Image: biole state Image:	
Note Note </td <td></td>	
No. No. <td></td>	
No <td></td>	
NAM NAM NAME NAME NAME NAME NAME NAME NAME IAM Rame Rame<	ogicals for drugs
No. No. <td>Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL,</td>	Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL,
ND ND<	logicals for drugs
Note Side Made Mad Made Made <thm< td=""><td>logicals for drugs</td></thm<>	logicals for drugs
NM NM NM NMM NMMM NMMMM NMMMMM NMMMMMM NMMMMMMM NMMMMMMM NMMMMMMM NMMMMMM NMMMMMMM NMMMMMMM NMMMMMMM NMMMMMMMM NMMMMMMMM NMMMMMMMM NMMMMMMMM NMMMMMMM NMMMMMMMMMMMM NMMMMMMMMMM NMMMMMMMMMMMM NMMMMMMMMMMMM NMMMMMMMMMMMMMMMMMMMMMM NMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMM	Jogicals for drugs
NM NAMM Solution Solut	
InclAndAndrameAndrameAndrameAndrameAndrameAndrame1015010501	logicals for drugs
No <td>logicals for drugs</td>	logicals for drugs
NormNo	logicals for drugs
No <td></td>	
NotNo	logicals for drugs
NMIMNICUMEMN	
MarcalMarca	logicals for drugs
MatchMR07Ald07ACopationCopationMethod (the Man Pharmacy Services)Ald07A (summalia)Ald07A (summalia)MAP Per Autoritation needed outlined in the Medaare Beeff Policy Manual (the). 10.2), (Linget PS, 50 Drug and BinMetal1640Ald07AGopationGopationCop	logicals for drugs
And and an an	
And PartialAnd OUV/TADADE Arrates is the preferred leastonab product at territementation (LOC), LOCA Coverage Determination (LO	
NameStateS	
Mather Mather Contrast Contrast <th< td=""><td>Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL,</td></th<>	Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL,
Mate N25 ANVUTRA Automation and the material states of the mate	Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL,
Medical JT25, JT25, JT26, JT26	
Minimeripart Action and Acti	logicals for drugs
	ogicals for drugs
Rule Rule Reference (all reference)))); reference (all reference)); reference); reference (all reference)); reference); reference (all reference)); reference); reference)	lagicals for drugs
Medical Piss Asthemophic Factor IX (Applannes S), Monoimer (Applannes S), Monoimer (Ap	legicali for drugs
Medical 2277 AMEXIA motioafortide Vis, brough the Pian Pharmacy Services AMEXIA (motioafortide) AMEXIA (motioafortide) AMEXIA (motioafortide) AMEXIA (motioafortide)	logicals for drugs
Medical R35A ARALAST NP apla-1-proteinase inhibitor (human) Te, through the Ran Piarmacy Services. Restricted to an Piamonology specialize with automation.	logicals for drugs
Medical M881 ARAKESP disbogoesin alpha Yes, through the Pian Pharmacy services Add/CEP (dot begoesin alpha) AMAGEP (dot begoesin alpha) MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), (hapter 15, 550 Drugs and Bio	
Medical 26072 MACENIV ((VK) - non-preferred MACENIV ((VK) - non-preferred munue globulin (Human) Yes, through the Plan Planmacy Services requiring a failed trial or contraindication of all other immune globulin products.	logicals for drugs

No Normal Sector Sect		INJECT	ABLE MEDICINES			PREVEA360		
Normal Normal Normal Normal Normal Normal No No No Normal			This reference guide is a partial	listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	the biography incompany and the direction of earth here for your the		
NoNoNoSaleS		Updated: 05/01/2024	coverage review of any drug liste found on the Prevea360 website !	ed as not covered, please complete the Exception to Coverage form for medical submit to the Plan Pharmacy Services and for pharmac	The starting of the starting o	and binding you can start your search by entering just the first few letters of the me		
No.No.Summary and sectors in the sector of th	Benefit		Brand Names	Generic names		Policy	Prior Authorization Form	MAPD
nn <th< td=""><td>Medical</td><td>19035</td><td>AVASTIN</td><td>bevacizumab</td><td>does not require prior authorization. Avastin, Alymsys, Mwasi and Vegreina prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevaciumab is not required when used for ophtalmological indications.*** See the ALYMSYS [Bevaciumab] Poley for a Tak of applicable ophthalmological</td><td>AVASTIN (bevaciumab)</td><td>AVASTIN (bevacizumab)</td><td>MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDd, and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, NO.</td></th<>	Medical	19035	AVASTIN	bevacizumab	does not require prior authorization. Avastin, Alymsys, Mwasi and Vegreina prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevaciumab is not required when used for ophtalmological indications.*** See the ALYMSYS [Bevaciumab] Poley for a Tak of applicable ophthalmological	AVASTIN (bevaciumab)	AVASTIN (bevacizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDd, and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, NO.
Here Ref Second	Medical	Q5121	AVSOLA - non-preferred	influimab-axxq	Yes, through the Plan Pharmacy Plan after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology	AVSOLA - non preferred (influimab-awg)	AVSOLA (influimab axig)	NAPD Proc Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions Wi, IL, NQ,
NAME Ref Signed Signe Signe Signe	Medical	A9590	AZEDRA	iobenguane I-131	Yes, through the Plan Pharmacy Services	AZEDRA (lobenguane +131)	AZEDRA (iobenguanel-131)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
	Medical	19023	BAVENCIO	avelumab	Yes, through the Plan Pharmacy Services	BAVENCIO (avelumab)	BAVENCIO (avelumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Image No. No. </td <td>Medical</td> <td>19032</td> <td>BELEODAQ</td> <td>belinostat</td> <td>Yes, through the Plan Pharmacy Services</td> <td>BELEODAQ (belinostat)</td> <td>BELEODAQ (belinostat)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	19032	BELEODAQ	belinostat	Yes, through the Plan Pharmacy Services	BELEODAQ (belinostat)	BELEODAQ (belinostat)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. No. No. No. No. No. No. No. No.	Medical	19036	BELRAPZO	bendamustine	Yes, through the Plan Pharmacy Services	BELBAPZO (bendamustine)	BELPRAZO (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
MMMMMAMMAMMMAMMM <td>Medical</td> <td>19034</td> <td>BENDEKA</td> <td>bendamustine</td> <td>Yes, through the Plan Pharmacy Services</td> <td>BENDEKA (bendamustine)</td> <td>BENDEKA (bendamustine)</td> <td>MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	19034	BENDEKA	bendamustine	Yes, through the Plan Pharmacy Services	BENDEKA (bendamustine)	BENDEKA (bendamustine)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Mode Mode <th< td=""><td>Medical</td><td>10490</td><td>BENLYSTA (IV)</td><td>belimumab</td><td>consultation with) a Rheumatology, Dermatology, or Nephrology</td><td>BENLYSTA IV (belimumab)</td><td>BENIXYSTA IV (belimumab)</td><td>MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td></th<>	Medical	10490	BENLYSTA (IV)	belimumab	consultation with) a Rheumatology, Dermatology, or Nephrology	BENLYSTA IV (belimumab)	BENIXYSTA IV (belimumab)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. No. <td>Pharmacy</td> <td>10490</td> <td>BENLYSTA (SC)</td> <td>belimumab</td> <td>Rheumatology, Dermatology, or Nephrology specialists with</td> <td>BENLYSTA SC (beilmumab)</td> <td>BENLYSTA SC (beilmumab)</td> <td>MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Pharmacy	10490	BENLYSTA (SC)	belimumab	Rheumatology, Dermatology, or Nephrology specialists with	BENLYSTA SC (beilmumab)	BENLYSTA SC (beilmumab)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
NAME	Medical	J0179	BEOVU	brolucizumab-dbll	None. Please see attached policy for criteria.	BEOVU (brolucizumab-dbll)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Normal Random Random <thrandom< th=""> <thrandom< th=""> <thrandom< td="" th<=""><td>Medical</td><td>J0179</td><td>BEOVU</td><td>brolucizumab-dbll</td><td>EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services</td><td>Coming Soon</td><td>Coming Soon</td><td></td></thrandom<></thrandom<></thrandom<>	Medical	J0179	BEOVU	brolucizumab-dbll	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Image Note Network Network Network Network Network Note Note <td>Medical</td> <td>19229</td> <td>BESPONSA</td> <td>inotuzumab ozogamicin</td> <td>Yes, through the Plan Pharmacy Services</td> <td>BESPONSA (inotuzumab ozogamicin)</td> <td>BESPONSA (inotuzumab dbil)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	19229	BESPONSA	inotuzumab ozogamicin	Yes, through the Plan Pharmacy Services	BESPONSA (inotuzumab ozogamicin)	BESPONSA (inotuzumab dbil)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Image by the symbol is a s	Medical	J1556		immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	BIVIGAM (IVIG)	BIVIGAM (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
NAME Res Res <td>Medical</td> <td>19039</td> <td>BLINCYTO</td> <td>blinatumomab</td> <td>Yes, through the Plan Pharmacy Services</td> <td>BLINCYTO (blinatumomab)</td> <td>BUNCYTO (blinatumomab)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	19039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services	BLINCYTO (blinatumomab)	BUNCYTO (blinatumomab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
NAME Ref Ref <td>Medical</td> <td>19322</td> <td>BLUEPOINT</td> <td>pemetrexed</td> <td>Yes, through the Plan Pharmacy Services</td> <td>BLUEPOINT (pernetrexed)</td> <td>BLUEPOINT (permetrexed)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	19322	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	BLUEPOINT (pernetrexed)	BLUEPOINT (permetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
