Zing Health

TITLE: **Utilization Management Part B Step Therapy**

POLICY #: TBD	
Approval Date: October 1, 2024,	**EFFECTIVE DATE:** October 1, 2024,
REVISED DATE(S): NA	
POLICY DEPARTMENT: Utilization Management	
AFFILIATED DEPARTMENTS: Medical and Utilization Management (UM)	
NEXT REVIEW DATE: 10/1/25	
Applies to: • States: All states • Products: ○ MAPD, D-SNP, and C-SNP	

POLICY STATEMENT/OVERVIEW:

Some medically administered Medicare Part B drugs may have additional requirements or limits on coverage. These requirements and limits may include step therapy. Step therapy is where the member is required to first try certain preferred drug to treat their medical conditions before Zing Health will cover another non-preferred drug for that condition.

This policy supplements Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) for the purpose of determining coverage under Medicare Part B medical benefits and applies a step therapy requirement for the drugs listed below. Should a conflict arise the Medicare NCD/LCD manual will apply.

This drug policy is provided for informational purposes and does not constitute medical advice. Treating physicians and/or healthcare providers are solely responsible for making any decisions about medical care.

A member cannot be required under this policy to change a current drug/product. For the purposes of this policy a current drug means the member has a paid claim for the drug within the past 365 days or there is clinical documentation of the

member utilizing a non-preferred drug. For requests for a non-preferred drug, Zing Health UM department will outreach to the ordering physician to obtain additional clinical information in order to approve the non-preferred medication.

- Example(s):
    - A new plan member currently utilizing a particular drug or product will not be required to switch to the preferred drug/product upon enrollment.
    - An existing member currently using a particular drug will not be required to change the drug/product in the event this policy is updated.

Preferred products must be used first.

- An exception process is in place for specific circumstances that may warrant a need for a non-preferred product*. For example, this step therapy requirement does not apply to plan's members who are actively receiving treatment (i.e., members with a paid claim within the past 365 days) with non-preferred product

Drug Class	Preferred Drug /Product(s)	HCPC Codes	Non-Preferred Drug/Product(s)*	HCPC Codes
Acromegaly-Long Acting	Somatuline Depot	J1930	Lanreotide Acetate Sandostatin LAR Signifor LAR	J1930, J1932 J2353 J2502
Alpha-1 Antitrypsin Deficiency	Prolastin-C Zemaira	J0256 J0256	Aralast Glassia	J0256 J0257
Antimetabolites	Pemetrexed	J9305 J9314	Alimta Pemfexy	J9305 J9304
Autoimmune Infused Infliximab	Inflectra Renflexis	Q5013 Q5104	Avsola Infliximab Remicade	Q5121 J1745 J1745
Autoimmune Infused Other	Entyvio Simponi Aria	J3380, J3590 J1602	Actemra Cimzia Ilumya Orencia Stelara	J3262 J0717 J3245 J0129 J3358
Avastin/Biosimilars (Oncology)	Mvasi Zirabev	Q5107 Q5118	Alymsys Avastin Vegzelma	C9142, J3490, J9999, Q5126 C9257, J9035 Q5129

Botulinum Toxins	Dysport Xeomin	J0586 C9278, J0588	Botox Myobloc	J0585 J0587
Breast Cancer MAb	Phesgo	J9316	Perjeta	J9306
Complement Inhibitors (aHUS, gMG, PNH)	Soliris Ultomiris	J1300 J1303, J3490, J3590	N/A	N/A
Complement Inhibitors (NMOSD)	Soliris	J1300	Uplizna	J1823
Geographic Atrophy	Syfovre	J2781, J3490	Izervay	J2782, J3490
Hematologic, Erythropoiesis Stimulating Agents	Aranesp Retacrit	J0881, J0882 Q5105, Q5016	Epogen Mircera Procrit	J0885, Q4081 J0887, J0999 J0885, Q4081
Hematologic, Neutropenia Colony Stimulating Factors Long Acting	Fulphila Ziextenzo	Q5018 Q5120	Fylnetra Neulasta Nyvepria Rolvedon Stimufend Udenyca	J3490, Q5130 J2505, J2506 Q5122 J1449, J3490 J3490, Q5127 Q5111
Hematologic, Neutropenia Colony Stimulating Factors Short Acting	Zarxio	Q5101	Granix Leukine Neupogen Nivestym Releuko	J1447 J2820 J1442 Q5110 J3490
Hematopoietic Agents Iron	Ferrlecit Infed Sodium Ferric Gluconate Venofer	J2915 J1750 J2916 J1756	Feraheme Injectafer Monoferric	Q0138
Hemophilia Factor VIII Long Acting	Adynovate Altuviiio Jivi	J7207 J3490, J7199, J7214 J3490, J7199, J1298	N/A	N/A
Hemophilia Factor VIII Recombinant	Afstyla Kovaltry	J3490, J7199, J7210 J7192, J7211	Advate Kogenate Novoeight Nuwiq Recombinate Xyntha Xyntha Solo.	J7192 J7192 J7182 J7209 J7192 J7185 J7185

