

INJECTABLE MEDICINES				PREVEA360 health plan centered around you			
SEARCH TIPS:							
Updated: 06/01/2022		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please 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.		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	Q2055	ABECMA	Idecabtagene vicleuce <sup>l</sup>	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist or Hematologist specialist with authorization.	<a href="#">ABECMA (idecabtagene vicleuce<sup>l</sup>)</a>	<a href="#">ABECMA (idecabtagene vicleuce<sup>l</sup>)</a>	
Medical	J9264	ABRAXANE	paclitaxel protein bound	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ABRAXANE (paclitaxel protein bound)</a>	<a href="#">ABRAXANE (paclitaxel protein bound)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J3262	ACTEMRA	tocilizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	<a href="#">ACTEMRA IV (tocilizumab)</a>	<a href="#">ACTEMRA IV (tocilizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	I3262	ACTEMRA	tocilizumab	Yes, through Navitus. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	<a href="#">ACTEMRA (tocilizumab)</a>	<a href="#">ACTEMRA SC (tocilizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy	J0800	ACTHAR GEL	repository corticotropin injection	PHARMACY BENEFIT ONLY. Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		<a href="#">ACTHAR GEL (repository corticotropin injection)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0791	ADAKVEO	crizanlizumab-tmca	Yes, through the Plan Pharmacy Services. Restricted to an Hematology specialist with authorization.	<a href="#">ADAKVEO (crizanlizumab-tmca)</a>	<a href="#">ADAKVEO (crizanlizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9042	ADCETRIS	brentuximab vedotin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ADCETRIS (brentuximab vedotin)</a>	<a href="#">ADCETRIS (brentuximab vedotin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0172	ADUHELM	aducanumab	None. Please see attached policy for criteria	<a href="#">ADUHELM (aducanumab)</a>		
Medical	I1931	ALDURAZYME	laronidase	Yes, through the Plan Pharmacy Services. Restricted to (or in consultation with) medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis with authorization.	<a href="#">ALDURAZYME (laronidase)</a>	<a href="#">ALDURAZYME (laronidase)</a>	
Medical	J9305	ALIMTA	pemetrexed	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ALIMTA (pemetrexed)</a>	<a href="#">ALIMTA (pemetrexed)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1426	AMONDYS	casimersen	None. Not Covered.	<a href="#">AMONDYS (casimersen)</a>		
Medical	J7169	ANDEXXA	andexanet alfa	None. Please see attached policy for criteria.	<a href="#">ANDEXXA (andexanet alfa)</a>		
Medical	J7175, J7178, J7179, J7180, J7181, J7188, J7189, J7198, J7212	Antihemophilia Factor and Clotting Factors (Coagadex, RiaSTAP, Vonvend, Corifact, Tretten, Obizur, Novoseven RT, Feiba NF, Sevenfact)	(coagulation factor x (human), fibrinogen concentrate (human), von Willebrand Factor (recombinant), factor XIII concentrate (human), coagulation factor XIII A-subunit (recombinant), antihemophilic factor (porcine), coagulation factor VIIa (recombinant), anti-inhibitor coagulant complex, Coagulation factor VIIa (recombinant)-jcw)	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	<a href="#">Antihemophilia Factor and Clotting Factors</a>	<a href="#">Antihemophilia Factor and Clotting Factors</a>	
Medical	J7182, J7183, J7185, J7186, J7187, J7190, J7192, J7204, J7205, J7207, J7208, J7209, J7210, J7211	Antihemophilic Factor VIII (Novoeight, Wilate, Xyntha, Alphanate, Humate-P, Hemoffil M, Koate-DVI, Advate, Kogenate FS, Recombinate, Esperoct, Atsyla, Elocate, Adynovate, IIVI, Nuwiq, Kovaltry)	(antihemophilic factor (recombinant), von Willebrand factor/coagulation factor VIII complex (human), antihemophilic factor (recombinant), antihemophilic factor/von Willebrand factor complex (human), antihemophilic factor/von Willebrand factor complex (human), antihemophilic factor (human), antihemophilic factor (human), antihemophilic factor (recombinant), antihemophilic factor (recombinant), antihemophilic factor (recombinant), antihemophilic factor (recombinant) glycol-pegylated, antihemophilic factor (recombinant) single chain, antihemophilic factor (recombinant), antihemophilic factor (recombinant) pegylated, antihemophilic factor (recombinant) pegylated-aud, antihemophilic factor (recombinant) human, antihemophilic factor (recombinant))	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	<a href="#">Antihemophilic Factor VIII</a>	<a href="#">Antihemophilic Factor VIII</a>	
Medical	J7193, J7194, J7195, J7200, J7201, J7202, J7203	Antihemophilic Factor IX (Alphanine SD, Monoline, Profiline, Benefix, Ixinity, Rixubis, Alprolix, Idelvion, Rebinyr)	(coagulation Factor IX, coagulation Factor IX, factor IX complex, coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), human, coagulation factor IX (recombinant), glycopegylated)	Yes, through Dean Health Plan Utilization Management Department. Restricted to Hematology specialist with authorization.	<a href="#">Antihemophilic Factor IX</a>	<a href="#">Antihemophilic Factor IX</a>	
Medical	J0256	ARALAST NP	alpha-1-proteinase inhibitor (human)	Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	<a href="#">ARALAST NP (alpha-1-proteinase inhibitor)</a>	<a href="#">ARALAST NP (alpha-1-proteinase inhibitor)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0881, J0882	ARANESP	darbepoetin alpha	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">ARANESP (darbepoetin alpha)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9302	ARZERRA	ofatumumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ARZERRA (ofatumumab)</a>	<a href="#">ARZERRA (ofatumumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	C9072	Asceniv -non-preferred	immune globulin (Human)	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of all other immune globulin products.	<a href="#">Asceniv-non-preferred (immune globulin) (Human)</a>	<a href="#">Asceniv (Immune Globulin) (Human)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	C9072	Asceniv (IVIG) - non-preferred	immune globulin (Human)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of all other immune globulin products.	<a href="#">Asceniv (IVIG)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9118	ASPARLAS	calaspargase pegol	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ASPARLAS (calaspargase pegol)</a>	<a href="#">ASPARLAS (calaspargase pegol)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9035	AVASTIN - non-preferred	bevacizumab	MVASI and ZIRABEV will be the preferred bevacizumab products. No prior authorization required. Please see attached policy for criteria.	<a href="#">AVASTIN - non-preferred (bevacizumab)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5121	AVSOLA - non-preferred	infliximab-axxq	Yes, through the Plan Pharmacy Plan after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialists with authorization.	<a href="#">AVSOLA - non-preferred (infliximab-axxq)</a>	<a href="#">AVSOLA (Infliximab-axxq)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9023	BAVENCO	avelumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BAVENCO (avelumab)</a>	<a href="#">BAVENCO (avelumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9032	BELEODAQ	belinostat	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BELEODAQ (belinostat)</a>	<a href="#">BELEODAQ (belinostat)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9036	BELRAPZO	bendamustine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BELRAPZO (bendamustine)</a>	<a href="#">BELRAPZO (bendamustine)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9034	BENDEKA	bendamustine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BENDEKA (bendamustine)</a>	<a href="#">BENDEKA (bendamustine)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0490	BENLYSTA	belimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	<a href="#">BENLYSTA IV (belimumab)</a>	<a href="#">BENLYSTA IV (belimumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy	J0490	BENLYSTA	belimumab	Yes, through Navitus. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	<a href="#">BENLYSTA SC (belimumab)</a>	<a href="#">BENLYSTA SC (belimumab)</a>	