NAME SPACE	Medical	19044	BORTEZOMIB	bortezomib - preferred	Yes, through the Plan Pharmacy Services	BORTEZOMIB_	BORTEZOMIB	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Note Note <th< td=""><td>Medical</td><td>10585</td><td>BOTOX</td><td>onabotulinumtoxin</td><td>No prior authorization is required.</td><td>BOTOX (onabotulinumtoxinA)</td><td></td><td>MAPD Prior Authorization based on National Coverage Determination (NCD), local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO</td></th<>	Medical	10585	BOTOX	onabotulinumtoxin	No prior authorization is required.	BOTOX (onabotulinumtoxinA)		MAPD Prior Authorization based on National Coverage Determination (NCD), local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Note Note <th< td=""><td>Medical</td><td>Q2054</td><td>BREYANZI</td><td>lisocabtagene maraleucel</td><td>Yes, through the Plan Pharmacy Services</td><td>BREYANZI (lisocabtagene maraleucel)</td><td>BREYANZI (lisocabtagene maraleusel)</td><td>MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO</td></th<>	Medical	Q2054	BREYANZI	lisocabtagene maraleucel	Yes, through the Plan Pharmacy Services	BREYANZI (lisocabtagene maraleucel)	BREYANZI (lisocabtagene maraleusel)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Min Num N	Medical	12329	BRIUMVI	ublituximab-xily	Yes, through the Plan Pharmacy Services	BRIUMVV** (ublituximab-sliv)	BRIUMVI''' (ublituximab oliy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. N	Medical	J0567, C9014	BRINEURA	ceriponase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the Late infantile Ceroid lipofucinosis with authorization.	BRNEURA (certiponase alfa)	BRINEURA (certiponase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
No.No	Medical	Q5124	BYOOVIZ	ranibizumab	No. No prior authorization required	<u>8r00VIZ** (rainibizumab)</u>	<u>BYDOVIZ" (rainibizumab)</u>	MMID Pror Authorization based on Rational Coverage Determination (RCD), Local Coverage Determinations (ECD), and Local Coverage Articles (ECA) for guidance where applicable for Autodictions W, II, MO
AndAn		Q5124	BYOOVIZ	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	<u>Coming Soon</u>	Coming Soon	
Note And	Medical	19043	CABAZITAXEL	Cabazitaxel (Jevtana)	Yes, through the Plan Pharmacy Services	CABAZITAXEL(levtana)	CABAZITAXEL(Jevtana)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Note And	Medical	C2056	CARVYKTI	ciltacabtagene autoleucel	Yes, through the Plan Pharmacy Services	CARVYKTI (ciltacabtagene autoleucel)	CARVYKTI (ciitacabtagene autoleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Name	Medical	13590	CASGEVY	exagamglogene autotemcel	Yes, through the Plan Pharmacy Services	CASGEVY (exagamglogene autotemcel)	CASGEVY (exagamplogene autotemcel)	
InInInInInInInInInInInInInSine </td <td>Medical</td> <td>J1786</td> <td>CEREZYME</td> <td>imiglucerase (Intravenous)</td> <td>consultation with) a Medical Geneticist or other prescriber specialized</td> <td>CEBEZYME (imiglucerase) (intravenous)</td> <td>CEREZYME (imiglucerase) (intravenous)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 550 Drugs and Biologicals for drugs</td>	Medical	J1786	CEREZYME	imiglucerase (Intravenous)	consultation with) a Medical Geneticist or other prescriber specialized	CEBEZYME (imiglucerase) (intravenous)	CEREZYME (imiglucerase) (intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 550 Drugs and Biologicals for drugs
Image: A state Image	Medical	Q5128	CIMERLI	ranibizumab	No. No prior authorization required	OMERU (ranibizumab)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAc) for guidance where applicable for Jurisdictions Wi, IL, MO
HIME VI LAGA Genatura pepi cassing the member formular,		Q5128	CIMERLI	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Scon	
Mark Mark <t< td=""><td>Pharmacy</td><td>J0717</td><td>CIMZIA</td><td>certolizumab pegol</td><td></td><td></td><td></td><td></td></t<>	Pharmacy	J0717	CIMZIA	certolizumab pegol				
Medical 1932 DPA lancetide dept consultation with a Endocrinologit, Orcologit, or gattemetrologit specialities with a Endocrinologit, Orcologit, or gattemetrologit specialities with authorization.	Medical	12786	CINQAIR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	ONGAIR (reditumab)	CINQAIR (red zumab)	MAVD Pror Authorization needed outlined in the Medican Benefit Policy Manual (No. 100 2), Chapter 15, 500 Drugs and Biologicals for drug
Medical 8286 COLUMN1 gloftamab-gebm Yes, through the Pian Plarmacy Services. COLUMN17 (gloftamab-gebm) COLUMN17 (gloftamab-gebm) MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug	Medical	J1932	CIPLA	lanreotide depot	consultation with) an Endocrinologist, Oncologist, or	CIPLA (somatuline depot)	CIPLA (larreotide depot)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drug
	Medical	19286	COLUMVI	glofitamab-gxbm	Yes, through the Plan Pharmacy Services.	COLUMVI''' (glofitamab-gubm)	COLUMVI** (glofitamab-gibm)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug

	INJECTABLE MEDICINES			PREVEA360			
	Updated: 05/01/2024		listing of the most commonly prescribed drugs under the medical not yet reviewed and whether a prior authoritation is required. For d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	SEARCH TPS: This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the	•	
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1448	COSELA	trilaciclib	Yes, through the Plan Pharmacy Services	COSELA (trilacidib)	COSELA (trilaciclib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	C9166	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	COSENTYX IV (secukinumab)	COSENTYX IV (secukinumab)	
Medical	10584	CRYSVITA	burosumab	Yes, through the Plan Pharmacy Services. Restricted to Endocrinologist Nephrologist, Medical Geneticist, or Specialist experienced in treatment of Metabolic Bone Disorders with authorization.	CRYSVITA (burosumab)	CRYSVITA (burosumab)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	11555	CUVITRU (SCIG), IMMUNE GLOBULIN	immune globulin (cuvitru)	Yes, through the Plan Pharmacy Services	OMITRUISOS)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drug
Medical	19308	CYRAMZA	ramucirumab	Yes, through the Plan Pharmacy Services	CYRAMZA (ramucirumab)	CYRAMZA (ramudrumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	19348	DANYELZA	naxitamab	Yes, through the Plan Pharmacy Services	DANYEZA (navitamab).	DANYELZA (navitamab)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drug
Medical	J9145	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services	DARZALEX (daratmumab)	DARZALEX (daratumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	J9144, C9062	DARZALEX FASPRO	daratumumab/hyaluronidase-fihj	Yes, through the Plan Pharmacy Services	DARZALEX FASPRO (daraumumab/hyaluronidase-fihj)	DARZALEX FASPRO (daratumumab/hyaluronidase-fihj)	MAPD Prior Authorization needed outlined in the Medicare Bernefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	10589	DAXXIFY	daxibotulinumtoxinA	None. Please see attached policy for criteria.	DAI00FY* (daxibotulinumtoxinA)	DAX00FY* (daxibotulinumtoxinA)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	17318	DUROLANE - non-preferred	sodium hyaluronate	As of 08/01/2022: HYALGAM, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of DUROLANE requires a filled trial of a preferred product. Prior authorization is required through the Pian Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pian Medicine specialist with authorization.	DUROLANE - non-preferred (sodium hysiuronate)	DURCHANE loodium hyalunovatel	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions WC 4, MO.
Medical	J0586	DYSPORT	abobotulinumtoxinA	No prior authorization is required.	DYSPORT (abobotulinumtoxinA)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions Wi, IL, MO.
Medical	19304	EAGLE	pemetrexed	Yes, through the Plan Pharmacy Services	EAGLE (pemetrexed)	EAGLE (pemetroxed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19063	ELAHERE	mirvetuximab soravtansine-gynx	EFFECTIVE 04/01/2023. Yes, through the Plan Pharmacy Services	ELAHERE (mirvetuximab soravtansine-gynx)	ELAHERE (mirvetuximab soravtansine-gynx)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1743	ELAPRASE	idursulfase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis II with authorization.	ELAPRASE (idumuffase)	ELAPRASE (Idumulface)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1413	ELEVIDYS	delandistrogene moxeparvovecroki	None. Not Covered.	ELEVIDYS Idelandistrogene mouspanouvecroki)		
Medical	13060	ELELYSO	talig/ucerase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher 1 DX with authorization.	ELELYSO (talighucerase alfa)	ELELYSO (talighucerase alfa)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 120-21), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12508	ELFABRIO	pegunigalsidase-alfa-lwxj	Yes, through the Plan Pharmacy Services	ELFABRIO [®] (pegunigalsidase alfa-iwoj)	ELFARRO* (orgunigalsidase alfa-ivoj)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1323	ELREXIFO	elranatamab-bcmm	Yes, through the Plan Pharmacy Services	ELEDIFO" (elranatamab-bomm)	ELREFIXO"" (elranatamala-bernm)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19269	ELZONRIS	tagraxofusp-erzs	Yes, through the Plan Pharmacy Services	ELZONRIS (tagraxofusp-erzs)	ELZONRIS (tagraxofuso-erzs)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9176	EMPLICITI	elotuzumab	Yes, through the Plan Pharmacy Services	EMPLICITI (elotuzumab)	EMPUCITI (elotuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19358	ENHERTU	fam-trastuzumab deruxtecan-nxki	Yes, through the Plan Pharmacy Services	ENHERTU (fam trastuzumab deruxtecan -ixki)	ENHERTU (fam-trastuzumab deruxtecan-nxki)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1302	ENJAYMO	sutimlimab	Yes, through Plan Pharmacy Services	ENJAYMD (sutimilimab-jome)	ENIAYMO (sutimilmab-jome)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C9399, J3590	ENSPRYNG	satralizumab-mwge	Yes, Through the Plan Pharmacy Services	ENSPRYNG* (satralizumab-mwge)	ENSPRYNG® (satralizumab-mwge)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13380	ENTYVIO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	ENTYVIO (vedolizumab)	ENTIVIO (vedelizumab)	MAYD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Ohapter 15, 550 Drugs and Biologicals for drugs
Medical	J9321	EPKINLY	epcoritamab-bysp	Yes, through the Plan Pharmacy Services.	EPKINI.V** (epcoritamab-bysp)	EPKINLY** (epcoritamab-bysp)	MAPD Prior Authorization needed audined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10885	EPOGEN	epoetin alfa, (for non-esrd use)	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epogen and Procife prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	EPOGEN (epoetin alfa)	EPOGEN (eportin alpha)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions Wi, IL, MO.
