Medicare Part B Step Therapy Programs

Policy Number: IAP.001.31
Effective Date: October 1, 2026

Instructions for Use

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Medicare Advantage Medical Policy
• Medications/Drugs (Outpatient/Part B)

Application

This policy is applicable to most UnitedHealthcare Medicare Advantage plans offered by UnitedHealthcare and its affiliates. Refer to the **Plan Exceptions** below:

Plan Type	Excluded Plans
Non-Employer Group Medicare Advantage	• UnitedHealthcare Medicare Direct (Private Fee-For-Service, PFFS): H5435-001, H5435-024 • Certain UnitedHealthcare Dual Complete and Dual Choice plans: ○ Arizona: H0321-004 ○ District of Columbia: H2406-053, H7464-010 ○ Florida: H1045-063, H1045-065, H1889-026, H2509-001, H2509-003, H5420-016 ○ Hawaii: H6824-002 ○ Idaho: H4032-001 ○ Indiana: H2385-003, H2385-004 ○ Massachusetts: H2226-001, H2226-003, H4610-001, H4610-002 ○ Michigan: H2247-005 ○ New Jersey: H3113-005 ○ New Mexico: H0294-049 ○ New York: H3387-013 ○ Tennessee: H0251-004, H0251-008 ○ Texas: H3868-001 ○ Virginia: H0421-001, H2445-001, H2445-003, H2445-005
Employer Group Medicare Advantage	• All Group HMO plans • Select Group PPO plans: ○ Bristol-Myers Squibb: H2001-869 ○ Johnson & Johnson: H2001-869 ○ Kenvue: H2001-869 ○ United Auto Workers (UAW) Trust: H1537-869, H2001-870, H2001-850 ○ U.S. Government of the Virgin Islands (USGVI): H1537-868, H2001-859, H2001-868, H2001-896, H2001-897 ○ Verizon: H2001-869

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.

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Coverage Rationale

➲ See Benefit Considerations

This policy supplements Medicare NCDs, LCDs, and manuals for the purpose of determining coverage under Medicare Part B benefits. A member cannot be required under this policy to change a current drug/product. For the purposes of this policy, a current drug/product means the member has a paid claim for the drug/product within the past 365 days. For example, a new UnitedHealthcare plan member with claim history of a particular drug/product will not be required to switch to the preferred drug/product upon enrollment. Similarly, an existing UnitedHealthcare plan member with paid claims for a particular drug/product will not be required to change drugs/products in the event this policy is updated.

This policy applies to step therapy for the drugs/products in the tables below. Drugs/products must satisfy the step therapy criteria in this policy and, if approved, authorization will be provided for 12 months.

If a provider administers a non-preferred drug/product without obtaining prior authorization, UnitedHealthcare may deny claims for the non-preferred drug/product.

Classes of Medical Benefit Injectables		Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Antiemetics for Oncology [Neurokinin 1 Receptor Antagonist (NK1 RA), 5-hydroxytryptamine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA combination]		Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, Ondansetron	Akynzeo, Cinvanti, Focinvez, Posfrea, Sustol
Asthma Immunomodulators – Respiratory Interleukins		Fasenra, Nucala	Cinqair, Exdensur
ATTR-Mediated Amyloidosis With Cardiomyopathy Non-Employer Group MAPD Plans only		Attruby, Vyndamax	Amvuttra
Bevacizumab		Mvasi, Vegzelma, Zirabev	Alymsys, Avastin, Avzivi, Jobevne
Bone Density Agents – Oncology		Jubbonti, Osenvelt, Prolia, Stoboclo, Wyost, Xgeva	Bildyos, Bilprevda, Bomyntra, Conexxence, Enoby, Ospomyv, Xbryk, Xtrenbo
Bone Density Agents – Osteoporosis		Jubbonti, Prolia, Stoboclo	Bildyos, Conexxence, Enoby, Evenity, Ospomyv
Botulinum Toxins A and B		Botox, Xeomin	Daxxify, Dysport, Myobloc
Colony Stimulating Factors	Short Acting	Zarxio	Filkri, Granix, Neupogen, Nivestym, Nypozi, Releuko
	Long Acting	Neulasta, Fulphila, Udenyca	Armlupeg, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo
Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH)		Bkemv, Epysqli, Soliris, Ultomiris	PiaSky
Gemcitabine		Gemcitabine (HCPCS codes J9196 and J9201)	Avgemsi
Gonadotropin Releasing Hormone Analogs for Oncology		HCPCS codes J1954 and J9217 (leuprolide acetate, 7.5mg)	HCPCS code J1950 (leuprolide acetate, 3.75mg)
Gout Agents Non-Employer Group MAPD Plans only		Allopurinol, Febuxostat	Krystexxa
Hyaluronic Acid Polymers		Durolane, Gelsyn-3, Synvisc, Synvisc-One	Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovis, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz Fx, Synojoynt, Triluron, TriVisc, Visco-3

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Classes of Medical Benefit Injectables	Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Immune Globulins	Bivigam, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Alyglo, Asceniv, Cutaquig, HyQvia, Panzyga, Qivigy, Yimmugo
Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG)	Bkemv, Epysqli, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo	Imaavy, Rystiggo
Inflammatory Bowel Disease Agents	Entyvio, Steqeyma, Yesintek	Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, Wezlana
Infliximab	Avsola, Inflectra, Renflexis	Infliximab, Remicade
Intravenous Iron Replacement Therapy	Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Venofer (iron sucrose)	Injectafer, Monoferric
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Neovascular (Wet) Age-Related Macular Degeneration	Repackaged Avastin, then Eylea or Eylea HD or Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Retinal Conditions Other Than Neovascular (Wet) Age-Related Macular Degeneration	Eylea, Eylea HD, Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo
Irinotecan – Pancreatic Cancer	Camptosar, generic Irinotecan products (HCPCS code J9206)	Onivyde
Leucovorin/Levoleucovorin	Leucovorin	Fusilev, Khapzory, Levoleucovorin, Vykoura
Lipid Modifying Agents Non-Employer Group MAPD plans only	Praluent, Repatha	Leqvio
Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists Non-Employer Group MAPD plans only	Aimovig, Ajovy, Emgality	Vyepti
Multiple Sclerosis Agents	Ocrevus, Ocrevus Zunovo	Briumvi
Pemetrexed	Alimta, generic Pemetrexed products (J9294, J9296, J9297, J9305, J9314)	Axtle, Pemfexy, Pemrydi RTU
Rituximab	Riabni, Ruxience, Truxima	Rituxan, Rituxan Hycela
Systemic Lupus Erythematosus Agents	Benlysta	Saphnelo
Tocilizumab	Avtozma, Tofidence, Tyenne	Actemra
Trastuzumab	Kanjinti, Ogivri, Trazimera	Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Ontruzant