Medical	J0179	BEOVU	brolucizumab-dbil	None. Please see attached policy for criteria.	<a href="#">BEOVU (brolucizumab-dbil)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9229	BESPONSA	inotuzumab ozogamicin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BESPONSA (inotuzumab ozogamicin)</a>	<a href="#">BESPONSA (inotuzumab ozogamicin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1556	BIVIGAM, IMMUNE GLOBULIN	immune globulin (bivigam)	Yes, through the Plan Pharmacy Services.	<a href="#">BIVIGAM (immune globulin)</a>	<a href="#">BIVIGAM (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1556	BIVIGAM (IVIG), IMMUNE GLOBULIN	immune globulin (bivigam)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">BIVIGAM (IVIG)</a>	<a href="#">Coming Soon!</a>	
Medical	J9037	BLNREP	belantamab mafodotin-blmf	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BLNREP (belantamab mafodotin-blmf)</a>	<a href="#">BLNREP (belantamab mafodotin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BLINCYTO (blinatumomab)</a>	<a href="#">BLINCYTO (blinatumomab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0585	BOTOX	onabotulinumtoxin	No prior authorization is required.	<a href="#">BOTOX (onabotulinumtoxinA)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0741	CABENUVA	cabotegravir and rilpivirine	Yes, through the Plan Pharmacy Services.	<a href="#">CABENUVA (cabotegravir and rilpivirine)</a>	<a href="#">CABENUVA (cabotegravir and rilpivirine)</a>	
Medical	J1786	CEREZYME	imiglucerase (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.	<a href="#">CEREZYME (imiglucerase) (Intravenous)</a>	<a href="#">CEREZYME (imiglucerase) (Intravenous)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J2786	CINQAIR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	<a href="#">CINQAIR (reslizumab)</a>	<a href="#">CINQAIR (reslizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1448	COSELA	trilaciclib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology or Hematologist specialist with authorization.	<a href="#">COSELA (trilaciclib)</a>	<a href="#">COSELA (trilaciclib)</a>	

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Medical	J9120	COSMEGEN	dactinomycin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology specialist with authorization.	<a href="#">COSMEGEN (dactinomycin)</a>	<a href="#">COSMEGEN (dactinomycin)</a>	
Medical	J0584	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.	<a href="#">CRYSVITA (burosumab)</a>	<a href="#">CRYSVITA (burosumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1555	CUVITRU, IMMUNE GLOBULIN	immune globulin (cuvitru)	Yes, through the Plan Pharmacy Services.	<a href="#">CUVITRU (immune globulin)</a>	<a href="#">CUVITRU (Immune Globulin)</a>	
Medical	J1555	CUVITRU (SCIG), IMMUNE GLOBULIN	immune globulin (cuvitru)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">CUVITRU (SCIG)</a>	<a href="#">Coming Soon!</a>	
Medical	J9308	CYRAMZA	ramucirumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">CYRAMZA (ramucirumab)</a>	<a href="#">CYRAMZA (ramucirumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9348	DANYELZA	naxitamab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">DANYELZA (naxitamab)</a>	<a href="#">DANYELZA (naxitamab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9145	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation) an Oncology or hematologist specialist with authorization.	<a href="#">DARZALEX (daratumumab)</a>	<a href="#">DARZALEX (daratumumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9144, C9062	DARZALEX FASPRO	daratumumab/hyaluronidase-fihj	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation) an Oncology or hematologist specialist with authorization.	<a href="#">DARZALEX FASPRO (daratumumab/hyaluronidase-fihj)</a>	<a href="#">DARZALEX FASPRO (daratumumab/hyaluronidase-fihj)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J7318	DUROLANE - non-preferred	sodium hyaluronate	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLIRON will be the preferred product. Coverage of DUROLANE requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">DUROLANE - non-preferred (sodium hyaluronate)</a>	<a href="#">DUROLANE (sodium hyaluronate)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0586	DYSPORT	abobotulinumtoxinA	No prior authorization is required.	<a href="#">DYSPORT (abobotulinumtoxinA)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
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.	<a href="#">ELAPRASE (idursulfase)</a>	<a href="#">ELAPRASE (idursulfase)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3061	ELELYSO	taliglucerase 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.	<a href="#">ELELYSO (taliglucerase alfa)</a>	<a href="#">ELELYSO (taliglucerase alfa)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9269	ELZONRIS	tagraxofusp-erzs	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">ELZONRIS (tagraxofusp-erzs)</a>	<a href="#">ELZONRIS (tagraxofusp)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9269	ELZONRIS	tagraxofusp-erzs	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology or Hematology specialist with authorization.	<a href="#">ELZONRIS (tagraxofusp-erzs)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9176	EMPLICITI	elotuzumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">EMPLICITI (elotuzumab)</a>	<a href="#">EMPLICITI (elotuzumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9358	ENHERTU	fam-trastuzumab deruxtecan-nxki	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ENHERTU (fam-trastuzumab deruxtecan-nxki)</a>	<a href="#">ENHERTU (trastuzumab deruxtecan)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3380	ENTYVIO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	<a href="#">ENTYVIO (vedolizumab)</a>	<a href="#">ENTYVIO (vedolizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J0885, Q4081	EPOGEN	epoetin alfa, (for non-esrd use)	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">EPOGEN (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0885, Q4081	EPOGEN	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.	<a href="#">EPOGEN (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy	J0885, Q4081	EPOGEN - preferred	epoetin alfa, (for non-esrd use)	EFFECTIVE 07/01/2022: Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">EPOGEN (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.