Medical	19055	ERBITUX	cetuximab	Yes, through the Plan Pharmacy Services	ERBITUX (cetuximab)	ERBITUX (cetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17323	EUFLEXXA - non-preferred	sodium hyaluronate, 1%	As of 08/02/2022 HYALGAN, SYNVISC, SYNVISC, ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of EUTEEXXA requires a failed trial of a preferred product. Prora rathorization is required through the PBan Pharmacy Services and is restricted to a Bhoumatology, Chrisbedic, Sports Medicine, or Pain Medicine specialist with authorization.	EUFLEXX (andium hysiorenate, 3%)	(UFLEXXA (codum hysteronate, <u>1%)</u>	MAYD Proc Authorization based on National Coverage Determination (NCD), local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for surisdictions Wit, IL MO
Medical	J3111	EVENITY	romosozumab-aqqg	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Endocrinology or Rheumatology specialists with authorization.	EVENITY (romosozumab-aqog)	EVENITY (romosozumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1305	EVKEEZA	evinacumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Cardiologist, Lipidologist, or Endocrinologist specialist with authorization.	EVKEEZA (evinacumab)	EVKEEZA (evina.cumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		EVRYSDI	risdiplam	Yes, through Navitus. Restricted to a pediatric neurologist at a Muscular Dystrophy Association care center with authorization.	EVRYSDI (risdiplam)	EVRYSDI (risdiplam)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	J1428	EXONDYS 51	eteplirsen	None. Not Covered.	EXONDYS 51 (eteplinsen)		

	INJECT	ABLE MEDICINES		SEARCH TIPS:	PREVEA3600		
	This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not vet reviewed and whether a prior authorization is required. For			Scal ed for This is a large document, but you can search quickly and early by dickine on the binocular icon on your toobar. It will then display a search box for you to			
	coverage review of any frug listed as not covered, plass complete the Exception to Coverage form found on the Prevea360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.			type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the me		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J0178	EYLEA	aflibercept	None. Please see attached policy for criteria.	EYLEA (aflibercept)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
	J0178	EYLEA	afilbercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0177	EYLEA HD	aflibercept	None. Please see attached policy for criteria.	Eylea* HD (Aflibercept)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
	J0177	EYLEA HD	aflibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0180	FABRYZYME	agalsidase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical geneticist or other prescriber specialized in the treatment of Fabry DX with authorization.	FABRAZYME (agalsidase)	FABRAZYME (agalsidase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J0517	FASENRA	benralizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	FASENRA (benralizumab)	FASENRA (benralizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q0138, Q0139	FERAHEME - preferred	ferumoxytol	As of 08/01/2022 VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INECTAFER, MONERRIC, TRIFERE, and TRIFENE AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERAHEME (forumowytol)		
Medical	J2916	FERRLECIT - preferred	sodium ferric gluconate complex	As of 08/01/2022 VENCHER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INECTAFAR, MONOPERR, TRIFERC, and TRIFERC AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERRECT (sodium ferric aluconate complex)		
Medical	J1744	FIRAZYR	icatibant	Yes, through the Plan Pharmacy Services.	FIRAZYR* (catibant)	FIRAZYR* (katibant)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1572	FLEBOGAMMA/FLEBOGAMMA DIF (IVIG), IMMUNE GLOBULIN	flebogamma	Yes, through the Plan Pharmacy Services	ELEBOGAMMA/FLEBOGAMMA DIF (N/G)	FLEBOGAMMA/FLEBOGAMME DIF (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for larticicions Wi, IN, MD
Medical	Q5108	FULPHILA	pegfilgrastim-ymbd	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Peglingsatim products and do not require prior authorization. Must have a failed traid of ZEXTEND AND FULPHILA before coverage of Neulata, UDENCYA, FVINETRA, STIMUFEND and ZEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<u>FURPHUA (pogfigrastim-imbd)</u>	ELEPHIA (poglifrastin-smbd)	MAPD Prior Authoritation based on National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MD
Medical	10641	FUSILEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	FLSILEV (levoleucovorin)	FUSILEV (levoleucavorin)	MARD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICD), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	19331	FYARRO	sirolimus albumin-bound	Yes, through the Plan Pharmacy Services	FYARRD (strolimus albumin-bound)	FYARRO (sirolmus albumin-bound)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5130	FYLNETRA - non-preferred	pegfilgrastim-pbbk	EFFECTIVE 01/01/2024: FULPHILA and INVEPRIA are the preferred Pegligrastim products and do not require prior authorization. Must have a failed Taid IZEXTENDA NOR FULPHILA Before coverage of Neulata. JUENCYA, FULPERA, STIMUFEND and ZEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	PYINETRA (posfigratim globi)	DYNTRA (postiwanim pibli)	MARD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9210	GAMIFANT	emapalumab-lzsg	Yes, through the Plan Pharmacy Services	GAMIFANT* (emapalumab-lzsg)	GAMIFANT* (emapalumab-lasg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1569	GAMMAGARD (SCIG), IMMUNE GLOBULIN	immune globulin, (gammagard liquid)	Yes, through the Plan Pharmacy Services	GAMMAGARD (SCIG)	GAMIMAGARD (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1557	GAMMAPLEX (IVIG), IMMUNE GLOBULIN	immune globulin (gammaplex liquid)	Yes, through the Plan Pharmacy Services	GAMMAPLEX (IVIG)	GAMMAPLEX (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDd), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1561	GAMUNEX-C/GAMMAKED (SCIG) IMMUNE GLOBULIN	, gamunex injection	Yes, through the Plan Pharmacy Services	GAMUNEX-C/GAMMAXED (SCIG)	GAMUNEX-C/GAMMAKED (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 350 Drugs and Biologicals for drugs
Medical	19301	GAZYVA	obinutuzumab	Yes, through the Plan Pharmacy Services	GAZYVA (obinutuzumab)	GAZYVA (obinutuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17326	GEL-ONE - non-preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVYS, and TRULINGN will be the preferred hyalaronic acid products and do not engine prior automatication. Monovisc, Duralen, Gel-One, Cillenou, Gelyma, Nicca J, andrum Hyalaroniata, TriVice, Orthonice, Sayara TX, and GenvingSida and the non-preferred hyalonica acid products and prior automatication in equipped though the Plan Planmary Service. Plana see Middla Policy for criteria	(ELCOL Explorate adunt	<u>GIL ONE developments outputs</u>	MAPD Prior Authorization based on National Cowrage Determination (NCD), Local Cowrage Determinations (ICD), and Local Cowrage Articles (ICAs) for guidance where applicable for Articletions WI, IL, MO
Medical	17328	GELSYN-3 - non-preferred	hyaluronate sodium	As of 68/02/022: HTALGAN, STNING, STNING, STNING, ONE, HTMOVIS, and BTULINDN will be the preferred hybrinonic aid products and do not require prior authorization. Monovice, Durulane, Gel-One, Fullexan, Gelsym-3, Visco-3, sodium hydruronate, TriVisc, Orthovice, Suparta FX, and Gerivicz80 are the non-preference hydroxine, aid products and prior authorization is required through the Plan Pharmacy Services. Please see Medica Policy for criteria	GELSTM-1 (hyplurnaste sotium)	EE SYN 3 Byslumnate sodium)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions VH, N, MO
Medical	17320	GENVISC 850 - non-preferred	hyaluronan or derivitive	As of 08/07/2022-14/14/GAN_SYNVISC_SYNVISC_0016, and TRUMON will be the preferred palanonic and products and do nee require prior automatication. Monoretic councils, Gel-Ova, Lidinou, Gely-Da, Xixo-D, sodium hystowate, TriVisc_Othorius, Sapart RA, and GranikeSBD are the non-preferred hystomic add products and prior automatication required through the Plan Planmacy Services. Places are Medical Televy for criteria	GENVISS, ISS (hydrocen or deviation)	<u>EENVISE Bill Ihvalvansan er demostori.</u>	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICD), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisd clions Wi, N, MO
Medical	J0223	GIVLAARI	givosiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematologist or specialist with expertise in diagnosis and management of AHP with authorization.	<u>GIVLAARI (givosiran)</u>	STVLAARI (pivosiran)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for larticitions Wi, II, MO
Medical	10257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	GLASSIA (alpha-1-proteinase inhibitor)	GLASSIA (alpha-1proteinase ihibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1447	GRANIX	tbo-filgrastim	EFFECTIVE 01/01/2023: Nivestym and Zanxio are the preferred Filgrastim products and do not require prior authorization. Please see Medical Policy for criteria.	GRANIX (the-filgrastim)	GRAND- the-filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J7170	HEMLIBRA	emkizumab	Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		HEMLIBRA (emicizumab)	
Medical	J7170	HEMLIBRA	emicizumab	Yes, through the Plan Pharmacy Services	HEMLIBRA (emicizumab)	HEMLIBRA (emicizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19355	HERCEPTIN	trastuzumab injection	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy	HERCEPTIN (tracturumab injection)	HERCEPTIN (trastuzumab injection)	MARD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
meuical	,2333	TRACEP III	transferration injection	Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.			nun n. un

	INJECT	ABLE MEDICINES			PREVEA360		
		This reference quide is a partial	listing of the most commonly prescribed drugs under the medical	SEARCH TUPE: contend onund you			
	Updated: 05/01/2024	benefit are covered, not covered, o	name of the intervent dama in proceedings of the second periods are required. I do not yet reviewed and whether a prior authorization is required, of as not covered, please complete the Exception to Coverage form for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	 This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correc n 	t the binocular icon on your toolbar. It will then display a search box for you to spelling, you can start your search by entering just the first few letters of the ame	D	
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19356	HERCEPTIN HYLECTA	trastuzumab and hyaluronidase-oysk	Yes, through the Plan Pharmacy Services	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1411	HEMGENIX	etranacogene dezaparvovec-drib	Yes, through the Plan Pharmacy Services	HEMGENIX (etranacogene dezaparvovec-drbl)	HEMGENIX (etranacogene dezaparvovec drb/)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5113	HERZUMA	trastuzumab-pkrb	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HERZUMA (trastuzumab-pkrb)	HERZUMA (trastuzumab pirb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11559	HIZENTRA (SCIG), IMMUNE GLOBULIN	immune globulin (hizentra)	Yes, through the Plan Pharmacy Services	HIZENTRA (SCIG)	HIZENTRA (SCIG)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19294	HOSPIRA	pemetrexed	Yes, through the Plan Pharmacy Services	HOSPIRA (pemetrexed)	HOSPIRA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17321	HYALGAN - preferred	hyaluronate or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVYS, and TRULIRON will be the preferred hyalaronic acid products and do not quarter prior automatication. Monovice, Jonatona, Gel-One, fullness, Gelyna, J. Visca, J. acidium hyalaronater, TriVice, Orthouse, Sapart EV, and the synthesis of the synthesis of the synthesis of the synthesis and the synthesis of the synthesis of the synthesis of the relation automations in registeric through the Hum Hummay Services. Rease see Medical Policy for orteria	titikääti livakensete on desinativat		MAPD Prior Authorization based on National Coverage Determinations (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, N, MO.
Medical	19351	HYCAMTIN	topotecan	IV dosage form does not require PA Oral dosage form requires PA - Restricted to Oncologists with authorization through the Plan Pharmacy Services.		HYCAMTIN (topotecan)	
Medical	17322	HYMOVIS - preferred	hyaluronan	As of DR/D1/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRULRON will be the preferred hyalanose and products and do not galary prior automation. Monosole, colorade, Gel-Ora, fullness, Gelyna 3, Visco 3, sodium hyalanosta to Tivisc, Othorson, Sayara TA, do GardingEdia and the monory directed hyalanosta and products and products and the monory directed hyalanosta and products and products and products and products and products and products and Policy for oriente	1996/99 (Parlowers)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, N, MO.
