has received treatment with the requested non-preferred product in the past 365 days**; OR** • Member has had a documented intolerable adverse event to all of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

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2. Herceptin Hylecta [package insert]. South San Francisco, CA: Genentech, Inc.; June 2024.
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