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Medical	J9055	ERBITUX	cetuximab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ERBITUX (cetuximab)</a>	<a href="#">ERBITUX (cetuximab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9019	ERWINAZE	asparaginase erwinia chrysanthemi	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">ERWINAZE (asparaginase erwinia chrysanthemi)</a>	<a href="#">ERWINAZE (asparaginase erwinia chrysanthemi)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J7323	EUFLEXXA - non-preferred	sodium hyaluronate, 1%	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of EUFLEXXA requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">EUFLEXXA (sodium hyaluronate, 1%)</a>	<a href="#">EUFLEXXA (sodium hyaluronate, 1%)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J3111	EVENTY	romosozumab-aqqg	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Endocrinology or Rheumatology specialists with authorization.	<a href="#">EVENTY (romosozumab-aqqg)</a>	<a href="#">EVENTY (romosozumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
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.	<a href="#">EVKEEZA (evinacumab)</a>	<a href="#">EVKEEZA (evinacumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy		EVRYSDI	risdiplam	Yes, through Navitus. Restricted to a pediatric neurologist at a Muscular Dystrophy Association care center with authorization.	<a href="#">EVRYSDI (risdiplam)</a>	<a href="#">EVRYSDI (risdiplam)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1428	EXONDYS 51	eteplrsen	None. Not Covered.	<a href="#">EXONDYS 51 (eteplrsen)</a>		
Medical	J0178	EYLEA	afibercept	None. Please see attached policy for criteria.	<a href="#">EYLEA (afibercept)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
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.	<a href="#">FABRYZYME (agalsidase)</a>	<a href="#">FABRYZYME (agalsidase)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0517	FASENRA	benralizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	<a href="#">FASENRA (benralizumab)</a>	<a href="#">FASENRA (benralizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1951	FENSOLVI - non-preferred	leuprolide acetate	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of all other leuprolide products. Restricted to (in at least consultation with) a Oncology, Urology, OB/GYN, Internal medicine, Family medicine, or Pediatrics specialist with authorization.	<a href="#">FENSOLVI (leuprolide acetate)</a>	<a href="#">FENSOLVI (leuprolide acetate)</a>	
Medical	Q0138, Q0139	FERAHEME - preferred	ferumoxytol	VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER and MONOFERRIC are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">FERAHEME (ferumoxytol)</a>		
Medical	Q0138, Q0139	FERAHEME - preferred	ferumoxytol	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">FERAHEME (ferumoxytol)</a>		
Medical	J2916	FERRLECIT - preferred	sodium ferric gluconate complex	VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER and MONOFERRIC are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">FERRLECIT (sodium ferric gluconate complex)</a>		
Medical	J2916	FERRLECIT - preferred	sodium ferric gluconate complex	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">FERRLECIT (sodium ferric gluconate complex)</a>		
Medical	J1572	FLEBOGAMMA, IMMUNE GLOBULIN, IVIG	flibogamma	Yes, through the Plan Pharmacy Services.	<a href="#">FLEBOGAMMA (Immune Globulin)</a>	<a href="#">FLEBOGAMMA (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1572	FLEBOGAMMA/FLEBOGAMMA DIF (IVIG), IMMUNE GLOBULIN	flibogamma	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">FLEBOGAMMA/FLEBOGAMMA DIF (IVIG)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.