Medical	J1575	HYQVIA (SCIG), IMMUNE GLOBULIN	immune globulin (hyqvia)	Yes, through the Plan Pharmacy Services	HYQVIA (SOG)	HYQVIA (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3245	ILUMYA	tildrakizumab-asmn	Yes, through the Plan Pharmacy Services	LUMYA* (tildrakizumab-asmn)	ILUMYA* (tildrakizumab-asmn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9173	IMFINZI	durvalumab	Yes, through the Plan Pharmacy Services	MFINZI (durvalumab)	IMFINZI (durvalumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19347	IMJUDO	tremelimumab-actl	Yes, through the Plan Pharmacy Services	MUDD (tremelimumab-acti)	IMJUDO (tremelimumab-act)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19325	IMLYGIC	talimogene laherparepvec	Yes, through the Plan Pharmacy Services	IMLYGIC (talimogene laherparepvec)	IMLYGIC (talimogene laherparepvec)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11750	INFED - preferred	iron dextran	As of 08/01/2022 VENOFER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONGFERRIC, TRIFERIC, and TRIFERIC AVMU are the non-preferred parenteral iron products and prior authorization is required through the Flain Pharmacy Services with authorization.	NYTO (ron destran)		
Medical	Q5103	INFLECTRA - non-preferred	infliximab-dyyb	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	INFLECTRA (infliximab-dyyb)	INFLECTRA (Infliximals-dyyb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdicions Wi, IL, MO
Medical	J9198	INFUGEM	premixed gemcitabine in sodium chloride solution	Yes, through the Plan Pharmacy Services	NFUGEM (premixed geneitabine in sodium chloride solution)	INFUGEM (premixed gencitabine in sodium chloride solution)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11439	INJECTAFER - non-preferred	ferric caroxymaltose	As of 08/01/2022 VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INECTAFER, MONOFERS, TRIFFER, GATIBIETER AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	By IFCT AFER (forric carraymationa)	NIECTAFE (foric groupsalloge)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	IN SULIN PUMPS	INSULIN PUMPS	
Medical	J1566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NF)	immune globulin, powder	Yes, through the Plan Pharmacy Services	SCIG (immune Globulin)	SCIG (Immune Globulin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services	N/G (Immune Globulin)	WK (immune Globulin)	MAPD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jarisdictions Wi, IL, MO
Medical	12782	IZERVAY	avacincaptad pegol	Yes, through the Plan Pharmacy Services	IZERVAY ^m (avacincaptad pegol)	IZERVAY ^m (avacincaptad pegol)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9281	JELMYTO	mitomycin	Yes, through the Plan Pharmacy Services	JEUMYTO (mitomycin)	JELMYTD (mitomycin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19272	JEMPERLI	dostarlimab	Yes, through the Plan Pharmacy Services	JEMPERLI (dostariimab-gxiy)	JEMPERLI (dostarlimab-guly)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19043	JEVTANA	cabazitaxel	Yes, through the Plan Pharmacy Services	JEVTANA (cabazitaxel)	JEVTANA (cobazitaxel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13590	JUBBONTI	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	JUBBONTI (denosumab)	JUBBONTI (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD). Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, NO
Medical	19354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services	KADCYLA (ado-trasturumab emtansine)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub, 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
						KADC/LA (ado-trastuzumab-emtansine)	
Medical	J1290	KALBITOR	Kalbitor (ecallantide)	Yes, through the Plan Pharmacy Services Herzuma and Trazimera are the preferred Trastuzumab products and	KALBITOR (ecallantide)	KALBITOR (ecaliantide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5117	KANJINTI	trastuzumab-anns	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivit, Kanjiniti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	KANIINTI (trastuzumabianns)	KANINTI (trastorumab-anns)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2840	KANUMA IV	sebelipase alfa	Yes, through the Plan Pharmacy Services	KANUMA IV (sebelipase alfa)	KANUMA IV (sebelipase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13490	KETAMINE For Chronic Pain and Mental Health and Substance Related Disorder	ketamine	None. Not Covered.	KETAMINE FOR CHRONIC PAIN		
Medical	J9271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	KEYTRUDA (pembrolizumab)	KEYTRUDA (pembrolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19274	KIMMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	KIMMTRAK (tebentafusp-tebn)	KIMMTRAK (tebentafusp-tebn)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Aub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

					PREVEA300		
	INJECTA	BLE MEDICINES		SEARCH TIPS:	r KEV EA health plan-		
	Updated: 05/01/2024	This reference guide is a partial II benefit are covered, not covered, or coverage review of any drug listed found on the Prevea360 website fo	isting of the most commonly prescribed drugs under the medical not yet reviewed and whether a prior authorization is required. For a not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by dicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	KYRSTEXXA (pegioticase)	KRYSTEXXA (pogloticase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q2042	KYMRIAH	tisagenlecleucel	Yes, through the Plan Pharmacy Services	KYMRIAH (tisagenledeucel)	KYMRIAH (tisangeniecieucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19047	KYPROLIS	carfilzomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	KYPROUS (carfilzomib)	KYPROLIS (carfilzomib)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0217	LAMZEDE	velmanase alfa-tycv	Yes, through the Plan Pharmacy Services	LAMZEDE* (velmanase alfa-tycv)_	LAMZEDE* (velmanase alfa-tycv)_	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13490, C9399	LANREOTIDE	somatuline depot	Yes, through the Plan Pharmacy Services	LANREOTIDE (somatuline depot)	LANREOTIDE (somatuline depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicale for drugs
Medical	13590	LANTIDRA	donislecel-jujn	Yes, through the Plan Pharmacy Services	LANTRIDA ^m (donislecel-jujn)	LANTIDRA''' (donislecel-jujn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0202	LEMTRADA	alemtuzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialist with authorization. Infusions must be administered at a facility certified for LEMTRADA infusions.	LEMTRADA (alemtuzumab)	LEMTRADA (alemtuzumab)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J0174	LEQEMBI	lecanemab-irmb	Yes, through the Plan Pharmacy Services	LEGEMBI** (lecanemab-irmb)	LEQEMBI** (lecanemab-irmb)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1306	LEQVIO	inclisiran	None. Not covered.	LEQVIO (inclisiran)		
Meducal	J0641, J0642	LEVOLEUCOVORIN	fusilev khapzory	Yes, through the Plan Pharmacy Services	LEVOLEUCOVORIN	LEVOLEUCOVORIN (fusilev khapzory)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0650	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INJECTION (INTRAVENOUS)	LEVOTHYROXINE INJECTION (INTRAVENOUS)	
Medical	J9119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	UBTAYO (cemiplimab-rwlc)	UBTAYO (cemiplimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2001	LIDOCAINE for Chronic Pain	lidocaine	None. Not Covered.	LIDOCAINE FOR CHRONIC PAIN		
Medical	19999	LOQTORZI	toripalimab-tpzi	Yes, through the Plan Pharmacy Services	LOQTORZI (toripalimab-tpzi)	LOQTORZI (toripalimab-tp:)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2778	LUCENTIS	ranibizumab	No. No prior authorization required	LUCENTIS (ranibizumab)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
	J2778	LUCENTIS	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0221	LUMIZYME	algiucosidase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX with authorization.	LUMIZYME (alglucosidase alfa) (intravenous)	LUMIZYME (alglucosidase alfa) (Intravenous)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	19313	LUMOXITI	moxetumomab pasudotox	Yes, through the Plan Pharmacy Services	LUMOXITI (moxetumomab pasudotox-tdfk)	LUMOXITI (movetumomab pasudotox)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	19350	LUNSUMIO	mosunetuzumab-axgb	Yes, through the Plan Pharmacu Services	LUNSUMIC (mosunetuzumab-axgb)	LUNSUMIO (mosunetuzumab-axgb)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	A9513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services	LUTATHERA (Jutetium Lu 177)	LUTATHERA (lutetium Lu 177)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	13398	LUXTURNA	voretigene neparvovec-rzyl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the retinal dystrophy with authorization.	LUXTURNA (voretigene neparvovec-rzyl)	LUXTURNA (voretigene neparvovec-rzvl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13590	LYFGENIA	lovotibeglogene autoemcel	Yes, through the Plan Pharmacy Services	LYFGENIA (lovotibeglogene autoemcel)	LYEGENIA flovotibeglogene autoemcell	
Medical	19353	MARGENZA	margetuximab	Yes, through the Plan Pharmacy Services	MARGENZA (margetuximab)	MARGENZA (margetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13397	MEPSEVII	vestronidase alfa-vjbk (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VII with authorization.	MEPSEVII ivestronidase alfa «Jbki (intravenous)	MEPSEVII (vestronidase alfa vjbš) (Intravenous).	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19349	MONJUVI	tafasitamab-cxix	Yes, through the Plan Pharmacy Services	MONILNI (tafasitamab-csix)	MONIUNI (tafasitamab-csis)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11437	MONOFERRIC - non-preferred	ferric derisomaltose	As of D8/01/2022: VENOFER, INFED, FERRECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INECTAFER, MONOFERR, TRIFERIC, and AVWI are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	MONOFERIC (Innic derisonal tous)	MONOTERIC (Inric derizonaltose)	MAPD Prior Authorization needed autlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	17327	MONOVISC - non-preferred	hyaluronan or derivative	As of OR/D1/2022: HYALGAN, SYNVISC, SYNVISC, ONE, HYMOVIS, and TRILLIRON will be the preferred hydracine.cod products and do not require prior autorization. Monorosc, Davidine, Gel-One, Euflewan, Gedinya J, Nates J, and the hydraconstate, Triffice, Drihorate, Saparta TK, Johnson J, Santan H, Santan M, Santan J, Santan J, Santan M, Santan J, Santan J, Santan J, Santan J, Santan J, Santan M, Santan J, Santan J, Santan J, Santan J, Santan J, Santan M, Santan J, Santan J, Santan J, Santan J, Santan J, Santan J, Santan M, Santan J, San	MOROVIIC (hyplurgean or derivative)	<u>NONOVIIC (huphronan or derivative)</u>	MAPG Prior Authonization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions Wi, IL, MO.
Medical	Q5107	MVASI	bevacizumab-awwb	As of 03/02/2024: Zinaber is the preferred Benacournab product and been not require prior authorization. Auxilin, Alymay, Maxia and Vegzelma prior authorization is required through the Plan Pharmacy Service: ***Prior authorization for benacionated is not required when used for ophitamological indication: ** See the ALYMSY's (bevacionate) Policy for a list of applicable ophthalmological diagnoses.	MVASI (hervacioumab-arevela)	MVASI (herachumak-anarb)	MAPD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MO.
Medical	19203	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	MYLOTARG (gemtuzumab ozogamicin)	MYLOTARG (gemtuzumab ozogamicin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	10587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	MYOBLAC (rimabotulinumtoxinB)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions W, IL, MD.
Medical	J1458	NAGLAZYME	galsulfase (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VI with authorization.	NAGLAZYME (galsulfase) (intravenous)	NAGLAZYME (galsulfase) (intravenous)	MAPD Prior Authenization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2323	NATALIZUMAB	tysabri	Yes, through the Plan Pharmacy Services	NATALIZUMAB: [Tyrabin; Tyruko]	NATALIZUMAB: (Tysebri, Tynko)	MAPD Prior Authentation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs

	INJECTA	BLE MEDICINES		SEARCH TIPS:	PREVEA3000		
		benefit are covered not covered o	isting of the most commonly prescribed drugs under the medical not yet reviewed and whether a prior authorization is required. For da a not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	Johnen urs. This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the		
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12506	NEULASTA	pegfligrastim	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pagligrastim products and do not require prior authorization. Must have a failed trial of ZEXTRVO 2004 FULPHILA before coverage of Neulasta. UDENCYA, FVINETRA, STIMUFEND and ZEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<u>NEULASTA (pogfligratim)</u>	NEULASTA (positi (arastim)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	12506	NEULASTA	pegfilgrastim	Yes, through Navitus	NEULASTA (coeffigrastim)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11442	NEUPOGEN	filgrastim	EFFECTIVE 01/01/2023: Nivestrym and Zanxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEUPOGEN (filgrastim)	NEUPOGEN (filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW	New to Market Medical Pharmacy Products currently under clinical review	New policy regarding Medical Pharmacy products under current clinical review	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER.		