Classes of Medical Benefit Injectables	Indication(s)	Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Antineoplastic Monoclonal Antibodies –	Head and Neck Cancers: Cancer of the Nasopharynx, Recurrent, Unresectable, Oligometastatic, or Metastatic Disease	Loqtorzi	Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, Tevimbra

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Classes of Medical Benefit Injectables	Indication(s)	Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1)	Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive ≥ 50%	Keytruda, Keytruda Qlex, Libtayo, Tecentriq, Tecentriq Hybreza	Opdivo plus Yervoy
Bispecific T-Cell Engaging (BiTE) Antibody	Multiple Myeloma	Tecvayli	Elrexfio

Antiemetics for Oncology [Neurokinin 1 Receptor Antagonist (NK1 RA), 5-Hydroxytryptamine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA Combination] [Akynzeo, Aloxi (palonosetron), Cinvanti, Emend (fosaprepitant), Focinvez, Granisetron, Ondansetron, Posfrea, Sustol]

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, Ondansetron	Akynzeo, Cinvanti, Focinvez, Posfrea, Sustol

Non-Preferred Product Step Therapy Criteria

Akynzeo, Cinvanti, Focinvez, Posfrea, or Sustol may be covered when any of the criteria listed below are satisfied:

- History of use of Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, or Ondansetron resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Aloxi (palonosetron), Emend (fosaprepitant), Granisetron, or Ondansetron; **or**
- Continuation of prior therapy within the past 365 days.

Asthma Immunomodulators – Respiratory Interleukins (Cinqair, Exdensur, Fasenra, Nucala)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Fasenra, Nucala	Cinqair, Exdensur

Non-Preferred Product Step Therapy Criteria

Cinqair or Exdensur, when used for the treatment of severe asthma, may be covered when any of the criteria listed below are satisfied:

- History of use of Fasenra or Nucala resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Fasenra or Nucala; **or**
- Continuation of prior therapy within the past 365 days.

ATTR-Mediated Amyloidosis With Cardiomyopathy (Amvuttra, Attruby, Vyndamax) – Non-Employer Group MAPD Plans Only

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Attruby, Vyndamax	Amvuttra

Non-Preferred Product Step Therapy Criteria

Amvuttra, when used for the treatment of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis without evidence of polyneuropathy, may be covered when any of the criteria listed below are satisfied:

- History of use of Attruby or Vyndamax with progressive worsening or an event resulting in hospitalization related to ATTR-mediated amyloidosis with cardiomyopathy; **or**
- History of intolerance or adverse event(s) to Attruby or Vyndamax; **or**
- Continuation of prior therapy within the past 365 days.

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Bevacizumab (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev) – Oncology Uses Only

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Mvasi, Vegzelma, Zirabev	Alymsys, Avastin, Avzivi, Jobevne

Non-Preferred Product Step Therapy Criteria

Alymsys, Avastin, Avzivi, or Jobevne, when prescribed for a cancer condition, may be covered when any of the criteria listed below are satisfied:

- History of use of Mvasi, Vegzelma, or Zirabev resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Mvasi, Vegzelma, or Zirabev; **or**
- Continuation of prior therapy within the past 365 days.

Bone Density Agents – Oncology (Bildyos, Bilprevda, Bomyntra, Conexxence, Enoby, Jubbonti, Osenvelt, Ospomyv, Prolia, Stoboclo, Wyost, Xbryk, Xgeva, Xtrenbo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Jubbonti, Osenvelt, Prolia, Stoboclo, Wyost, Xgeva	Bildyos, Bilprevda, Bomyntra, Conexxence, Enoby, Ospomyv, Xbryk, Xtrenbo

Bilprevda, Bomyntra, Xbryk, and Xtrenbo Non-Preferred Product Step Therapy Criteria

Bilprevda, Bomyntra, Xbryk, or Xtrenbo, when used for treatment of the following conditions, may be covered when any of the criteria listed below are satisfied:

- **Conditions**
  - Prevention of skeletal related events in patients with multiple myeloma
  - Prevention of skeletal related events in patients with bone metastases from solid tumors
  - Hypercalcemia of malignancy
  - Osteopenia/osteoporosis in patients with systemic mastocytosis with bone pain
- **Criteria**
  - History of use of Osenvelt, Wyost, or Xgeva resulting in minimal clinical response to therapy; **or**
  - History of contraindication, intolerance, or adverse event(s) to Osenvelt, Wyost, or Xgeva; **or**
  - Continuation of prior therapy within the past 365 days.

Bildyos, Conexxence, Enoby, and Ospomyv Non-Preferred Product Step Therapy

Bildyos, Conexxence, Enoby, or Ospomyv may be covered when any of the criteria listed below are satisfied:[9]

- History of use of Jubbonti, Prolia, or Stoboclo resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to Jubbonti, Prolia, or Stoboclo; **or**
- Continuation of prior therapy within the past 365 days.