INJECTABLE MEDICINES		SEARCH TIPS:		PREVEA360 health plan centered around you			
Updated: 06/01/2022		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please 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.		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1325	FLOLAN	epoprostenol sodium	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Cardiology or Pulmonology specialist with authorization.	<a href="#">FLOLAN (epoprostenol sodium)</a>	<a href="#">FLOLAN (epoprostenol)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9307	FOLOTYN	pralatrexate	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">FOLOTYN (pralatrexate)</a>	<a href="#">FOLOTYN (pralatrexate)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q5108	FULPHILA - preferred	pegfilgrastim-jmbd	PREFERRED PEGFILGRASTIM PRODUCT. No prior authorization required. Restricted to (in at least consultation with) a Oncology or Hematology specialist.	<a href="#">FULPHILA (pegfilgrastim-jmbd)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0641	FUSILEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">FUSILEV (levoleucovorin)</a>	<a href="#">FUSILEV (levoleucovorin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1569	GAMMAGARD, IVIG, IMMUNE GLOBULIN	immune globulin, (gammagard liquid)	Yes, through the Plan Pharmacy Services.	<a href="#">GAMMAGARD, IVIG (immune globulin) (gammagard liquid)</a>	<a href="#">GAMMAGARD, IVIG (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1569	GAMMAGARD (SCIG), IMMUNE GLOBULIN	immune globulin, (gammagard liquid)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">GAMMAGARD (SCIG)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1557	GAMMAPLEX, IVIG, IMMUNE GLOBULIN	immune globulin (gammaplex liquid)	Yes, through the Plan Pharmacy Services.	<a href="#">GAMMAPLEX, IVIG (immune globulin) (gammaplex liquid)</a>	<a href="#">GAMMAPLEX, IVIG (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1557	GAMMAPLEX (IVIG), IMMUNE GLOBULIN	immune globulin (gammaplex liquid)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">GAMMAPLEX (IVIG)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1561	GAMMUNEX, IVIG, IMMUNE GLOBULIN	gamunex injection	Yes, through the Plan Pharmacy Services.	<a href="#">GAMMUNEX, IVIG (immune globulin)</a>	<a href="#">GAMMUNEX, IVIG (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1561	GAMMUNEX-C/GAMMAKED (SCIG), IMMUNE GLOBULIN	gamunex injection	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">GAMMUNEX-C/GAMMAKED (SCIG)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9301	GAZYVA	obinutuzumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">GAZYVA (obinutuzumab)</a>	<a href="#">GAZYVA (obinutuzumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J7326	GEL-ONE - non-preferred	hyaluronate sodium	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of GEL-ONE requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">GEL-ONE (hyaluronate sodium)</a>	<a href="#">GEL-ONE (hyaluronate sodium)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J7328	GELSYN-3 - non-preferred	hyaluronate sodium	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of GELSYN-3 requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">GELSYN-3 (hyaluronate sodium)</a>	<a href="#">GELSYN-3 (hyaluronate sodium)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J7320	GENVISC 850 - non-preferred	hyaluronan or derivative	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of GENVISC 850 requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">GENVISC 850 (hyaluronan or derivative)</a>	<a href="#">GENVISC 850 (hyaluronan or derivative)</a>	See CMS Guidance for Jurisdictions of WI, IL, 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.	<a href="#">GIVLAARI (givosiran)</a>	<a href="#">GIVLAARI (givosiran)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	<a href="#">GLASSIA (alpha-1-proteinase inhibitor)</a>	<a href="#">GLASSIA (alpha-1-proteinase inhibitor)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9179	HALAVEN	eribulin mesylate	Yes through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">HALAVEN (eribulin mesylate)</a>	<a href="#">HALAVEN (eribulin mesylate)</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy	J7170	HEMLIBRA	emicizumab	PHARMACY BENEFIT ONLY. Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		<a href="#">HEMLIBRA (emicizumab)</a>	
Medical	J9355	HERCEPTIN - non-preferred	trastuzumab injection	Herzuma, Trazimera, Pheugo will be the preferred trastuzumab products. Coverage of HERCEPTIN requires failed trials of all preferred alternatives. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Oncology or Hematology specialist.	<a href="#">HERCEPTIN (trastuzumab injection)</a>	<a href="#">HERCEPTIN (trastuzumab injection)</a>	Medicare Prior Authorization is required. See Medical Policy.

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	05113	HERZUMA - preferred	trastuzumab-pkrb	Herzuma, Trazimera, Phego will be the preferred trastuzumab products. Prior authorization is required through the Plan Pharmacy Services and is restricted to Oncology or Hematology specialist.	<a href="#">HERZUMA (trastuzumab-pkrb)</a>	<a href="#">HERZUMA (trastuzumab-pkrb)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	11559	HIZENTRA, IMMUNE GLOBULIN	immune globulin (hizentra)	Yes, through the Plan Pharmacy Services.	<a href="#">HIZENTRA (Immune Globulin)</a>	<a href="#">HIZENTRA (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	11559	HIZENTRA (SCIG), IMMUNE GLOBULIN	immune globulin (hizentra)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">HIZENTRA (SCIG)</a>	Coming Soon!	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	17321	HYALGAN - preferred	hyaluronate or derivative	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred products. No Prior Authorization needed for preferred products.	<a href="#">HYALGAN (hyaluronate or derivative)</a>		See CMS Guidance for Jurisdictions of WI, IL, 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.		<a href="#">HYCAMTIN (topotecan)</a>	
Medical	17322	HYMOVIS - preferred	hyaluronan	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred products. No Prior Authorization needed for preferred products.	<a href="#">HYMOVIS (hyaluronan)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	11575	HYQVIA, IMMUNE GLOBULIN	immune globulin (hyqvia)	Yes, through the Plan Pharmacy Services.	<a href="#">HYQVIA (Immune Globulin)</a>	<a href="#">HYQVIA (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	11575	HYQVIA (SCIG), IMMUNE GLOBULIN	immune globulin (hyqvia)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">HYQVIA (SCIG)</a>	Coming Soon!	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	19173	IMFINZI	durvalumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">IMFINZI (durvalumab)</a>	<a href="#">IMFINZI (durvalumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	11750	INFED - preferred	iron dextran	VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER and MONOFERRIC are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">INFED (iron dextran)</a>		
Medical	11750	INFED - preferred	iron dextran	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">INFED (iron dextran)</a>		
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.	<a href="#">INFLECTRA (infliximab-dyyb)</a>	<a href="#">INFLECTRA (infliximab-dyyb)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	19198	INFUGEM	premixed gemcitabine in sodium chloride solution	Yes, through the Plan Pharmacy Services. Restricted to an oncologist with authorization.	<a href="#">INFUGEM (premixed gemcitabine in sodium chloride solution)</a>	<a href="#">INFUGEM (premixed gemcitabine in sodium chloride solution)</a>	
Medical	11439	INJECTAFER - non-preferred	ferric carboxymaltose	VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER and MONOFERRIC are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">INJECTAFER (ferric carboxymaltose)</a>	<a href="#">INJECTAFER (ferric carboxymaltose)</a>	
Medical	11439	INJECTAFER - non-preferred	ferric carboxymaltose	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">INJECTAFER (ferric carboxymaltose)</a>	Coming Soon!	