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS	New to Market Medical Pharmacy Products	New policy regarding New to Market Medical Products	NEW TO MARKET MEDICAL PHARMACY PRODUCTS		
Medical	J0219	NEXVIAZYME	avalgiucoslidase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX.	NEXVIAZYME (avalglucosidane alfa)	NEXVIAZYME (avalglucosidase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5110	NIVESTYM	filgrastim-aafi	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authoritation. Neupogen, Relevko and Grank, require prior authoritation through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NIVESTYM (filgraetim-aaft)	NIVESTYM (Bigrastim-aafi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2796	NPLATE	romipostim	Yes, through the Plan Pharmacy Services	NPLATE (romipostim)	NPLATE (romipostim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12182	NUCALA	mepolizumab	Ves, through the Flan Pharmacy Services. Eosinophilic asthmac Restricted to Pulmonology, Allergy, and Immunology specialists with authorization. Eosinophilic granulomatosis with polyangitis (EGPA): Restricted to a Pulmonology, Immunology, Allergy or Rheumatology specialist with authorization.	NUCALA (mepolizumab)	NUCALA (mepolizumab)	MAPD Prior Authorization needed outlined in the Medicani Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13490, C9399	NULIBRY	fosdenopterin	Yes, through the Plan Pharmacy Services. Restricted to a neurologist, medical geneticist, or a provider who specializes in management of inborn errors of metabolism with authorization.	NULIBRY (fostenopterin)	NULIBRY (fosdenopterin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5122	NYVEPRIA	pegfligrastim-opgf	EFFECTIVE 01/01/2023: FULPHLA and 216XTENZO are the preferred Pegfigrastim products and do not require prior authorization. Must have a failed trial of ZIXTENZO AND FULPHLA before coverage of Neulasta. UECRXIC, NIVEFRIA, PLAYTERA, and STIMUETRO require a prior autonization through the Plan Pharmacy Services. Please see Medical Policy for criteria	NYVIPRA (pepfigration angf)	NYVEPBA (configuration angel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2350	OCREVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	OCREVUS (ocreizumab)	OCREVUS (ocrelizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1568	OCTAGAM (IVIG), IMMUNE GLOBULIN	immune globulin (octagam liquid)	Yes, through the Plan Pharmacy Services	OCTAGAM (MG)	OCTAGAM (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WJ, IL, MD
Medical	Q5114	OGIVRI	trastuzumab-dkst	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	OGTVRI (trastuzumab-dkat)	OGIVRI (trastuzumab-dist)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	OMISIRGE	omidubicel-only	Yes, through the Plan Pharmacy Services	OMISIRGE* (omidubicel-only)	OMISIRGE* (omidubicel only)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C9168	OMVOH	mirikizumab-mrkz	Yes, through the Plan Pharmacy Services	OMVOH (mirikizumab-mikz)	OMVOH (mirikizumab-mrkz)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19205	ONIVYDE	irinotecan liposome injection	Yes, through the Plan Pharmacy Services	ONIVYDE (Irinotecan liposome injection)	ONIVYDE (irinotecan liposome injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0222	ONPATTRO	patisiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Hematology or Neurology specialist with authorization.	ONPATTRO (patisiran)	ONPATTRO (patisiran)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Obapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5112	ONTRUZANT	trastuzumab-dttb	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ONTRUZANT (trastuzumab-dttb)	ONTRUZANT (trasturumab-dttb)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19299	OPDIVO	nivolumab	Yes, through the Plan Pharmacy Services	OPDIVO (nivolumab)	OPDIVO (nivolumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19298	OPDUALAG	nivolumab/relatlimab-rmbw	Yes, through the Plan Pharmacy Services	OPOUALAG (nivolumab/relatlimab-rmbw)	OPDUALAG (nivolumab/relatimab-rmbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0129	ORENCIA (IV)	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	ORENCIA IV (abatacept)	<u>ORENCIA IV (abatacept)</u>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Poli: 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	J0129	ORENCIA (SC)	abatacept	Yes, through Navitus. Restricted to an Rheumatology specialist with authorization.	ORENCIA SC (abatacept).	ORENCIA SC (abatacept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	17324	ORTHOVISC - non-preferred	hyaluronan or derivative	As of 08/03/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRULINON will be the preferred hyphronics and products and do not prove procession. Monosce, Construct, Scholm, Callenson, and Cantholication. Monosce, Cantonica, Scholm, Callenson, and Ganhard and the non-preferred hyphronic and product and provariationation in required through the Plan Pharmacy Services. Rease see: Medical Policy for criteria	GETTECKYNTC (hyskunneten or denskaatteel)	CRTHONIC (hystemisen or deviation).	MAPD Prior Authonization based on National Coverage Determination (NCD), Local Coverage Determinations (ICD), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisd class Wi, IL, MD
Medical	J0224	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	OXLUMO (lumasiran)	OXLUMO (lumasiran)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19259	PACITAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services	PACITAXEL PROTEIN-BOUND PARTICLES	PACITAXEL PROTEIN BOUND PARTICLES	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions W, IL, MD
Medical	19177	PADCEV	enfortumab vedotin-ejfv	Yes, through the Plan Pharmacy Services	PADCEV (enfortumab vendotin-ejfv)	PADCEV (enfortumab-vedotin-ejfv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0208	PEDMARK	sodium thiosulfate	Yes, through the Plan Pharmacy Services.	PEDMARK (sodium thiosulfate)	PEDMARK (sodium thiosulfate)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19304	PEMFEXY	pemetrexed	Yes, through the Plan Pharmacy Services	PEMFEXY (pemetrexed)	PEMFEXY (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19247	PEPAXTO	(melphalan flufenamide	Yes, through the Plan Pharmacy Services	PEPAXTO* (melphalan flufenamide)	PEPAXTO* (melphalan flufenamide)	MAPD Prior Authoritation needed outlined in the Medicane Benefit Policy Manual (Pub. 100 2), Chapter 15, 350 Drugs and Biologicals for drugs.

	INIECTA	BLE MEDICINES			PREVEA360		
	INJECTA			SEARCH TIPS:	centered around you		
	Updated: 05/01/2024	benefit are covered, not covered, o coverage review of any drug liste	listing of the most commonly prescribed drugs under the medical r not yet reviewed and whether a prior authorization is required. For d as not covered, please complete the Exception to Coverage form for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct na	s the binocular icon on your toolbar. It will then display a search box for you to spelling, you can start your search by entering just the first few letters of the ame		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19306	PERJETA	pertuzumab	Yes, through the Plan Pharmacy Services	PERJETA (pertuzumab)	PERJETA (pertuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	PHESGO (pertuzumab)	PHESGO (pertuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	A9699	PLUVICTO	lutetium Lu 177 vipivotide tetraxetan	Yes, through the Plan Pharmacy Services	PLUVICTO (lutetium Lu 177 vipivotide tetraxetan)	PLUVICTO (lutetium LU 177 vipivotide tetraxtan)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19309	POLIVY	polatuzumab vedotin-pilq	Yes, through the Plan Pharmacy Services	POLIVY (polatuzumab vedotin-piiq)	POLIVY (polatuzumab vedotin-piig)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1203	POMBILITI	cipaglucosidase alfa-atga	Yes, through the Plan Pharmacy Services	POMBILITI (cipaglucosidase alfa-atga)	POMBIUTI (cipaglucosidase alfa-atga)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19295	PORTRAZZA	necitumumab	Yes, through the Plan Pharmacy Services	PORTRAZZA (necitumumab)	PORTRAZZA (necitumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9204	POTELIGEO	mogamulizumab-kpkc)	Yes, through the Plan Pharmacy Services	POTELIGEO (mogamulizumab-łpkc)	POTELIGEO (mogamulizumab-kpkc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1459	PRIVIGEN (IVIG), IMMUNE GLOBULIN	privigen	Yes, through the Plan Pharmacy Services	PRIVIGEN (IVIG)	PRIVISEN (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions Wi, IL, MO.
Pharmacy	J0885	PROCRIT - non-preferred	epoetin alfa, (for non-esrd use)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	PROCRIT (epoetin alpha)	PROCRIT (epoetin alpha)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J0885, Q4082	PROCRIT	epoetin alfa, (for non-esrd use)	mepimody specials with automation. As of 01/01/2132 Retarch is the preferred Experim Alfa products and does not require prior authorization. Epogen and Procert prior authorization is required through the Plan Hammacy Services. Please see Medical Policy for criteria.	PROCTRIT (epoets alls, for non-end use)	PEOCRIT (epoctin alpha)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
Medical	J9015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services	PROLEUKIN (aldesleukin)	PROLEUKIN (aldesleukin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10897	PROLIA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	PROLA (denosumab)	PROLIA (denosumab)	MAPD Proc Authoritation based on National Coverage Determination (NCD), local Coverage Determinations ()CD), and Local Coverage Articles ()CA) for guidance where applicable for Aveidations WI, IL, MO
Medical	Q2043	PROVENGE	sipuleucel-T	Yes, through the Plan Pharmacy Services	PROVENGE (sipuleucel-T)	PROVENGE (sipuleucel-T)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MO
Medical	J1304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	QALSODY*** (tofersen)	OALSODY"" (tofersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1301	RADICAVA	edaravone	Yes, through the Plan Pharmacy Services. Restricted to an Neurology specialist with authorization.	RADICAVA (edaravone)	RADICAVA (edaravone)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 150-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J0896	REBLOZYL	lusptercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	REBLOZYL (luspatercept-aamt)	REBLOZYL (luspatercept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5125	RELEUKO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zanolo are the preferred Filgrastim products and do not require prior authorization. Neupogen Releuko and Grank, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<u>NELLURO (filgratim-syow)</u>	RELEUKO (filgrastim-ayow)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1745	REMICADE - non-preferred	Infliximab	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXOS Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization. Generic Trepostinii will be covered with prior Authorization through	REMICADE (influemab)	REMICADE (influimab)	MARY Proc Authorization based on National Coverage Determination (NCD), Local Coverage Determinations ();CD), and Local Coverage Articles ();CA) for guidance where applicable for AutoActions (); L MD.
Medical	13285	REMODULIN IV	treprostinil	the Plan Pharmacy Services. Brand REMODULIN will not be covered. Restricted to (in at least consultation with) a Cardiology or Pulmonology specialists with authorization.	SEMODULIN IV (treprostinil)	REMODUUN IV (treprostinii)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5104	RENFLEXIS - preferred infliximab product	infliximab-abda	As of 10/01/2019 Prior authorization for the preferred infliximab product will only require provider attestation to an appropriate indication through the Plan Pharmary Services. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<u>EENELENE (Influenal: abda)</u>	RENELEXCE influenzab abdal	MAPD Prox Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Junidistron Wi, H, MO.