Bone Density Agents – Osteoporosis (Bildyos, Conexxence, Enoby, Evenity, Jubbonti, Ospomyv, Prolia, Stoboclo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Jubbonti, Prolia, Stoboclo	Bildyos, Conexxence, Enoby, Evenity, Ospomyv

Non-Preferred Product Step Therapy Criteria

Bildyos, Conexxence, Enoby, Evenity, or Ospomyv may be covered when any of the criteria listed below are satisfied:

- History of use of Jubbonti, Prolia, or Stoboclo resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to Jubbonti, Prolia, or Stoboclo; **or**
- Continuation of prior therapy within the past 365 days.

Botulinum Toxins A and B (Botox, Daxxify, Dysport, Myobloc, Xeomin)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Botox, Xeomin	Daxxify, Dysport, Myobloc

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Non-Preferred Product Step Therapy Criteria

Daxxify, Dysport, and Myobloc may be covered when any of the criteria listed below are satisfied:

- History of use of Botox or Xeomin resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Botox or Xeomin; **or**
- Continuation of prior therapy within the past 365 days.

Colony Stimulating Factors

Short-Acting (Filkri, Granix, Neupogen, Nivestym, Nypozi, Releuko, Zarxio)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Zarxio	Filkri, Granix, Neupogen, Nivestym, Nypozi, Releuko

Non-Preferred Product Step Therapy Criteria

Filkri, Granix, Neupogen, Nivestym, Nypozi, or Releuko may be covered when any of the criteria listed below are satisfied:

- History of use of Zarxio resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Zarxio; **or**
- Continuation of prior therapy within the past 365 days.

Long-Acting (Armlupeg, Fulphila, Fylnetra, Neulasta, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca, Ziextenzo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Fulphila, Neulasta, Udenyca	Armlupeg, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo

Non-Preferred Product Step Therapy Criteria

Armlupeg, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, or Ziextenzo may be covered when any of the criteria listed below are satisfied:

- History of use of Fulphila, Neulasta, or Udenyca, resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Fulphila, Neulasta, or Udenyca; **or**
- Continuation of prior therapy within the past 365 days.

Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH) (Bkemv, Epysqli, PiaSky, Soliris, Ultomiris)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bkemv, Epysqli, Soliris, Ultomiris	PiaSky

Non-Preferred Product Step Therapy Criteria

PiaSky may be covered when any of the criteria listed below are satisfied:

- History of use of Bkemv, Epysqli, Soliris, or Ultomiris resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Bkemv, Epysqli, Soliris, or Ultomiris; **or**
- Continuation of prior therapy within the past 365 days.

Gemcitabine (Avgemsi, Gemcitabine)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Gemcitabine (HCPCS codes J9196 and J9201)	Avgemsi

Non-Preferred Product Step Therapy Criteria

Avgemsi may be covered when any of the criteria listed below are satisfied:

- History of use of Gemcitabine (HCPCS codes J9196 and J9201) resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Gemcitabine (HCPCS codes J9196 and J9201); **or**
- Continuation of prior therapy within the past 365 days.

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Gonadotropin Releasing Hormone Analogs for Oncology (Leuprolide Acetate)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
HCPCS code J1954 [leuprolide acetate (lutrate depot), per 7.5mg], HCPCS code J9217 (leuprolide acetate, per 7.5mg)	HCPCS code J1950 (leuprolide acetate, per 3.75mg)

Non-Preferred Product Step Therapy Criteria

HCPCS code J1950 (leuprolide acetate, per 3.75mg) may be covered when the criteria listed below are satisfied:

- Continuation of prior therapy within the past 365 days.

Gout Agents (Allopurinol, Febuxostat, Krystexxa) – Non-Employer Group MAPD Plans Only

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Allopurinol, Febuxostat	Krystexxa

Non-Preferred Product Step Therapy Criteria

Krystexxa may be covered when any of the criteria listed below are satisfied:

- Both of the following:
  - Trial of at least 3 months of therapy (at the maximally medically appropriate dose) of Allopurinol resulting in minimal clinical response to therapy; **and**
  - Trial of at least 3 months of therapy (at the maximally medically appropriate dose) of Febuxostat resulting in minimal clinical response to therapy

  or
- History of contraindication, intolerance, or adverse event(s) to Allopurinol **and** Febuxostat; **or**
- Continuation of prior therapy within the past 365 days.

Hyaluronic Acid Polymers (Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz Fx, Synojoynt, Synvisc, Synvisc-One, Visco-3, Triluron, TriVisc)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Durolane, Gelsyn-3, Synvisc, Synvisc-One	Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovis, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz Fx, Synojoynt, Triluron, TriVisc, Visco-3

Non-Preferred Product Step Therapy Criteria

Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovis, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz FX, Synojoynt, Triluron, TriVisc, or Visco-3 may be covered when any of the criteria listed below are satisfied:

- Trial and failure of **all** of the following: Durolane, Gelsyn-3, **and** Synvisc/Synvisc-One, resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to **all** of the following: Durolane, Gelsyn-3, **and** Synvisc/Synvisc-One; **or**
- Continuation of prior therapy within the past 365 days.

Immune Globulins (Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Panzyga, Privigen, Qivigy, Xembify, Yimmugo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bivigam, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Alyglo, Asceniv, Cutaquig, HyQvia, Panzyga, Qivigy, Yimmugo

Non-Preferred Product Step Therapy Criteria

Alyglo, Asceniv, Cutaquig, HyQvia, Panzyga, Qivigy, or Yimmugo may be covered when any of the criteria listed below are satisfied:

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- History of use of at least **two** preferred Immune Globulin products (either IV or SC products), resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to at least **two** preferred Immune Globulin products (either IV or SC products); **or**
- Continuation of prior therapy within the past 365 days.

Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG) (Bkemv, Epysqli, Imaavy, Rystiggo, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Bkemv, Epysqli, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo	Imaavy, Rystiggo

Non-Preferred Product Step Therapy Criteria

Imaavy or Rystiggo may be covered when any of the criteria listed below are satisfied:

- History of use of **two** of the following resulting in minimal clinical response to therapy:
  - Bkemv
  - Epysqli
  - Soliris
  - Ultomiris
  - Vyvgart
  - Vyvgart Hytrulo

  or
- History of intolerance or adverse event(s) to **two** of the following:
  - Bkemv
  - Epysqli
  - Soliris
  - Ultomiris
  - Vyvgart
  - Vyvgart Hytrulo

  or
- Patient is anti-MuSK antibody positive (with medical records showing a positive serologic test for anti-MuSK antibodies); **or**
- Continuation of prior therapy within the past 365 days.

Inflammatory Bowel Disease Agents (Entyvio, Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, Wezlana, Yesintek)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Entyvio, Steqeyma, Yesintek	Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, Wezlana

Non-Preferred Product Step Therapy Criteria

Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Tremfya, or Wezlana may be covered when any of the criteria listed below are satisfied:

- History of use of **two** of the following resulting in minimal clinical response to therapy:
  - Entyvio
  - Steqeyma
  - Yesintek

  or
- History of intolerance or adverse event(s) to two of the following:
  - Entyvio
  - Steqeyma
  - Yesintek

  or
- Continuation of prior therapy within the past 365 days.

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Infliximab (Avsola, Inflectra, Infliximab, Remicade, Renflexis)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Avsola, Inflectra, Renflexis	Infliximab, Remicade

Non-Preferred Product Step Therapy Criteria

Infliximab or Remicade may be covered when any of the criteria listed below are satisfied:

- Trial of at least 14 weeks of Avsola, Inflectra, or Renflexis resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Avsola or Inflectra or Renflexis; **or**
- Continuation of prior therapy within the past 365 days.

Intravenous Iron Replacement Therapy [Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Injectafer, Monoferric, Venofer (iron sucrose)]

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Venofer (iron sucrose)	Injectafer, Monoferric

Non-Preferred Product Step Therapy Criteria

Injectafer or Monoferric may be covered for iron deficiency anemia without chronic kidney disease and iron deficiency anemia associated with chronic kidney disease (without end stage renal disease) when any of the criteria listed below are satisfied:

- Trial of at least 3 weeks of therapy, to at least **two** of the preferred intravenous iron therapies each, resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to at least **two** of the preferred intravenous iron therapies; **or**
- Continuation of prior therapy within the past 365 days.

Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Neovascular (Wet) Age-Related Macular Degeneration (Repackaged Avastin, Beovu, Byooviz, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, Vabysmo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Repackaged Avastin, then Eylea or Eylea HD or Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

Step Therapy Criteria

Eylea, Eylea HD, Pavblu

Eylea, Eylea HD, or Pavblu when prescribed for neovascular (wet) age-related macular degeneration, may be covered when any of the criteria listed below are satisfied:

- History of a trial of at least 3 doses (given no less frequently than every 6 weeks) of repackaged Avastin (bevacizumab), resulting in minimal clinical response to therapy; **or**
- History of contraindication or adverse event(s) to repackaged Avastin (bevacizumab); **or**
- Continuation of prior therapy within the past 365 days.

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo, when prescribed for neovascular (wet) age-related macular degeneration, may be covered when any of the criteria listed below are satisfied:

- Both of the following:
  - Trial of at least 3 doses (given no less frequently than every 6 weeks) of repackaged Avastin (bevacizumab), resulting in minimal clinical response to therapy; **and**
  - History of use of **one** of the following, resulting in minimal clinical response to therapy:
    - Eylea
    - Eylea HD
    - Pavblu

  or

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- History of contraindication, intolerance, or adverse event(s) to repackaged Avastin (bevacizumab) **and one** of the following: Eylea, Eylea HD, Pavblu; **or**
- Continuation of prior therapy within the past 365 days.

Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Retinal Conditions Other Than Neovascular (Wet) Age-Related Macular Degeneration (Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, Vabysmo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Eylea, Eylea HD, Pavblu	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

Non-Preferred Product Step Therapy Criteria

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo, when prescribed for a retinal condition other than neovascular (wet) age-related macular degeneration, may be covered when any of the criteria listed below are satisfied:

- History of use of **one** of the following, resulting in minimal clinical response to therapy: Eylea, Eylea HD, Pavblu; **or**
- History of contraindication or adverse event(s) to **one** of the following: Eylea, Eylea HD, Pavblu; **or**
- Continuation of prior therapy within the past 365 days.

Irinotecan – Pancreatic Cancer (Camptosar, Irinotecan, Onivyde)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Camptosar, generic Irinotecan products (HCPCS code J9206)	Onivyde

Non-Preferred Product Step Therapy Criteria

Onivyde, when prescribed for pancreatic cancer, may be covered when any of the criteria listed below are satisfied:

- History of use of Camptosar/generic Irinotecan resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Camptosar/generic Irinotecan; **or**
- Continuation of prior therapy within the past 365 days.

Leucovorin/Levoleucovorin (Fusilev, Khapzory, Leucovorin, Levoleucovorin, Vykoura)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Leucovorin	Fusilev, Khapzory, Levoleucovorin, Vykoura

Non-Preferred Product Step Therapy Criteria

Fusilev, Khapzory, Levoleucovorin, or Vykoura may be covered when any of the criteria listed below are satisfied:

- History of use of Leucovorin resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Leucovorin; **or**
- Continuation of prior therapy within the past 365 days.

Lipid Modifying Agents (Leqvio, Praluent, Repatha) (for Non-Employer Group MAPD Plans Only)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Praluent, Repatha	Leqvio

Non-Preferred Product Step Therapy Criteria

Leqvio may be covered when any of the criteria listed below are satisfied:

- Trial of at least 12 consecutive weeks of either Praluent or Repatha, resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to Praluent or Repatha; **or**
- Continuation of prior therapy within the past 365 days.