Medical	E0784, K0554	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	<a href="#">Insulin Pumps</a>	<a href="#">Insulin Pumps</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	19318, 19319	ISTODAX	romidepsin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ISTODAX (romidepsin)</a>	<a href="#">ISTODAX (romidepsin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	11566	IVIG, IMMUNE GLOBULIN	immune globulin, powder	Yes, through the Plan Pharmacy Services.	<a href="#">IVIG (Immune Globulin) (powder)</a>	<a href="#">IVIG (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	11566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NF)	immune globulin, powder	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">IVIG (Immune Globulin)</a>	Coming Soon!	See CMS Guidance for Jurisdictions of WI, IL, MO.

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services.	<a href="#">IVIG (Immune Globulin) (liquid)</a>	<a href="#">IVIG (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">IVIG (Immune Globulin)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5109	XIFI- non-preferred	infliximab-gbtx	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<a href="#">XIFI (infliximab-gbtx)</a>	<a href="#">XIFI (infliximab-gbtx)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9272	JEMPERLI	dostarlimab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or OB/GYN specialist with authorization.	<a href="#">JEMPERLI (dostarlimab)</a>	<a href="#">JEMPERLI (dostarlimab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9043	JEVTANA	cabazitaxel	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">JEVTANA (cabazitaxel)</a>	<a href="#">JEVTANA (cabazitaxel)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">KADCYLA (ado-trastuzumab emtansine)</a>	<a href="#">KADCYLA (ado-trastuzumab emtansine)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q5117	KANJINTI- non-preferred	trastuzumab-anns	Herzuma, Trazimera, Phesgo will be the preferred trastuzumab products. Coverage of KANJINTI requires failed trials of all preferred alternatives. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Oncology or Hematology specialist.	<a href="#">KANJINTI (trastuzumab-anns)</a>	<a href="#">KANJINTI (trastuzumab-anns)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3490	KETAMINE	ketamine	None. Not Covered.	<a href="#">KETAMINE (ketamine)</a>		
Medical	J9271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology specialist with authorization.	<a href="#">KEYTRUDA (pembrolizumab)</a>	<a href="#">KEYTRUDA (pembrolizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J2507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	<a href="#">KRYSTEXXA (pegloticase)</a>	<a href="#">KRYSTEXXA (pegloticase)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q2042	KYMRIAH	tisagenlecleucel	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">KYMRIAH (tisagenlecleucel)</a>	<a href="#">KYMRIAH (tisagenlecleucel)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q2042	KYMRIAH	tisagenlecleucel	EFFECTIVE 09/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">KYMRIAH (tisagenlecleucel)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9047	KYPROLIS	carfilzomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">KYPROLIS (carfilzomib)</a>	<a href="#">KYPROLIS (carfilzomib)</a>	Medicare Prior Authorization is required. See Medical Policy.
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.	<a href="#">LEMTRADA (alemtuzumab)</a>	<a href="#">LEMTRADA (alemtuzumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">LIBTAYO (cemiplimab)</a>	<a href="#">LIBTAYO (cemiplimab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J2001	LIDOCAINE	lidocaine	None. Not Covered.	<a href="#">LIDOCAINE (lidocaine)</a>		
Medical	J0221	LUMIZYME	alglucosidase 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.	<a href="#">LUMIZYME (alglucosidase alfa) (intravenous)</a>	<a href="#">LUMIZYME (alglucosidase alfa) (intravenous)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9313	LUMOXITI	moxetumomab pasudotox	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">LUMOXITI (moxetumomab pasudotox)</a>	<a href="#">LUMOXITI (moxetumomab pasudotox)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9217	LUPRON-ELIGARD	leuprolide	None. Please see attached policy for criteria	<a href="#">LUPRON-ELIGARD (leuprolide)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1950	LUPRON DEPOT	leuprolide acetate depot	None. Please see attached policy for criteria	<a href="#">LUPRON DEPOT (leuprolide acetate depot)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	A9513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology specialist with authorization.	<a href="#">LUTATHERA (lutetium Lu 177 dotatate)</a>	<a href="#">LUTATHERA (lutetium Lu 177 dotatate)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	A9513	LUTATHERA	lutetium Lu 177 dotatate	EFFECTIVE 09/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology specialist with authorization.	<a href="#">LUTATHERA (lutetium Lu 177 dotatate)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9353	MARGENZA	margetuximab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">MARGENZA (margetuximab)</a>	<a href="#">MARGENZA (margetuximab)</a>	Medicare Prior Authorization is required. See Medical Policy.

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Updated: 06/01/2022							
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J3397	MEPSEVII	vestronidase alfa-vjvk (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.	<a href="#">MEPSEVII (vestronidase-alfa-vjvk) (intravenous)</a>	<a href="#">MEPSEVII (vestronidase-alfa-vjvk) (intravenous)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9349	MONJUVI	tafasitamab-cxix	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">MONJUVI (tafasitamab-cxix)</a>	<a href="#">MONJUVI (tafasitamab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1437	MONOFERRIC - non-preferred	ferric derisomaltose	VENOFER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER and MONOFERRIC are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">MONOFERRIC (ferric derisomaltose)</a>	<a href="#">MONOFERRIC (ferric derisomaltose)</a>	
Medical	J1437	MONOFERRIC - non-preferred	ferric derisomaltose	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">MONOFERRIC (ferric derisomaltose)</a>	<a href="#">Coming Soon!</a>	
Medical	J7327	MONOVISC - non-preferred	hyaluronan or derivative	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of MONOVISC requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">MONOVISC (hyaluronan or derivative)</a>	<a href="#">MONOVISC (hyaluronan or derivative)</a>	See CMS Guidance for Jurisdictions of WI, IL, MD.