Pharmacy	Q5105	RETACRIT - preferred	epoetin alfa-epbx	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization. As of 01/01/2023: Retactit is the preferred Epoetin Alfa products and	RETACRIT (epoetin alfa-epbx)	<u>RETACRIT (epoetin alfa-eptx)</u>	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	Q5106	RETACRIT	epoetin alfa-epbx	As of 01/01/2023: Retarr is the preterred Epoetin Alta products and does not require prior authorization. Epogen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RETACRIT (epoetin alfa-episs)	RETACRIT (epoetin alfa-ephs)	MAPD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, BC).
Medical	J7311	RETISERT	fluocinolone acetonide intravitreal implant	None. Not Covered.	RETISERT (fluocinolone acetonide intravitreal implant)		
Medical	13590	RETHYMIC	allogeneic processed thymus tissue-agdc)	Yes, through the Plan Pharmacy Services	RETHYMIC (Allogenic processed thymus tissue-agdc)	RETHYMIC (Allogenic processed thymus tissue-agdc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	13950, C9399	REVCOVI	elapegademase-lvir	Yes, through the Plan Pharmacy Services.	REVCOVI* (elapegademase-lvlr)	REVCOVI* (elapegademase-lvir)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitus.	RHOPRESSA (netarsudii)	RHOPRESSA (netarsudil)	
Medical	Q5123	RIABNI	rituximab-arrx	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria	BiABNi (ritusimab-arrx)	<u>RIABNI (rituximab-arra)</u>	NAPD Prior Authorization based on National Coverage Determination (NCO), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MO
Medical	13490	RIVFLOZA	nedosiran	Yes, through the Plan Pharmacy Services	BIVFLOZA (nedosiran).	BIVELOZA (nedosiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9312	RITUXAN	rituximab	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria	SITUXAN (ritusimab)	RITUXAN (rituximab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	J9311	RITUXAN HYCELA	rituximab and hyaluronidase human	Yes, through the Plan Pharmacy Services	RTUXAN HYCELA (rituximab and hyaluronidase human)	RITUXAN HYCELA (rituximab and hyaluronidase human)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	J9312	RITUXIMAB IV	rituxan, truxima, ruxiencem riabni	Yes, through the Plan Pharmacy Services	RITUXIMAB IV (rituxan, truxima, ruxience, riabni)	RITUXIMAB IV (rituxan, truxima, ruxiencem riabni)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	J1412	ROCTAVIAN	valoctocogene roxaparvovec-rvox	Yes, through the Plan Pharmacy Services	ROCTAVIAN* (valoctocogene roxaparvovec-rvox)	ROCTAVIAN® (valoctocogene roxaparvovec-rvox)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	J1449	ROLVEDON	eflapegrastim-xnst	Yes, through the Plan Pharmacy Services.	ROLVEDON [™] (eflapograstim-xnst)	BOLVEDDN [™] (eflapegrastim-anst)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	11449	ROLVEDON	elfapegrastim-onst	EFFECTIVE 06/28/2024. Yes, through the Plan Pharmacy Services	Coming Sean	Coming Soon	NAPD Prior Authoritation needed outlined in the Medicane Benefit Policy Manual (Pub. 105-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5119	RUXIENCE	rituximab-pvvr	As of 01/01/2023: Rusience and Trusima are the preferred Ritusimab products and does not require prior authorization. Riabni and Ritusan prior authorization is required. Please see medical policy for criteria	REACENCE (ritualmab.pvvr)	RUZGENCE (riturimab-pvvr)	MARD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD,
Medical	J9061	RYBREVANT	amivantamab-vmjw	Yes, through the Plan Pharmacy Services	RYBREVANT (amivantamb-vm)w)	BYBSEVANT (amivantamab-vmjw)	NAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

	INJECTA	ABLE MEDICINES			PREVEA360		
		This reference guide is a partial	listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	continued amount you		
	Updated: 05/01/2024		r not yet reviewed and whether a prior authorization is required. Fo d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12998	RYPLAZIM	plasminogen, human-tvmh	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical Hernatologist or MD specializing in plasminogen deficiency (PLGD) with authorization.	EVFLAZM (plasminopen, human-tymh)	BYPLAZIM (plasminogen, human-tvmh)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19333	RYSTIGGO	rozanolisizumab-noli	Yes, through the Plan Pharmacy Services	RYSTIGGO* (rozanolixizumab-noli)	BYSTIGGO* (rozanolikizumab-noli)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13590	RYZNEUTA	efbemalenograstim alfa-vuxw	Yes, through the Plan Pharmacy Services	EVZNEUTA (efbernalenogratim alfa-vuxei)	<u>RYZNEUTA (efbernalenograstim alifa-vuaw)</u>	
Medical	13590	RYZNEUTA	efbemalenograstim alfa-vuxw	EFFECTIVE 06/28/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Seen	
Pharmacy		SANDOSTATIN	octreotide	Yes, through Navitus. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or Gastroenterologist specialist with authorization.	SANDOSTATIN (octreotide)		
Medical	12353	SANDOSTATIN LAR	octreatide suspension	Yes, through the Plan Pharmacy Services	SANDOSTATIN (octreotide suspension)	SANDOSTATIN LAR (octreotide suspension)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12354	SANDOSTATIN	octreotide suspension (non-depot form)	Yes, through the Plan Pharmacy Services	SANDOSTATIN (octreotide suspension (non depot form)	SANDOSTATIN (octreotide suspension (non depot form)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Servcies	SANDOZ (pometrexed)	SANDOZ (permetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0491	SAPHNELO	anifrolumab-fnia	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	SAPHNELO (anifrolumab-fnia)	SAPHNELO (anifrolumab-foia)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9227	SARCLISA	lsatuximab-irfc	Yes, through the Plan Pharmacy Services	SARCLISA (satuximab-irfc)	SARCLISA (isatusimab-irfc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17352	SCENESSE	afamelanotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Dermatologist, Medical Geneticist, or a Physician specializing in the treatment of cutaneous porphyrias with authorization.	SCENESSE (afamelanotide)	<u>SCENESSE (afamelanotide)</u>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy		SELF-ADMINISTERED DRUGS		PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.	SELF-ADMINISTERED DRUGS		
Medical	12502	SIGNIFOR LAR	pasireotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist specialist with authorization.	SIGNIFOR LAR (pasireortide)	SIGNIFOR LAR (pasireortide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1602	SIMPONI ARIA	golimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthrits, Peripheral Aniylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (golimumsib)	SIMPONI ARIA (golimumab)	NAME Price Authorization needed outlined in the Medicane Benefit Policy Manual (Nub. 100-3), Chapter 15, 550 Drugs and Biologicali for drugs
Pharmacy	11602	SIMPONI ARIA	golimumab	Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthrits, Peripheral Ankylosing Spondylitis, or Pooriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (polimumab)	SIMPONI ARIA (golimumab)	
Medical		SITE OF SERVICE		Yes, through the Han Pharmacy Services. Requests for select specially drugs as listed in the list in section 'Drugs in Scope' to be administered in a hospital outpatient setting may be directed to a preferred alternative site of care, such as home infusion provider or a physician office.	SITE OF SERVICE		
Medical	12327	SKYRIZI IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterologiy specialist with authorization.	SKYRIZI IV (risankizumab IV)	SKYRIZI IV (risankizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	SKYSONA	elivaldogene autotemcel	Yes, through the Plan Pharmacy Services.	SKYSONA® (elivaldogene autotemcel)	SKYSONA* (elivaldogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1300	SOLIRIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Nuero-Opthalmonogist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	<u>SOLIRIS (eculizumab)</u>	<u>SOLIRIS (eculizumab)</u>	NAPID Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for larticlations Wi, IL, MD
Medical	11930	SOMATULINE	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	SOMATULINE (lanreotide depot)	SOMATULINE (lanreotide depot)	MAYD Prior Authonization needed outlined in the Medicane Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1747	SPEVIGO	spesolimab	Yes, through the Plan Pharmacy Services	SPEVIGO* (spesolimab)	SFEVIGO* (spesolimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2326	SPINRAZA	nusinersen	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurology specialist with expertise in SMA treatment with authorization.	SPPRAZA (nusinersen)	SPINRAZA (nusinersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13490	SPRAVATO	esketamine	Yes, through Plan Pharmacy Services	SPRAVATO (esketamine)	SPRAVATO (esketamine)	MAVD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13358	STELARA (IV)	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	STELARA IV (ustekinumab)	STELARA IV (ustokinumab)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	13358	STELARA (SC)	ustekinumab	Yes, through Navitus. Restricted to an Gastroenterology specialist with authorization.	STELARA SC (ustekinumab)	STELARA SC (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	STIMUFEND	pegfilgrattm-pbbk	EFFECTIVE 01/01/2024: FJUPHILA and NYVEPRIA are the preferred Pegligrastim products and do not require prior authoritation. Must have a failed trial of ZEXTENDO AND FLIPHILA before coverage of Neulata, UDENCIA, FYNHETRA, STIMUEFRID and ZEXTENDO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<u>TTMUENG (podlaratimabba)</u>	TTMUFERD (pagfigrastim obbi)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy		Sublingual Immunotherapy (SLIT for ALLERGY products	GRASTEK (Timothy grass pollen allergen extract), RAGWITEK (Short ragweed pollen allergen extract), ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Biue grass mixed pollens allergen extract), ODACTRJ (House Dust Mite allergen extractt)	Yes, through Navitus. Must be prescribed by an allergist, immunologist, or physician with active and ongoing experience in the diagnosis and treatment of allergic disease and use of immunotherapy products with authorization	SUT for Allergy Products		