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Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (Aimovig, Ajovy, Emgality, Vyepti) (for Non-Employer Group MAPD Plans Only)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Aimovig, Ajovy, Emgality	Vyepti

Non-Preferred Product Step Therapy Criteria

Vyepti may be covered when any of the criteria listed below are satisfied:

- Trial of at least 3 months of therapy each, to **two** of the preferred drugs (e.g., Aimovig, Emgality), resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to two of the preferred drugs (e.g., Aimovig, Emgality); **or**
- Continuation of prior therapy within the past 365 days.

Multiple Sclerosis Agents (Briumvi, Ocrevus, Ocrevus Zunovo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Ocrevus, Ocrevus Zunovo	Briumvi

Non-Preferred Product Step Therapy Criteria

Briumvi may be covered when any of the criteria listed below are satisfied:

- History of use of Ocrevus or Ocrevus Zunovo resulting in minimal clinical response to therapy; **or**
- History of intolerance or adverse event(s) to Ocrevus or Ocrevus Zunovo; **or**
- Continuation of prior therapy within the past 365 days.

Pemetrexed (Alimta, Axtle, Pemetrexed, Pemfexy, Pemrydi RTU)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Alimta, generic Pemetrexed products (J9294, J9296, J9297, J9305, J9314)	Axtle, Pemfexy, Pemrydi RTU

Non-Preferred Product Step Therapy Criteria

Axtle, Pemfexy, or Pemrydi RTU may be covered when any of the criteria listed below are satisfied:

- History of use of Alimta/generic Pemetrexed resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Alimta/generic Pemetrexed; **or**
- Continuation of prior therapy within the past 365 days.

Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Riabni, Ruxience, Truxima	Rituxan, Rituxan Hycela

Non-Preferred Product Step Therapy Criteria

Rituxan or Rituxan Hycela may be covered when any of the criteria listed below are satisfied:

- History of use of Riabni, Ruxience, or Truxima resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Riabni, Ruxience, or Truxima; **or**
- Continuation of prior therapy within the past 365 days.

Systemic Lupus Erythematosus Agents (Benlysta, Saphnelo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Benlysta	Saphnelo

Non-Preferred Product Step Therapy Criteria

Saphnelo may be covered when any of the criteria listed below are satisfied:

- History of use of Benlysta resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to Benlysta; **or**

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- Continuation of prior therapy within the past 365 days.

Tocilizumab (Actemra, Avtozma, Tofidence, Tyenne)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Avtozma, Tofidence, Tyenne	Actemra

Non-Preferred Product Step Therapy Criteria

Actemra may be covered when any of the criteria listed below are satisfied:

- History of use of Avtozma, Tofidence or Tyenne resulting in minimal clinical response to therapy; **or**
- History of contraindication, intolerance, or adverse event(s) to Avtozma, Tofidence or Tyenne; **or**
- Continuation of prior therapy within the past 365 days.

Trastuzumab (Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Kanjinti, Ogivri, Trazimera	Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Ontruzant

Non-Preferred Product Step Therapy Criteria

Herceptin, Herceptin Hylecta, Hercessi, Herzuma, or Ontruzant, when prescribed for a cancer condition, may be covered when any of the criteria listed below are satisfied:

- History of use of Kanjinti, Ogivri, or Trazimera resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Kanjinti or Ogivri or Trazimera; **or**
- Continuation of prior therapy within the past 365 days.

Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1)

Head and Neck Cancers: Cancer of the Nasopharynx, Recurrent, Unresectable, Oligometastatic, or Metastatic Disease

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Loqtorzi	Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, Tevimbra

Non-Preferred Product Step Therapy Criteria

Keytruda, Keytruda Qlex, Opdivo, Opdivo Qvantig, or Tevimbra, when prescribed for nasopharyngeal carcinoma, may be covered when any of the criteria listed below are satisfied:

- History of use of Loqtorzi resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Loqtorzi; **or**
- Continuation of prior therapy within the past 365 days.

Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive ≥ 50%

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Keytruda, Keytruda Qlex, Libtayo, Tecentriq, Tecentriq Hybreza	Opdivo plus Yervoy

Non-Preferred Product Step Therapy Criteria

Opdivo plus Yervoy, when prescribed for non-small cell lung cancer, may be covered when any of the criteria listed below are satisfied:

- History of use of Keytruda, Keytruda Qlex, Libtayo, Tecentriq, or Tecentriq Hybreza resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Keytruda, Keytruda Qlex, Libtayo, Tecentriq, or Tecentriq Hybreza; **or**
- Continuation of prior therapy within the past 365 days.

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Bispecific T-Cell Engaging (BiTE) Antibody – Multiple Myeloma

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Tecvayli	Elrexfio

Non-Preferred Product Step Therapy Criteria

Elrexfio, when prescribed for multiple myeloma, may be covered when any of the criteria listed below are satisfied:

- History of use of Tecvayli resulting in minimal clinical response to therapy and residual disease activity; **or**
- History of intolerance or adverse event(s) to Tecvayli; **or**
- Continuation of prior therapy within the past 365 days.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

Antiemetics for Oncology [Neurokinin 1 Receptor Antagonist (NK1 RA), 5-Hydroxytryptamine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA Combination] (Akynzeo [palonosetron], Aloxi, Cinvanti, Emend [fosaprepitant], Focinvez, Granisetron, Ondansetron, Posfrea, Sustol)

HCPCS Code	Description
Preferred	
J1453	Injection, fosaprepitant, 1 mg
J1456	Injection, fosaprepitant (Teva), not therapeutically equivalent to J1453, 1 mg
J1626	Injection, granisetron hydrochloride, 100 mcg
J2405	Injection, ondansetron hydrochloride, per 1 mg
J2469	Injection, palonosetron HCl, 25 mcg
Q0162	Ondansetron 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q0166	Granisetron hydrochloride, 1 mg oral, FDA-approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen
Non-Preferred	
J0185	Injection, aprepitant, 1 mg
J1434	Injection, fosaprepitant (Focinvez), 1 mg
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg
J1627	Injection, granisetron, extended-release, 0.1mg
J2468	Injection, palonosetron hydrochloride (Avyxa), not therapeutically equivalent to j2469, 25 micrograms