Medical	J7327	MONOVISC - non-preferred	hyaluronan or derivative	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">MONOVISC (hyaluronan or derivative)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MD.
Medical	Q5107	MVASI - preferred	bevacizumab-awwb	MVASI and ZIRABEV will be the preferred bevacizumab products. No prior authorization required. Please see attached policy for criteria.	<a href="#">MVASI (bevacizumab-awwb)</a>		See CMS Guidance for Jurisdictions of WI, IL, MD.
Medical	J0587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	<a href="#">MYOBLOC (rimabotulinumtoxinB)</a>		See CMS Guidance for Jurisdictions of WI, IL, MD.
Medical	J7352	MYOZYME	alglucosidase 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.	<a href="#">MYOZYME (alglucosidase alfa) (intravenous)</a>	<a href="#">MYOZYME (alglucosidase alfa)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3490	N/A	Levothyroxine Injection (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	<a href="#">Levothyroxine Injection (intravenous)</a>	<a href="#">Coming Soon!</a>	
Medical	J1459	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.	<a href="#">NAGLAZYME (galsulfase) (intravenous)</a>	<a href="#">NAGLAZYME (galsulfase) (intravenous)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J2506	NEULASTA - non-preferred	pegfilgrastim	FULPHILA AND ZIEXTENZO WILL BE PREFERRED. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">NEULASTA (pegfilgrastim)</a>	<a href="#">NEULASTA (pegfilgrastim)</a>	See CMS Guidance for Jurisdictions of WI, IL, MD.
Pharmacy	J2506	NEULASTA - non-preferred	pegfilgrastim	FULPHILA AND ZIEXTENZO WILL BE PREFERRED. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. Yes, through Navitus. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">NEULASTA (pegfilgrastim)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MD.
Medical	J3590, C9085	NEXVIAZYME	avalglucosidase 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.	<a href="#">NEXVIAZYME (avalglucosidase alfa)</a>	<a href="#">NEXVIAZYME (avalglucosidase alfa)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J2182	NUCALA	mepolizumab	Yes, through the Plan Pharmacy Services. Eosinophilic asthma: 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.	<a href="#">NUCALA (mepolizumab)</a>	<a href="#">NUCALA (mepolizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MD.
Medical	J3490, 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.	<a href="#">NULIBRY (fosdenopterin)</a>	<a href="#">NULIBRY (fosdenopterin)</a>	



INJECTABLE MEDICINES				SEARCH TIPS:	PREVEA360 health plan centered around you		
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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J0485	NULOIX	belatacept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Renal Transplant or Immunosuppressive Therapy specialist with authorization.	<a href="#">NULOIX (belatacept)</a>	<a href="#">NULOIX (belatacept)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5122	NYVEPRIA - non-preferred	pegfilgrastim-aggf	FULPHILA AND ZIEXTENZO WILL BE PREFERRED. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of NYVEPRIA. Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">NYVEPRIA (pegfilgrastim-aggf)</a>	<a href="#">NYVEPRIA (pegfilgrastim)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J2350	OCREVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	<a href="#">OCREVUS (ocrelizumab)</a>	<a href="#">OCREVUS (ocrelizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1568	OCTAGAM, IVIG, IMMUNE GLOBULIN	immune globulin (octagam liquid)	Yes, through the Plan Pharmacy Services.	<a href="#">OCTAGAM, IVIG (Immune Globulin) (octagam liquid)</a>	<a href="#">OCTAGAM (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1568	OCTAGAM (IVIG), IMMUNE GLOBULIN	immune globulin (octagam liquid)	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">OCTAGAM (ivig)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5114	OGIVRI - non-preferred	trastuzumab-dkst	Herzuma, trazimera, phego will be the preferred trastuzumab products. Coverage of Ogivri requires failed trials of all preferred alternatives. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Oncology or Hematology specialist.	<a href="#">OGIVRI (trastuzumab-dkst)</a>	<a href="#">OGIVRI (trastuzumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9266	ONCASPAR	pegaspargase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ONCASPAR (pegaspargase)</a>	<a href="#">ONCASPAR (pegaspargase)</a>	Medicare Prior Authorization is required. See Medical Policy.
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.	<a href="#">ONPATTRO (patisiran)</a>	<a href="#">ONPATTRO (patisiran)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5112	ONTRUZANT - non-preferred	trastuzumab-dttb	Herzuma, Trazimera, Phego will be the preferred trastuzumab products. Coverage of ONTRUZANT requires failed trials of all preferred alternatives. Prior authorization is required through the Plan and Pharmacy Services and is restricted to Oncology or Hematology specialist.	<a href="#">ONTRUZANT (trastuzumab-dttb)</a>	<a href="#">ONTRUZANT (trastuzumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9299	OPDIVO	nivolumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematologist specialist with authorization.	<a href="#">OPDIVO (nivolumab)</a>	<a href="#">OPDIVO (nivolumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0129	ORENCIA	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	<a href="#">ORENCIA IV (abatacept)</a>	<a href="#">ORENCIA IV (abatacept)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J0129	ORENCIA	abatacept	Yes, through Navitus. Restricted to an Rheumatology specialist with authorization.	<a href="#">ORENCIA SC (abatacept)</a>	<a href="#">ORENCIA SC (abatacept)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J3490	ORGOVYX	relugolix	Yes through Navitus. Restricted to (in at least consultation with) an Oncologist or Urologist specialist with authorization.	<a href="#">ORGOVYX (relugolix)</a>	<a href="#">ORGOVYX (relugolix)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J7324	ORTHOVISC - non-preferred	hyaluronan or derivative	HYALGAN, SYNWISC, SYNWISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of ORTHOVISC requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">ORTHOVISC (hyaluronan or derivative)</a>	<a href="#">ORTHOVISC (hyaluronan or derivative)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J3490, C9074	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	<a href="#">OXLUMO (lumasiran)</a>	<a href="#">OXLUMO (lumasiran)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9177	PADCEV	enfortumab vedotin-efv	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">PADCEV (enfortumab vedotin-efv)</a>	<a href="#">PADCEV (enfortumab vedotin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9247	PEPAXTO	melphalan	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">PEPAXTO (melphalan)</a>	<a href="#">PEPAXTO (melphalan)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9247	PEPAXTO	melphalan	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology or Hematology specialist with authorization.	<a href="#">PEPAXTO (melphalan)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9306	PERIETA	pertuzumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">PERIETA (pertuzumab)</a>	<a href="#">PERIETA (pertuzumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9306	PERIETA	pertuzumab	EFFECTIVE 09/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Hematology specialist with authorization.	<a href="#">PERIETA (pertuzumab)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.