Medical	17321	SUPARTZ FX - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC, ONE, HYMOVIS, and TRULINON will be the preferred hyakanenic acid products and do not require prior advisoration. Monovis, Doralan, Gi-Gi-Oo, Eulensa, Gelym-3, Visco-3, aodium hyakanenia et al. TriVisc, Orthowics, Supart EX, and GenViscS30 are the non-preferred hyakanetic add products and prior authoritation is required through the Plan Hyarmacy Services. Please see Medica Holey for criteria	BLEART FX Byshennen or derivative)	1187ARTZ FX Duplacement of defaultant	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, M
Medical	J1627	SUSTOL	granisetron extended-release	Yes, through the Plan Pharmacy Services	SUSTOL (granisetron extended-release)	SUSTOL (granisetron extended release)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

Image: Note of the state of		INJECTA	BLE MEDICINES			PREVEA360		
<table-row><table-row><table-row></table-row><table-row><table-row></table-row><table-row><table-row></table-row></table-row></table-row></table-row></table-row>		Undersel (6/01/2014		root yet reviewed and whether a prior authorization is required. For d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy	This is a large decument, but you can search quickly and early by disking on	spelling, you can start your search by entering just the first few letters of the	,	
No. No. No. No. No. No. No. No. No. No. No. No. No. Second Se							Prior Authorization Form	
No. No. No. No. No. No. Social	Medical	J2860	SYLVANT	siltuximab	Yes, through the Plan Pharmacy Services	SYLVANT (slituximab)	SYLVANT (siltuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No <td>Medical</td> <td>90378</td> <td>SYNAGIS</td> <td>palivizumab</td> <td>Neonatologist, or Pediatric specialist (including family practice, general pediatrics, pediatric pulmonology, and pediatric cardiology) with</td> <td>STNAGIS (palvoumsto)</td> <td>EVNAGIS Institutionabi</td> <td></td>	Medical	90378	SYNAGIS	palivizumab	Neonatologist, or Pediatric specialist (including family practice, general pediatrics, pediatric pulmonology, and pediatric cardiology) with	STNAGIS (palvoumsto)	EVNAGIS Institutionabi	
No. No. <td>Medical</td> <td>17325</td> <td>SYNVISC - preferred</td> <td>hyaluronan or derivative</td> <td>TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym3, Viccos, Josdium Myaluronate, Trilvics, Orthovics, Suparte FX, and GenVics250 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services.</td> <td>SYNVISC (hydurpnan or directive)</td> <td></td> <td>MAPD Pror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions W, IL, MO</td>	Medical	17325	SYNVISC - preferred	hyaluronan or derivative	TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym3, Viccos, Josdium Myaluronate, Trilvics, Orthovics, Suparte FX, and GenVics250 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services.	SYNVISC (hydurpnan or directive)		MAPD Pror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions W, IL, MO
No <td>Medical</td> <td>17325</td> <td>SYNVISC ONE - preferred</td> <td>hyaluronan or derivative</td> <td>TRULINON will be the preferred hyakronic add products and do not require prior authorization. Monovisc, Durolane, Gel-One, Eufexoa, Gelyn-3, Visco-3, sodium hyakronate, TriVisc, Orthovics, Supartz FX, and GenVisc850 are the non-preferred hyakronic acid products and prior authorization is required through the Plan Pharmacy Services.</td> <td>TINVISC ONE Dynamous of deviations</td> <td></td> <td>MAPD Pror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for surfactions (W, IL, MD</td>	Medical	17325	SYNVISC ONE - preferred	hyaluronan or derivative	TRULINON will be the preferred hyakronic add products and do not require prior authorization. Monovisc, Durolane, Gel-One, Eufexoa, Gelyn-3, Visco-3, sodium hyakronate, TriVisc, Orthovics, Supartz FX, and GenVisc850 are the non-preferred hyakronic acid products and prior authorization is required through the Plan Pharmacy Services.	TINVISC ONE Dynamous of deviations		MAPD Pror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for surfactions (W, IL, MD
Note Note Name Name Name Name Name Name Note No	Medical	13055	TALVEY	talquetamab-tgvs	Yes, through the Plan Pharmacy Services	TALVEY" (talgustamab-tava)	TALVEY" (talquetamab-tovs)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No <td>Medical</td> <td>Q2053</td> <td>TECARTUS</td> <td>brexucabtagene autoleucel</td> <td>Yes, through the Plan Pharmacy Services</td> <td>TECARTUS (browcabtagene autoleucel)</td> <td>TECARTUS (brexusablagene autoleusel)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	Q2053	TECARTUS	brexucabtagene autoleucel	Yes, through the Plan Pharmacy Services	TECARTUS (browcabtagene autoleucel)	TECARTUS (brexusablagene autoleusel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. No. <td>Medical</td> <td>J9022</td> <td>TECENTRIQ</td> <td>atezolizumab</td> <td>Yes, through the Plan Pharmacy Services</td> <td>TECENTRIQ (atezolizumab)</td> <td>TECENTRIQ (atezolizumab)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	J9022	TECENTRIQ	atezolizumab	Yes, through the Plan Pharmacy Services	TECENTRIQ (atezolizumab)	TECENTRIQ (atezolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. No. <td>Medical</td> <td>C9148</td> <td>TECVAYLI</td> <td>teciistamab-cqyv</td> <td>Yes, through the Plan Pharmacy Services</td> <td>TECVAYLI (teclistamab-covv)</td> <td>TECVAVLI (teclistamab-covv)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	C9148	TECVAYLI	teciistamab-cqyv	Yes, through the Plan Pharmacy Services	TECVAYLI (teclistamab-covv)	TECVAVLI (teclistamab-covv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
NoNoNoNoNoNoNoNo10NoNoNoNoNoNoNoNo10NoNoNoNoNoNoNoNoNo10NoNoNoNoNoNoNoNoNoNo10NoNoNoNoNoNoNoNoNoNoNo10NoNoNoNoNoNoNoNoNoNoNoNo10No	Medical	J3241	TEPEZZA	teprotumumab-trbw	consultation with) a Ophthalmologist and Endocrinologist specialist	TEPEZZA (teprotumumab-trbw)	TEPEZZA (teprotumumab trbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
N N	Medical	J9314	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	TEVEA (pemeterzed)	TEVA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. Sind Sind <ths< td=""><td>Medical</td><td>J2356</td><td>TEZSPIRE</td><td>tezepelumab</td><td>Yes, through the Plan Pharmacy Services</td><td>TEZSPIRE (teaepolumab)</td><td>TEZSPIRE (tezepelumab)</td><td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td></ths<>	Medical	J2356	TEZSPIRE	tezepelumab	Yes, through the Plan Pharmacy Services	TEZSPIRE (teaepolumab)	TEZSPIRE (tezepelumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. No. <td>Medical</td> <td>J9273</td> <td>TIVDAK</td> <td>tisotumab vedotin-tftv)</td> <td>Yes, through the Plan Pharmacy Services</td> <td>TIVDAK (tisotumab vedotin-tftv)</td> <td>TIVDAK (tisotumab vedotin-tftv)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	J9273	TIVDAK	tisotumab vedotin-tftv)	Yes, through the Plan Pharmacy Services	TIVDAK (tisotumab vedotin-tftv)	TIVDAK (tisotumab vedotin-tftv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. Name Subscience Subscin	Medical	Q5133	TOFIDENCE	tocilizumab-bavi	Yes, through the Plan Pharmacy Services	TOFIDENCE (tocilizumab-bavi)	TOFIDENCE (tocilizumab-bavi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
No. No. <td>Medical</td> <td>Q5116</td> <td>TRAZIMERA</td> <td>trastuzumab-qyyp</td> <td>do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy</td> <td>TRAZIMERA (trasturumab-gyyp)</td> <td>JRAZIMERA (trastuzumab vedotin-ffty)</td> <td>MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 105-2), Chapter 15, \$50 Drugs and Biologicals for drugs</td>	Medical	Q5116	TRAZIMERA	trastuzumab-qyyp	do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy	TRAZIMERA (trasturumab-gyyp)	JRAZIMERA (trastuzumab vedotin-ffty)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 105-2), Chapter 15, \$50 Drugs and Biologicals for drugs
N1 N1<	Medical	19033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services	TREANDA (bendamustine)	TREANDA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
IndexSince Since	Medical	17332	TRILURON - preferred	sodium hyaluronate	TRILURON will be the preferred products. No Prior Authorization	TREURON (sodium hyaluronate)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions W, IL, MO
Not Not <td>Medical</td> <td>17329</td> <td>TRIVISC - non-preferred</td> <td>hyaluronan or derivative</td> <td>TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym 3, Visco 3, sodium hyaluronate, TriVisc, Orthovics, Supartr FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services.</td> <td>139995C Byakuronan or derivative).</td> <td>18V45C (hyskuronan or demostrat)</td> <td>MAPD Prior Authorization based on National Coverage Determinations (ICD), Local Coverage Determinations (ICD), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions Wi, IL, MO</td>	Medical	17329	TRIVISC - non-preferred	hyaluronan or derivative	TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym 3, Visco 3, sodium hyaluronate, TriVisc, Orthovics, Supartr FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services.	139995C Byakuronan or derivative).	18V45C (hyskuronan or demostrat)	MAPD Prior Authorization based on National Coverage Determinations (ICD), Local Coverage Determinations (ICD), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions Wi, IL, MO
Not Not <td>Medical</td> <td>J9317</td> <td>TRODELVY</td> <td>sacituzumab govitecan-hziy</td> <td>Yes, through the Plan Pharmacy Services</td> <td>TRODELVY (sacituzumab govitecan-hziv)</td> <td>TRODELVY (sacituzumab govitecan-hziy)</td> <td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td>	Medical	J9317	TRODELVY	sacituzumab govitecan-hziy	Yes, through the Plan Pharmacy Services	TRODELVY (sacituzumab govitecan-hziv)	TRODELVY (sacituzumab govitecan-hziy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
NumNumNumeNumeNumeNum <th< td=""><td>Medical</td><td>J1746</td><td>TROGARZO</td><td>ibalizumab</td><td>Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Infectious Disease specialist with authorization.</td><td>TROGARZO (ibalizumab)</td><td>TROGARZO (ibalizumanages)</td><td>MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs</td></th<>	Medical	J1746	TROGARZO	ibalizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Infectious Disease specialist with authorization.	TROGARZO (ibalizumab)	TROGARZO (ibalizumanages)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
NotNotRanceRanc	Medical	Q5115	TRUXIMA	rituximab-abbs	products and does not require prior authorization. Riabni and Rituxan	TRURIMA (riturimab abbd)	TRUXIMA (rituximab-abbs)	MATD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDa), and Local Coverage Articles (LCAs) for guidance where applicable for Artidictions W, IL, MO.