Hemophilia Factor IX Recombinant	Alprolix Idelvion	J7201 J7202	N/A	N/A
Hereditary Transthyretin Amyloidosis	Amvuttra Onpattro	J0225, J3490 J0222, J3490	N/A	N/A
Immune Globulin-IV	Flebogamma Gammaked Gamunex-C Octagam Privigen	J1572 J1561 J1561 J1568 J1469	Asceniv Bivigam Gammagard Liq. Gammaplex Panzyga	J1554, J1599 J1556 J1569 J1557 J1576, J1599
Immune Globulin-SC	Hizentra	J1559	Cutaquig Cuvitru HyQvia Xembify	J1551, J3490, J3590 J1555, J3490, J7799 J1575 J1558, J3490
Lysosomal Storage Disorders- Gaucher Disease	Cerezyme Elelyso	J1786 J3060	VPRIV	J3385
Mitotic Inhibitors	Docetaxel Paclitaxel	J9170, J9171 J9267	Abraxane	J9264
Multiple Myeloma Proteasome Inhibitors	Bortezomib	J9041, J9044, J9046, J9048, J9049	Empliciti Kyprolis Sarclisa Velcade	J9176 J9047 J9227, J9999 J9041
Multiple Sclerosis (Infused)	Ocrevus Tyruko	J2350 J359	Briumvi Lemtrada Tysabri	J2329, J3490, J3590 J0202 J2323

Osteoarthritis, Viscosupplements Multi	Euflexxa Synvisc	J7323 J7325	Gelsyn-3 GenVisc Hyalgan Hymovis Orthovisc Supartz FX Triluron TriVisc Visco-3	J7328 J7320 J7321 J7322 J7324 J7321 J7332 J7329 J7321
Osteoarthritis, Viscosupplements Single Injection	Durolane Synvisc-One	J7318 J7325	Gel-One Monovisc	J7326 J7327
Osteoporosis-Bone Density	Prolia Zoledronic Acid	J0897 J3489	Evenity	J3111, J3590
Osteoporosis-Hypercalcemia of Malignancy	Pamidronate Zoledronic Acid	J2430 J34898	Xgeva	J0897
PD1/L1 Immune Checkpoint Inhibitors-Basal Cell & Squamous Cell	Libtayo	J3490, J3590	Keytruda	J9271
PD1/L1 Immune Checkpoint Inhibitors-NSCLC	Libtayo	J3490, J3590	Imfinzi Keytruda Opdivo Tecentriq	J3490, J9173 J9271 J3590, J9299 J3490, J9022
Prostate Cancer-Luteinizing Hormone Releasing Hormone (LHRH) Agents	Eligard	H1950, J9217	Camcevi Lupron Depot Trelstar Zoladex	J1952, J9999 J1950, J9217 J3315 J9202
Prostate Cancer-Luteinizing Hormone Releasing Hormone (LHRH) Antagonist Agents	Firmagon	J9155	N/A	N/A
Retinal Disorders Agents- (ARMD) Age-Related Macular Degeneration	Avastin, **then** Byooviz,	J9035 Q5124	Beovu Cimerli Lucentis Susvimo Vabysmo	 J0179 J3490, Q5128, J0171 J2778

	Eylea, **or** Eylea HD	J0178 J0177, J3490		J2779, J3590, J2777, J3590
Rituximab	Ruxience Truxima	J3490, Q5119 Q5115	Riabni Rituxan Rituxan Hycela	J3490, J9999 J9310, J9312 J3490, J9311, J9999
Severe Asthma	Fasenra Xolair	J0517, J3490, J3590 J2357	Cinqair Nucala Tezspire	J2786 J2182 J2356, J3490
Trastuzumab	Kanjinti Ogivri Trazimera	Q5117 Q5114 Q5116	Herceptin Herceptin Hy. Herzuma Ontruzant	J9355 J9356 Q5113 Q5112

SCOPE:

Zing Health adopts and maintains medical necessity criteria for the use in medical necessity determinations regarding members in the health plan, specified by contract or required by state and federal regulations. Medical necessity criteria must be established and approved according to the requirements in this policy. The Part B Step Therapy Policy is for informational purposes only and does not constitute or replace medical advice. Physicians, hospitals, and other providers are expected to care for their patients in such a way that they can use or administer drugs/biologicals in the most effective and clinically appropriate manner. Physicians and health care providers are solely responsible for making any decisions about medical care.

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

CLINICAL GUIDELINE/COVERAGE CRITERIA:

- In addition to any prior authorization requirements by the plan, a non-preferred drug or product must satisfy the following criteria:

1. **<u>Documentation of (1) one of the following:</u>**
    a. History of use of all preferred drugs/products resulting in sub-standard (minimal) response to therapy

    OR

    b. History of intolerance or adverse effect to all preferred drugs/products

    OR

c. Rationale that the preferred drugs/products are not clinically appropriate (contraindicated)
    - **Note**: Convenience does NOT quality as clinical rationale for inappropriateness of a preferred drug/product.

OR

d. Continuation of prior therapy within the past 365 days.

- If approved:
    - authorization for the approved drug/product will be provided for 12 months.
- If a provider administers a non-preferred product without obtaining prior authorization:
    - the plan may deny claims for the non-preferred product

Limitation:

- Authorizations for a non-preferred product due to a drug shortage of a preferred product(s) will be limited to three (3) months. All other authorizations will be for 1 year.

Special Instructions: NA

APPROVAL & REVISION HISTORY:

Reviewed and approved by:

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(Title of Reviewer) Date

Reviewed and approved by:

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(Title of Committee or Reviewing Group) Date

References:

CMS/MMCM:	National Coverage Determinations, Local Coverage Determinations, Medicare Policy Benefit Manual, Medicare Managed Care Manual Federal Register: Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf (cms.gov) Medicare Advantage Prior Authorization and Step Therapy for Part B Drugs | CMS HCPCS Quarterly Update | CMS Biosimilars | FDA

CFR:	
State Administrative Codes:	
Contract Requirements:	
Related Policies:	Utilization Management Prior authorization
Related Desk Level Procedures or Job Aids:	