Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:
Medical Benefit Drugs
# Medical Benefit Step Therapy

*Effective: January 1, 2025*

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|---|---|
| **Guideline Type** | ☐ Prior Authorization<br>☐ Non-Formulary<br>☒ Step-Therapy<br>☐ Administrative |

**Applies to:**

**Commercial Products**

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
☒ Tufts Health Plan Commercial products; Fax 617-673-0988
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Public Plans Products**

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939
☐ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual-eligible product); Fax 617-673-0956
*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

**Senior Products**

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

## Overview

| Drug Class | Non-preferred Product(s) | Preferred Product(s) |
|---|---|---|
| **Acromegaly** | Signifor LAR<br>Somatuline Depot | lanreotide<br>lanreotide (cipla)<br>Sandostatin LAR |
| **Antiemetics** | Akynzeo<br>Aponvie<br>Cinvanti<br>Emend<br>Focinvez<br>Sustol | fosaprepitant<br>granisetron<br>ondansetron<br>palonosetron |
| **Bendamustine HCl Injection** | Bendeka<br>Treanda<br>Vivimusta | bendamustine<br>Belrapzo |
| **Iron Preparation, Parenteral** | Feraheme<br>Injectafer<br>Monoferric | Ferrlecit<br>Infed<br>Venofer |

| | | |
|---|---|---|
| **Leucovorin / LEVOleucovorin Injection** | Fusilev<br>Khapzory<br>LEVOleucovorin | leucovorin injection |
| **Pemetrexed** | Alimta<br>Pemfexy<br>Pemrydi | Pemetrexed (all manufacturers) |
| **Retinal Disorders** | Beovu<br>Byooviz<br>Cimerli<br>Eylea<br>Lucentis<br>Susvimo<br>Visudyne | Avastin |
| | Eylea HD<br>Vabysmo | Avastin<br>Eylea<br>Ranibizumab |
| **Triamcinolone Acetonide Injection** | Zilretta | Triamcinolone acetonide injection |

## Clinical Guideline Coverage Criteria

In addition to any prior authorization requirements by the plan, a non-preferred product must satisfy the following criteria. If a provider administers a non-preferred product without obtaining prior authorization, the plan may deny claims for the non-preferred product.

**Acromegaly**

The plan may authorize coverage of a non-preferred Acromegaly product when all of the following criteria are met:

1. Documentation of a history of use of at least one preferred Acromegaly product resulting in a substandard response to therapy

**Antiemetics**

The plan may authorize coverage of a non-preferred Antiemetic product when all of the following criteria are met:

1. Documentation of a history of use of at least one preferred Antiemetic product resulting in a substandard response to therapy

**Bendamustine HCl Injection**

The plan may authorize coverage of a non-preferred Bendamustine HCl Injection product when all of the following criteria are met:

1. Documentation of a history of use of at least one preferred Bendamustine HCl Injection product resulting in a substandard response to therapy

**Iron Preparation, Parental**

The plan may authorize coverage of a non-preferred Iron Preparation, Parental product when all of the following criteria are met:

1. Documentation of a history of a trial of at least three (3) weeks of at least one preferred Iron Preparation, Parental product resulting in a substandard response to therapy

**Leucovorin / LEVOleucovorin Injection**

The plan may authorize coverage of a non-preferred Leucovorin / LEVOleucovorin Injection product when all of the following criteria are met:

1. Documentation of a history of use of at least one preferred Leucovorin / LEVOleucovorin Injection product resulting in a substandard response to therapy

**Pemetrexed**

The plan may authorize coverage of a non-preferred Pemetrexed product when all of the following criteria are met:

1. Documentation of a history of use of at least one preferred Pemetrexed product resulting in a substandard response to therapy

**Retinal Disorders**

The plan may authorize coverage of Beovu, Byooviz, Cimerli, Eylea, Lucentis, Susvimo, or Visudyne when all of the following criteria are met:

1. Documentation of a history of a trial of at least 3 consecutive doses of Avastin in either eye given monthly resulting in a substandard response to therapy

The plan may authorize coverage of Eylea HD or Vabysmo when all of the following criteria are met:

2. Documentation of **both** of the following:
    a. History of a trial of at least 3 consecutive doses of Avastin in either eye given monthly resulting in a substandard response to therapy
    b. History of a trial of Eylea or ranibizumab resulting in a substandard response to therapy

**Triamcinolone Acetonide Injection**

The plan may authorize coverage of a non-preferred Triamcinolone Acetonide Injection product when all of the following criteria are met:

1. Documentation of a history of use of at least one preferred Triamcinolone Acetonide Injection product resulting in a substandard response to therapy

## Limitations

- None

## Codes

The following code(s) require prior authorization:

**Table 1: HCPCS Codes**

| HCPCS Codes | Description |
|---|---|
| J2502 | Injection, pasireotide long acting, 1 mg |
| J1930 | Injection, lanreotide, 1 mg |
| J1454 | Injection, fosnetupitant 235 mg and palonosetron 0.25 mg |
| C9145 | Injection, aprepitant, (aponvie), 1 mg |
| J0185 | Injection, aprepitant, 1 mg |
| J1434 | Injection, fosaprepitant (focinvez), 1 mg |
| J1627 | Injection, granisetron, extended-release, 0.1 mg |
| J9034 | Injection, bendamustine HCl (Bendeka), 1 mg |
| J9056 | Injection, bendamustine hydrochloride. (vivimusta), 1 mg |
| Q0138 | Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) |
| J1439 | Injection, ferric carboxymaltose, 1 mg |
| J1437 | Injection, ferric derisomaltose, 10 mg |
| J0641 | Injection, levoleucovorin, not otherwise specified, 0.5 mg |
| J0642 | Injection, levoleucovorin (khapzory), 0.5 mg |
| J9304 | Injection, pemetrexed (pemfexy), 10 mg |
| J9324 | Injection, pemetrexed (pemrydi rtu), 10 mg |
| J0179 | Injection, brolucizumab-dbll, 1 mg |
| Q5124 | Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1mg |
| Q5128 | Injection, ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg |
| J0178 | Injection, aflibercept, 1 mg |

| HCPCS Codes | Description |
|---|---|
| J0177 | Injection, aflibercept HD, 1 mg |
| J2778 | Injection, ranibizumab, 0.1 mg |
| J2779 | Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg |
| J2777 | Injection, faricimab-svoa, 0.1 mg |
| J3396 | Injection, verteporfin, 0.1 mg |
| J3304 | Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg |

## References


1. Flaxel CJ, Adelman RA, Bailey ST, Representative RS, Fawzi A, Representative MS, Lim JI, Vemulakonda GA, Ying G-s, Age-Related Macular Degeneration Preferred Practice Pattern®, Ophthalmology (2019), doi: https://doi.org/10.1016/j.ophtha.2019.09.024.
2. INFeD (iron dextran injection) [prescribing information]. North Chicago, IL: AbbVie Inc.; August 2024.
3. Remicade (infliximab) [prescribing information]. Horsham, PA: Janssen Biotech, Inc.; October 2021.


## Approval And Revision History

September 10, 2024: Reviewed by Pharmacy and Therapeutics Committee (P&T) (eff 1/1/25)

## Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.