A NotA Not	Medical	Q5134	TYRUKO	natalizumab	Yes, though the Plan Pharmacy Services	TYRUKO (natalizumab)	TYRUKO (natalizumab)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
No.No	Medical	12323	TYSABRI	natalizumab injection	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	TYSABRI (natalizumab)	TYSABRI (natalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
ActalBitsUNNAeffiguation devideEffiguation devide on transport on the profession de DATINGTION DURANT LABORATION DURANT LA	Medical	C9149	TZIELD	teplizumab-mzwv	Yes, through the Plan Pharmacy Services.	TZELD (teplizumab-mzwy)	TZIELD (teplizumab-mzwy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Made Mills Multimation Multim	Medical	Q5111	UDENYCA	pegfligratim-cbqv	Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services.	LOENCK (oppligzstim skod	LDEINYA (seqtigratin-cloud	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Image: A set in the set	Medical	J1303	ULTOMIRIS	ravulizumab	consultation with) a Hematology, Oncology, or Immunology specialist	ULTOMIRIS (ravultzumab)	ULTOMIRIS (ravulizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Markan Answe Consultation with a cardiologist or pulmonologist with authoritation. Consultation with a cardiologist or pulmonologist with authoritation. Image: Second Sec	Medical	J1823	UPLIZNA	inebilizumab-cdon	Yes, through the Plan Pharmacy Services	UPUZNA* (inebilizumab-cdon)	UPUZNA* (inebilizumabicdon)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Parmacy UPTRAVI selexipag Ves, hough Navius. Restricted to (in at aleast consultation with) a upTRAVI interpage	Medical	18499	UPTRAVI-IV	selexipag	Yes, though the Plan Pharmacy Services. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI-IV (selexipag)	UPTRAVLIV (celesipag)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
	Pharmacy		UPTRAVI	selexipag	Yes, though Navitus. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	LIPTRAVI (selexipag)	UPTRAVI (selexipag)	

	INJECT	ABLE MEDICINES			PREVEA3600 heatth plan-		
		This reference guide is a partial	listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	Lenting lenking pu		
	Updated: 05/01/2024	coverage review of any drug liste	r not yet reviewed and whether a prior authorization is required. Fo da son occoverad, please complete the Exception to Coverage form for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	If This is a large document, but you can search quickly and easily by clicking on bype in the name of drug you want to locate. If you do not know the correct na	the binocular icon on your toolbar. It will then display a search box for you to spelling, you can start your search by entering just the first few letters of the me		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12777	VABYSMO	faricimab-svoa	No. No prior authorization required.	VABYSMO ^{rre} (faricimab-svoa)		MAPD Prior Authentization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MO
Medical	12777	VABYSMO	faricimab-svoa	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Scon	<u>Comine Soon</u>	NAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, N, NO
Medical	19303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	VECTIBIX (panitumumab)	VECTIBIX (panitumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	VELCADE (bortezomib)	VELCADE (bortezomib)	MAPD Prior Authorization based on National Coverage Determination (NCD). Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q5129	VEGZELMA	bevacizumab-adcd	As of 03/01/2024 Zinabev is the preferred Bevaciumab product and does not require prior authorization. Avastin, Alymays, Massi and Vegelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevaciumab is not required when used for ophthumological indications: *** See the ALYMSYS (bevaciumab) Policy for a list of applicable ophthalmological diamones.	<u>VEGZUMA (bevadzumab adod)</u>	VIGZUMA (prvaciaumab adici)	MAPD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MD
Medical	J1756	VENOFER - preferred	Kon sucrose	As of 08/03/2022. VENOFER, INFED, FERRECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INECTAFER, MONOFERS, TRYFRIC, and TRYFRIC AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<u>VINOFE (inn suntee)</u>		
Medical	19376	VEOPOZ	pozelimab-bbfg	Yes, through the Plan Pharmacy Services	VEOPOZ* (poselimab-bb(g)	VEOPO2* (pazelimab-bbfg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1427	VILTEPSO	viltolarsen	None. Not Covered.	VILTEPSO (viltolarsen)		
Medical	J1323	VIMIZIM	elosulfase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis IVA with authorization.	XIM2IM (elocalface)	VIM/IM (closulface)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs.
Medical	17321	VISCO-3 - non-preferred	hyaluronan or derivative	As of D8/D1/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMDVIS, and TRULIRON will be the preferred hysikronic acid products and do not require prior automation. Monoroc, Danielos, Gel Ove, Eldinosa, Gelyna J, Nicco J, sodium hysikronizate, TriVico, Dithorisc, Saparz TA, eldinosa, Sapardian Manager, Saparz TA, eldinosa, and Saparz M, Saparz M, Saparz M, Saparz SA, eldinosa automationa in signieris dithorgis, the Plan Pharmary Services. Plasas see Medical Policy for criteria	19503 i Dipatorenan ar distruttive)	VIICO 3 Physicscene or derivative)	MAPD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WC, IL, MO.
Medical	19999	VIVIMUSTA	bendamustine	EFFECTIVE 05/01/2023. Yes, through the Plan Pharmay Services	VIVIMUSTA (bendamustine)	VIVIMUSTA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13385	VPRIV	velaglucerase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX with authorization.	<u>VPRIV (velagtucerase atfa)</u>	<u>YPRIY helagiscenase alfa)</u>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 350 Drugs and Biologicals for drugs
Medical	13032	VYEPTI	eptinezumab-jjmr	Yes, through the Plan Pharmacy Services	VYEPTI (eptinezumab)	VYEPTI (eptinezumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3401	VYJUVEK	beremagene geperpavec-svdt	Yes, through the Plan Pharmacy Services	<u>VYIUVEK** (beremagene geperpavec-svdt)</u>	VYIUVEK ^{III} (beremagene geperpavec-svdt)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11429	VYONDYS 53	golodirsen	None. Not Covered.	VYONDYS 53 (golodirsen)		
Medical	19332	VYVGART	efgartigimod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	<u>VYVGART (efgartigmoid)</u>	VIVGART (efgartigimed alfa-fcab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Obapter 15, 550 Drugs and Biologicals for drugs
Medical	19334	VYVGART-HYTRULO	efgartigimod alfa-fcab and hyaluronidase-qvfc	Yes, through the Plan Pharmacy Services.	VYVGART* Hytrulo (efgartigimod alfa-fcab and hyaluronidase-ovfc)	VYVGART® Hytrulo (efgartisimod alfa-fcab and hyaluronidase-ovfc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9153	VYXEOS	daunorubicin and cytarabine – liposome	Yes, through the Plan Pharmacy Services	VYXEOS (daunorubicin and cytarabine – liposome).	VYXEOS (danuorubicin and cytarabine-liposome)	MAPD Prior Authorization needed outlined in the Medicare Benefic Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		VYZULTA	latanoprostene bunod	PHARMACY BENEFIT ONLY. Yes, through Navitus.	VYZULTA (latanoprostene bunod)	VYZULTA (latanoprostene bunod)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	wyost	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	WYOST (denosumab)	WYOST (denosumab)	NAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions W, N, ND
Medical	J1558	XEMBIFY (SCIG)	immune globulin	Yes, through the Plan Pharmacy Services	XEMBIFY (SCIG)	XEMBIFY-(SCIG).	NAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0218	XENPOZYME	olipudase alfa	Yes, through the Plan Pharmacy Services.	XENPOZYME" (olipudase alfa)	XENPOZYME" (olipudase alfa)	MAPP Proc Authoritation based on National Coverage Determination (NCD). Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions Wi, IL, MO
Medical	10588	XEOMIN	incobatulinumtaxinA	No prior authorization is required.	XEOMIN (incobotulinumtoxinA)		MAPD Prior Authorization based on National Coverage Determination (NCD). Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions W, H, MO
Medical	J0897	XGEVA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with	<u>XGEVA (denosumab)</u>	XGEVA (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for autidistions WI, II, MO
Medical	13299	XIPERE	triamcinolone acetonide injectable suspension	authorization Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an opthamalogist specialist with authorization.	XIPERE (triamcinolone acetonide injectable suspension)	XIPERE (triamcinolone acetonide injectable suspension)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictors Wi, II, MD
Medical	J2357	XOLAIR	omalizumab, Smg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	XOLAIR (omalizumab)	XOLAIR (omalizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	19228	YERVOY	Ipilimumab	Yes, through the Plan Pharmacy Services	YERVOY (iplimumab)	YERVOY (ipilimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q2041	YESCARTA	axicabtagene ciloleucel	Yes, through the Plan Pharmacy Services	YESCARTA (asicabragene ciloleucel)	YESCARTA (axicablagene ciloleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	19352	YONDELIS	trabectedin	Yes, through the Plan Pharmacy Services	YONDEUS (trabectedin)	YONDEUS (trabectedin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5101	ZARXIO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zankio are the preferred EFFECTIVE 01/01/2023: Nivestym and Zankio are the preferred Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ZABOD Higratim avova	ZAROO (filgratim ayon)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

					-6-	1	
	INJECT	ABLE MEDICINES		SEARCH TIPS:	PREVEA300		
	Updated: 05/01/2024	benefit are covered, not covered, or coverage review of any drug lister found on the Prevea360 website fo	listing of the most commonly prescribed drugs under the medical net yet reviewed and whether a prior authorization is required, at a net covered phase complete the Exception to Exception or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.		spelling, you can start your search by entering just the first few letters of the		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	10256	ZEMAIRA/PROLASTIN-C	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)	ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	ZEPZELCA (lurbinectedin)	ZEFZELCA (lurbinectedin)	MAPD Prior Authonization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5120	ZIEXTENZO	pegfligratim-bmez	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegligrastim products and do not require prior authorization. Must have failed ind / ZIXTENDO NOT FUHRILA before coverage of Neulata, UDENCYA, FVINETRA, STIMUFERID and ZIXTENDO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	2DXTEN2O (popfigration-breez)	20XII NZO (pagligastim binez)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5118	ZIRABEV	bevacizumab-bvzr	As of 03/02/0242 Zinabev in the preferred Bevaciumab product and does not require prior authorization. Avastin, Alympy, Massi and Vegelma prior authorization is rejured through the Flam Flammacy Services. ***Prior authorization for bevaciumab is not required when used for ophthamological indications: *** See the ALYMSYS (Bevaciumab) Policy for a list of applicable ophthalmological disamous:	28AREV (Devictournals bran)	2848EV (Swidamsh byr)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD-d, and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MC
Medical	C9399, 13590	ZOLGENSMA	onasemnogene abeparvovic-sioi	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Neurologist with expertise in the diagnosis of Spinal Muscular Atrophy (SMA) with authorization.	ZDLGENSMA (onzsemnogne zbeparvović xiol)	ZOLGENSMA (onasemnogene abeparvovic)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19359	ZYNLONTA	loncastuximab tesirine	Yes, through the Plan Pharmacy Services	ZYNLONTA (Ioncastuximab)	ZYNLONTA (Ioncastuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590,C9399	ZYNTEGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	ZYNTEGLO* (betibeglogene autotemcel).	ZYNTEGLO* (betibeglogene autotemcel)	MAPD Prior Authonization needed outlined in the Medicane Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19345	ZYNZ	retifanlimab-diwr	EFFECTIVE 08/01/2023. Yes, through the Plan Pharmacy Services	ZYNYZ (retifanlimab-diwr)	ZYNYZ (retifanlimab-dlwr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
			These drugs are all medical injectable drugs, and are not listed on the Prevea360 Health Plan drug formulary. The on- line formulary only lists drugs covered by the pharmacy benefit.	There are claim specific edits for namy of these drugs. The edits limit the uses of these drugs to approved indications and dospes. In addition, Prevea360 Health Plan has payment restrictions consistent with Prevea360 Health Plan Medical or Drug Policies.		The Instalth Flan will not cover U.S. Food and Drug Administration (FAA) approved drugs that are new to the market until the Pharmary and Therapendics (FR) Committee formally review and grants approval, within a maximum timeframe of 1 year from FAA approval. If a provide believes that used on a new drugs in the disculp recessary provide parts approval, they may submit an exception to coverage form request.	
			J3590 and J3490 are miscellaneous codes used for drugs that do not have a J code assigned by the FDA. New drugs may take between 12-18 months to get a J code assigned	Any drug submitted under either J3590 or J3490 with a cost of \$750 or greater will be reviewed post-claim by Prevea360 Health Plan.	It is recommended that any use of the miscellaneous codes be pre- approved ahead of time through Prevea360 Health Plan Utilization Management, especially for off-label uses from FDA indications.	Pharmacy Drug Exception to Coverage Request Form Medical Injectable Drug Exception to Coverage Request Form	