Asthma Immunomodulators – Respiratory Interleukins (Cinqair, Exdensur, Fasenra, Nucala)

HCPCS Code	Description
Preferred	
J0517	Injection, benralizumab, 1 mg
J2182	Injection, mepolizumab, 1 mg

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HCPCS Code	Description
Non-Preferred	
J2361	Injection, depemokimab-ulaa, 1mg
J2786	Injection, reslizumab, 1 mg

ATTR-Mediated Amyloidosis With Cardiomyopathy (Amvuttra, Attruby, Vyndamax)

HCPCS Code	Description
Preferred	
N/A	N/A
Non-Preferred	
J0225	Injection, vutrisiran, 1 mg

Bevacizumab (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev)

HCPCS Code	Description
Preferred	
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg
Non-Preferred	
J9035	Injection, bevacizumab, 10 mg
J9999	Not otherwise classified, antineoplastic drugs
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Q5160	Injection, bevacizumab-nwgd (Jobevne), biosimilar, 10 mg

Bone Density Agents – Oncology and Osteoporosis (Bildyos, Bilprevda, Bomyntra, Conexxence, Enoby, Evenity, Jubbonti, Osenvelt, Ospomyv, Prolia, Stoboclo, Wyost, Xbryk, Xgeva Xtrenbo)

HCPCS Code	Description
Preferred	
J0897	Injection, denosumab, 1 mg
Q5136	Injection, denosumab-bbdz (Jubbonti/Wyost), biosimilar, 1 mg
Q5157	Injection, denosumab-bmwo (Stoboclo/Osenvelt), biosimilar, 1 mg
Non-Preferred	
J3111	Injection, romosozumab-aqqg, 1 mg
Q5158	Injection, denosumab-bnht (Bomyntra/Conexxence), biosimilar, 1 mg
Q5159	Injection, denosumab-dssb (Ospomyv/Xbryk), biosimilar, 1 mg
Q5162	Injection, denosumab-nxxp (Bildyos/Bilprevda), biosimilar, 1 mg
Q5167	Injection, denosumab-qbde (Enoby/Xtrenbo), biosimilar, 1mg

Botulinum Toxins A and B (Botox, Daxxify, Dysport, Myobloc, Xeomin)

HCPCS Code	Description
Preferred	
J0585	Injection, onabotulinumtoxinA, 1 unit
J0588	Injection, incobotulinumtoxinA, 1 unit
Non-Preferred	
J0586	Injection, abobotulinumtoxinA, 5 units
J0587	Injection, rimabotulinumtoxinB, 100 units
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit

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Colony Stimulating Factors

Short-Acting (Filkri, Granix, Neupogen, Nivestym, Nypozi, Releuko, Zarxio)

HCPCS Code	Description
Preferred	
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio) 1 microgram
Non-Preferred	
J1442	Injection, filgrastim (G-CSF), (Neupogen) excludes biosimilars, 1 mcg
J1447	Injection, tbo-filgrastim, (Granix)1 microgram
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram
Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg
Q5148	Injection, filgrastim-txid (Nypozi), biosimilar, 1 mcg
Q5172	Injection, filgrastim-laha (Filkri), biosimilar, 1 microgram

Long-Acting (Armlupeg, Fulphila, Fylnetra, Neulasta, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca, Ziextenzo)

HCPCS Code	Description
Preferred	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg
Q5108	Injection, pegfilgrastim-jmdb (Fulphila), biosimilar, 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg
Non-Preferred	
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg
Q5120	Injection, pegfilgrastim-bmez, (Ziextenzo), biosimilar, 0.5 mg
Q5122	Injection, pegfilgrastim-apgf (Nyvepria), biosimilar, 0.5 mg
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg
Q5169	Injection, pegfilgrastim-unne (Armlupeg), biosimilar, 0.5 mg

Complement Inhibitors – Paroxysmal Nocturnal Hemoglobinuria (PNH) (Bkemv, Epysqli, PiaSky, Soliris, Ultomiris)

HCPCS Code	Description
Preferred	
J1299	Injection, eculizumab, 2 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
Q5151	Injection, eculizumab-aagh (Epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (Bkemv), biosimilar, 10 mg
Non-Preferred	
J1307	Injection, crovalimab-akkz, 10 mg

Gemcitabine (Avgemsi, Gemcitabine)

HCPCS Code	Description
Preferred	
J9196	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg
J9201	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg
Non-Preferred	
J9184	Injection, gemcitabine hydrochloride (Avyxa), 200 mg

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Gonadotropin Releasing Hormone Analogs for Oncology

HCPCS Code	Description
Preferred	
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
Non-Preferred	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg

Gout Agents (Krystexxa)

HCPCS Code	Description
Preferred	
N/A	N/A
Non-Preferred	
J2507	Injection, pegloticase, 1 mg

Hyaluronic Acid Polymers (Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Hymovis One, Monovisc, Orthovisc, Supartz, Supartz Fx, Synojoynt, Synvisc, Synvisc-One, Visco-3, Triluron, TriVisc)

HCPCS Code	Description
Preferred	
J7318	Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
J7328	Hyaluronan or derivative, Gelsyn-3, for intra-articular injection, 0.1 mg
Non-Preferred	
J7320	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis or Hymovis One, for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
J7329	Hyaluronan or derivative, TriVisc, for intra-articular injection, 1 mg
J7331	Hyaluronan or derivative, Synojoynt, for intra-articular injection, 1mg
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1mg

Immune Globulins (Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Panzyga, Privigen, Qivigy, Xembify, Yimmugo)

CPT/HCPCS Code	Description
Preferred	
90283	Immune globulin (IgIV), human, for intravenous use
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each
J1459	Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1555	Injection, immune globulin (Cuvitru), 100 mg
J1556	Injection, immune globulin (Bivigam), 500 mg
J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1558	Injection, immune globulin (Xembify), 100 mg