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Updated: 06/01/2022							
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	C9399, J9316	PHESGO - preferred	pertuzumab, trastuzumab, hyaluronidase	Herzuma, trazimera, phesgo will be the preferred trastuzumab products. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Oncology or Hematology specialist.	<a href="#">PHESGO (pertuzumab)</a> <a href="#">PHESGO (trastuzumab)</a>	<a href="#">PHESGO (pertuzumab)</a> <a href="#">PHESGO (trastuzumab)</a>	
Medical	C9399, J9316	PHESGO - preferred	pertuzumab, trastuzumab, hyaluronidase	EFFECTIVE 09/01/2022: Herzuma, trazimera, phesgo will be the preferred trastuzumab products. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Oncology or Hematology specialist.	<a href="#">PHESGO (pertuzumab)</a> <a href="#">PHESGO (trastuzumab)</a>	<a href="#">Coming Soon!</a> <a href="#">PHESGO (trastuzumab)</a>	
Medical	J9309	POLIVY	polatuzumab vedotin-piq	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) oncologist specialist with authorization.	<a href="#">POLIVY (polatuzumab vedotin-piq)</a>	<a href="#">POLIVY (polatuzumab vedotin-piq)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9295	PORTRAZZA	necitumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">PORTRAZZA (necitumab)</a>	<a href="#">PORTRAZZA (necitumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1459	PRIVIGEN, IVIG, IMMUNE GLOBULIN	privigen	Yes, through the Plan Pharmacy Services.	<a href="#">PRIVIGEN, IVIG (Immune Globulin)</a>	<a href="#">PRIVIGEN (Immune Globulin)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1459	PRIVIGEN (IVIG), IMMUNE GLOBULIN	privigen	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">PRIVIGEN (IVIG)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J0885, Q4081	PROCIT	epoetin alfa, (for non-esrd use)	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">PROCIT (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0885, Q4081	PROCIT	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.	<a href="#">PROCIT (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy	J0885, Q4081	PROCIT - non-preferred	epoetin alfa, (for non-esrd use)	EFFECTIVE 07/01/2022: Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">PROCIT (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0885, Q4082	PROCIT - non-preferred	epoetin alfa, (for non-esrd use)	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">PROCIT (epoetin alfa)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">PROLEUKIN (aldesleukin)</a>	<a href="#">PROLEUKIN (aldesleukin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0897	PROLIA, 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 authorization.	<a href="#">PROLIA, XGEVA (denosumab)</a>	<a href="#">PROLIA, XGEVA (denosumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1301	RADICAVA	edaravone	Yes, through the Plan Pharmacy Services. Restricted to an Neurology specialist with authorization.	<a href="#">RADICAVA (edaravone)</a>	<a href="#">RADICAVA (edaravone)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0896	REBLOZYL	luspterecept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">REBLOZYL (luspterecept-aamt)</a>	<a href="#">REBLOZYL (luspterecept)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1745	REMICADE - non-preferred	infliximab	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<a href="#">REMICADE (infliximab)</a>	<a href="#">REMICADE (infliximab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J3285	REMODULIN IV	treprostinil	EFFECTIVE 04/01/2022: Generic Treprostinil will be covered with prior Authorization through the Plan Pharmacy Services. Brand REMODULIN will not be covered. Restricted to (in at least consultation with) a Cardiology or Pulmonology specialists with authorization.	<a href="#">REMODULIN IV (treprostinil)</a>	<a href="#">REMODULIN IV (treprostinil)</a>	
Medical	Q5104	RENFLEXIS - preferred infliximab product	infliximab-abda	Prior authorization for the preferred infliximab product will only require provider attestation to an appropriate indication through the Plan Pharmacy Services. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<a href="#">RENFLEXIS (infliximab-abda)</a>	<a href="#">RENFLEXIS (infliximab-abda)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	Q5105, Q5106	RETACRIT	epoetin alfa-epbx	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q5105, Q5106	RETACRIT	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.	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy	Q5105, Q5106	RETACRIT - preferred	epoetin alfa-epbx	EFFECTIVE 07/01/2022: Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	Q5105, Q5106	RETACRIT - preferred	epoetin alfa-epbx	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitus.	<a href="#">RHOPRESSA (netarsudil)</a>	<a href="#">RHOPRESSA (netarsudil)</a>	
Medical	Q5123	RIABNI - non-preferred	rituximab-arrx	TRUXIMA and RUXIENCE will be the preferred rituximab products. Yes, through the Plan Pharmacy Services. RIABNI will be covered after a failed trial of TRUXIMA AND RUXIENCE. Restricted to (in at least consultation with) a Rheumatology, Transplant, Hematology, Neurology, Dermatology, ENT, Nephrology, or Oncology specialist with authorization.	<a href="#">RIABNI (rituximab-arrx)</a>	<a href="#">RIABNI (rituximab-arrx)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9312	RITUXAN - non-preferred	rituximab	TRUXIMA and RUXIENCE will be the preferred rituximab products. Yes, through the Plan Pharmacy Services. RITUXAN will be covered after a failed trial of TRUXIMA AND RUXIENCE. Restricted to (in at least consultation with) a Rheumatology, Transplant, Hematology, Neurology, Dermatology, ENT, Nephrology, or Oncology specialist with authorization.	<a href="#">RITUXAN (rituximab)</a>	<a href="#">RITUXAN (rituximab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9311	RITUXAN HYCELA	rituximab and hyaluronidase human	TRUXIMA and RUXIENCE will be the preferred rituximab products. Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Transplant, Hematology, Neurology, Dermatology, ENT, Nephrology, or Oncology specialist with authorization.	