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CPT/HCPCS Code	Description
Preferred	
J1559	Injection, immune globulin (Hizentra), 100 mg
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid/Gammagard liquid ERC), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, nonlyophilized (e.g., liquid), 500 mg
Non-Preferred	
J1551	Injection, immune globulin (Cutaquig), 100 mg
J1552	Injection, immune globulin (Alyglo), 100 mg
J1553	Injection, immune globulin (Yimmugo), 100 mg
J1554	Injection, immune globulin (Asceniv), 500 mg
J1575	Injection, immune globulin/hyaluronidase, (HyQvia), 100 mg immune globulin
J1576	Injection, immune globulin (Panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1577	Injection, immune globulin (Qivigy), 100mg
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg

Immunomodulator Therapy – Generalized Myasthenia Gravis (gMG) (Bkemv, Epysqli, Imaavy, Rystiggo, Soliris, Ultomiris, Vyvgart, Vyvgart Hytrulo)

HCPCS Code	Description
Preferred	
J1299	Injection, eculizumab, 2 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
J9332	Injection, efgartigimod alfa-fcab, 2mg
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg
Non-Preferred	
J9256	Injection, nipocalimab-aahu, 3 mg
J9333	Injection, rozanolixizumab-noli, 1 mg

Inflammatory Bowel Disease Agents (Entyvio, Imuldosa, Omvoh, Otulfi, Pyzchiva, Selarsdi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, Wezlana, Yesintek)

HCPCS Code	Description
Preferred	
J3380	Injection, vedolizumab, intravenous, 1 mg
Q5099	Injection, ustekinumab-stba (Steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (Yesintek), biosimilar, 1 mg
Non-Preferred	
J1628	Injection, guselkumab, 1 mg
J2267	Injection, mirikizumab-mrkz, 1 mg
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg

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HCPCS Code	Description
Non-Preferred	
Q5098	Injection, ustekinumab-srlf (Imuldosa), biosimilar, 1 mg
Q5138	Injection, ustekinumab-auub (Wezlana), biosimilar, intravenous, 1 mg
Q5164	Injection, ustekinumab-hmny (Starjemza), biosimilar, 1mg
Q9997	Injection, ustekinumab-ttwe (Pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (Selarsdi), biosimilar, 1 mg
Q9999	Injection, ustekinumab-aauz (Otulfi), biosimilar, 1 mg

Infliximab (Avsola, Inflectra, Infliximab, Remicade, Renflexis)

HCPCS Code	Description
Preferred	
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10mg
Non-Preferred	
J1745	Injection, infliximab, excludes biosimilar, 10 mg

Intravenous Iron Replacement Therapy [Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate complex), INFeD, Injectafer, Monoferric, Venofer (iron sucrose)]

HCPCS Code	Description
Preferred	
J1750	Injection, iron dextran, 50 mg
J1756	Injection, iron sucrose, 1 mg
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)
Non-Preferred	
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg

Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors (Repackaged Avastin, Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, Vabysmo)

HCPCS Code	Description
Preferred	
C9257	Injection, bevacizumab (Avastin), 0.25mg
J0177	Injection, aflibercept HD, 1 mg
J0178	Injection, aflibercept, 1 mg
J7999	Compounded drug, not otherwise classified
J9035	Injection, bevacizumab (Avastin), 10mg
Q5147	Injection, aflibercept-ayyh (Pavblu), biosimilar, 1 mg
Non-Preferred	
J0179	Injection, brolucizumab-dbll, 1 mg
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
J2779	Injection, ranibizumab, via intravitreal implant (Susvimo), 0.1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg

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HCPCS Code	Description
Non-Preferred	
Q5128	Injection, ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg

Diagnosis Code	Description
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
H35.3290	Exudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3291	Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization
H35.3292	Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization
H35.3293	Exudative age-related macular degeneration, unspecified eye, with inactive scar

Irinotecan – Pancreatic Cancer (Camptosar, Irinotecan, Onivyde)

HCPCS Code	Description
Preferred	
J9206	Injection, irinotecan, 20 mg
Non-Preferred	
J9205	Injection, irinotecan liposome, 1 mg

Leucovorin/Levoleucovorin (Fusilev, Khapzory, Leucovorin, Levoleucovorin, Vykoura)

HCPCS Code	Description
Preferred	
J0643	Injection, leucovorin calcium, not otherwise specified, 1 mg
Non-Preferred	
J0641	Injection, levoleucovorin, not otherwise specified, 0.5 mg
J0642	Injection, levoleucovorin (Khapzory), 0.5 mg
J0644	Injection, leucovorin calcium (Avyxa), 1mg

Lipid Modifying Agents (Leqvio)

HCPCS Code	Description
Preferred	
N/A	N/A
Non-Preferred	
J1306	Injection, inclisiran, 1 mg

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Migraine Prophylaxis – Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (Vyepti)

HCPCS Code	Description
Preferred	
N/A	N/A
Non-Preferred	
J3032	Injection, eptinezumab-jjmr, 1 mg

Multiple Sclerosis Agents (Briumvi, Ocrevus, Ocrevus Zunovo)

HCPCS Code	Description
Preferred	
J2350	Injection, ocrelizumab, 1 mg
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq
Non-Preferred	
J2329	Injection, ublituximab-xiiy, 1mg

Pemetrexed (Alimta, Axtle, Pemetrexed, Pemfexy, Pemrydi RTU)

HCPCS Code	Description
Preferred	
J9294	Injection, pemetrexed (Hospira), not therapeutically equivalent to j9305, 10 mg
J9296	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg
J9297	Injection, pemetrexed (Sandoz), not therapeutically equivalent to j9305, 10 mg
J9305	Injection, pemetrexed, not otherwise specified, 10 mg
J9314	Injection, pemetrexed (Teva), not therapeutically equivalent to j9305, 10 mg
Non-Preferred	
J9292	Injection, pemetrexed dipotassium, 10 mg
J9304	Injection, pemetrexed (Pemfexy), 10 mg
J9324	Injection, pemetrexed (Pemrydi RTU), 10 mg

Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima)

HCPCS Code	Description
Preferred	
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg
Non-Preferred	
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg

Systemic Lupus Erythematosus Agents (Benlysta, Saphnelo)

HCPCS Code	Description
Preferred	
J0490	Injection, belimumab, 10 mg
Non-Preferred	
J0491	Injection, anifrolumab-fnia, 1 mg

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Tocilizumab (Actemra, Avtozma, Tofidence, Tyenne)

HCPCS Code	Description
Preferred	
Q5133	Injection, tocilizumab-bavi (Tofidence), biosimilar, 1 mg
Q5135	Injection, tocilizumab-aazg (Tyenne), biosimilar, 1 mg
Q5156	Injection, tocilizumab-anoh (Avtozma), biosimilar, 1 mg
Non-Preferred	
J3262	Injection, tocilizumab, 1 mg

Trastuzumab (Herceptin, Herceptin Hylecta, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera)

HCPCS Code	Description
Preferred	
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg
Non-Preferred	
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg
Q5146	Injection, trastuzumab-strf (Hercessi), biosimilar, 10 mg

Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) (Head and Neck Cancers: Cancer of the Nasopharynx, Recurrent, Unresectable, Oligometastatic, or Metastatic Disease)

HCPCS Code	Description
Preferred	
J3263	Injection, toripalimab-tpzi, 1 mg
Non-Preferred	
J9271	Injection, pembrolizumab, 1 mg
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy
J9299	Injection, nivolumab, 1 mg
J9329	Injection, tislelizumab-jsgr, 1mg

Antineoplastic Monoclonal Antibodies – Programmed Death-1 (PD-1)/Programmed Death-Ligand 1 (PD-L1) (Non-Small Cell Lung Cancer: Advanced or Metastatic, Monotherapy, PD-L1 Expression Positive ≥50%)

HCPCS Code	Description
Preferred	
J9022	Injection, atezolizumab, 10 mg
J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs
J9119	Injection, cemiplimab-rwlc, 1 mg
J9271	Injection, pembrolizumab, 1 mg
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
Non-Preferred	
J9228	Injection, ipilimumab, 1 mg

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HCPCS Code	Description
Non-Preferred	
J9299	Injection, nivolumab, 1 mg

Bispecific T-Cell Engaging (BiTE) Antibody (Multiple Myeloma)

HCPCS Code	Description
Preferred	
J9380	Injection, teclistamab-cqyv, 0.5 mg
Non-Preferred	
J1323	Injection, elranatamab-bcmm, 1 mg

Background/Description of Services

Certain classes of medications covered under Medicare Part B will include non-preferred therapies. A non-preferred therapy will generally require history of use of a preferred therapy within the same class, among other criteria. This step therapy requirement will apply to some, but not all, Medicare Advantage Plans. Refer to the Plan Exceptions table.

Ten classes of medications (Bevacizumab, Colony Stimulating Factors, Denosumab, Eculizumab, Infliximab, Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, Rituximab, Tocilizumab, Trastuzumab, and Ustekinumab) covered under Medicare Part B that will include preferred and non-preferred drugs/products are biosimilar products.

A biosimilar product is a biologic product that is approved based on demonstrating that it is highly similar to an FDA-approved biologic product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Benefit Considerations

Before using this policy, check the member's EOC/SB and any federal or state mandates, if applicable.

Experimental and investigational procedures, items, and medications are not covered. Investigational Device Exemption Studies (IDE) are only covered when Medicare requirements are met. For coverage requirements, refer to www.cms.gov.

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6. https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-part-d-drug-pricing-final-rule-cms-4180-f.
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8. For CMS Memorandum titled *Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage*, dated August 7, 2018; refer to: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf.

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9. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®). Breast Cancer. Version 4.2026. Available at www.nccn.org.

Policy History/Revision Information

Date	Summary of Changes
10/01/2026	**Coverage Rationale** • Revised list of applicable drugs/products for: ***ATTR-Mediated Amyloidosis With Cardiomyopathy (Non-Employer Group MAPD Plans Only)*** ○ Added: ▪ Amvuttra (non-preferred) ▪ Attruby (preferred) ▪ Vyndamax (preferred) ***Colony Stimulating Factors: Short Acting*** ○ Added Filkri (non-preferred) ***Colony Stimulating Factors: Long Acting*** ○ Added Armlupeg (non-preferred) ***Tocilizumab*** ○ Changed product status for Avtozma from "non-preferred" to "preferred" • Added language to indicate step therapy criteria applies to the following non-preferred products: ○ Amvuttra ○ Armlupeg ○ Filkri • Removed language indicating step therapy criteria applies to Avtozma **Applicable Codes** ***ATTR-Mediated Amyloidosis With Cardiomyopathy (Non-Employer Group MAPD Plans Only)*** • Added HCPCS code J0225 (non-preferred) ***Colony Stimulating Factors: Short Acting*** • Updated list of applicable HCPCS codes to reflect quarterly codes; added Q5172 (non-preferred) ***Colony Stimulating Factors: Long Acting*** • Added HCPCS code Q5169 (non-preferred) ***Leucovorin/Levoleucovorin*** • Updated list of applicable HCPCS codes to reflect quarterly codes; replaced: ○ J0640 with J0643 (preferred) ○ C9399, J3490, and J3590 with J0644 (non-preferred) ***Tocilizumab*** • Changed product status for HCPCS code Q5156 from "non-preferred" to "preferred" **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version IAP.001.30

Instructions for Use

This Drug Policy is provided for informational purposes only and does not constitute medical advice. Treating physicians and health care providers are solely responsible for making any decisions about medical care.

Each benefit plan contains its own provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision(s) will govern.

In the event of a conflict between this policy and Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Medicare manuals, the Medicare NCD/LCD/manual will apply.

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