<a href="#">RITUXAN HYCELA (rituximab and hyaluronidase human)</a>	<a href="#">RITUXAN HYCELA (rituximab and hyaluronidase)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5119	RUXIENCE - preferred	rituximab-pvvr	TRUXIMA and RUXIENCE will be the preferred rituximab products. Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) Rheumatology, Transplant, Hematology, Neurology, Dermatology, ENT, Nephrology, or Oncology specialists with authorization.	<a href="#">RUXIENCE (rituximab-pvvr)</a>	<a href="#">RUXIENCE (rituximab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9061	RYBREVANT	amivantamab-vmjw	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncologist or Hematologist specialist with authorization.	<a href="#">RYBREVANT (amivantamab-vmjw)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J2353, J2354	SANDOSTATIN	octreotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Endocrinologist or Oncologist specialist with authorization.	<a href="#">SANDOSTATIN (octreotide)</a>	<a href="#">SANDOSTATIN (octreotide)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J2353, J2354	SANDOSTATIN	octreotide	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	<a href="#">SANDOSTATIN (octreotide)</a>	<a href="#">Coming Soon!</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0491	SAPHNELO	anifrolumab-fnia	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	<a href="#">SAPHNELO (anifrolumab-fnia)</a>	<a href="#">SAPHNELO (anifrolumab-fnia)</a>	
Medical	J9227	SARCLISA	isatuximab-irfc	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">SARCLISA (isatuximab-irfc)</a>	<a href="#">SARCLISA (isatuximab-irfc)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J7352	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.	<a href="#">SCENESSE (afamelanotide)</a>	<a href="#">SCENESSE (afamelanotide)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	90750	SHINGRIX	zoster vaccine	Yes, through the Plan Pharmacy Services for members under the age of 50.	<a href="#">SHINGRIX (zoster vaccine)</a>	<a href="#">SHINGRIX (zoster vaccine)</a>	No Prior Authorization Required. CMS guidelines must be followed.
Medical	J2502	SIGNIFOR LAR	pasireotide	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist specialist with authorization.	<a href="#">SIGNIFOR LAR (pasireotide)</a>	<a href="#">Coming Soon!</a>	
Medical	J1602	SIMPONI ARIA	golimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	<a href="#">SIMPONI ARIA (golimumab)</a>	<a href="#">SIMPONI ARIA (golimumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J1602	SIMPONI ARIA	golimumab	Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	<a href="#">SIMPONI ARIA (golimumab)</a>	<a href="#">SIMPONI ARIA (golimumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J7402	SINLIVA	mometasone furoate	Yes, through the Plan Pharmacy Services. Restricted to ENT specialist with authorization.	<a href="#">SINLIVA (mometasone furoate)</a>	<a href="#">SINLIVA (mometasone furoate)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical		SITE OF SERVICE		EFFECTIVE: 07/01/2022: Yes, through the Plan Pharmacy Services. Requests for select specialty 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.	<a href="#">SITE OF SERVICE</a>		Medicare Prior Authorization is required. See Medical Policy.

INJECTABLE MEDICINES				SEARCH TIPS:	PREVEA360 health plan centered around you		
		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please 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.  Updated: 06/01/2022		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1300	SOURIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Neuro-Ophthalmologist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	<a href="#">SOURIS (eculizumab)</a>	<a href="#">SOURIS (eculizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	I1930	SOMATULINE	lanreotide depot	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	<a href="#">SOMATULINE (lanreotide depot)</a>	Coming Soon!	
Medical	I2326	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.	<a href="#">SPINRAZA (nusinersen)</a>	<a href="#">SPINRAZA (nusinersen)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	G2082, G2083	SPRAVATO	esketamine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Psychiatrist or Psychiatric Nurse Practitioner with authorization.	<a href="#">SPRAVATO (esketamine)</a>	<a href="#">SPRAVATO (esketamine)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3358	STELARA	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	<a href="#">STELARA IV (ustekinumab)</a>	<a href="#">STELARA IV (ustekinumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J3358	STELARA	ustekinumab	Yes, through Navitus. Restricted to an Gastroenterology specialist with authorization.	<a href="#">STELARA SC (ustekinumab)</a>	<a href="#">STELARA SC (ustekinumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy		Sublingual Immunotherapy (SLIT) for ALLERGY products	GRASSTEX (Timothy grass pollen allergen extract), RAGWITEK (Short ragweed pollen allergen extract), ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens allergen extract), ODACTRA (House Dust Mite allergen extract)	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	<a href="#">SLIT for Allergy Products</a>	<a href="#">SLIT for Allergy Products</a>	
Medical	I7321	SUPARTZ FX - non-preferred	hyaluronan or derivative	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of SUPARTZ FX requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">SUPARTZ FX (hyaluronan or derivative)</a>	<a href="#">SUPARTZ FX (hyaluronan or derivative)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	90378	SYNAGIS	palivizumab	Yes, through the Plan Pharmacy Services. Restricted to NICU Physician, Neonatologist, or Pediatric specialist (including family practice, general pediatrics, pediatric pulmonology, and pediatric cardiology) with authorization.	<a href="#">SYNAGIS (palivizumab)</a>	<a href="#">SYNAGIS (palivizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9262	SYNRIBO	omacetaxine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">SYNRIBO (omacetaxine)</a>	<a href="#">SYNRIBO (omacetaxine)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	I7325	SYNVISC - preferred	hyaluronan or derivative	SYNVISC ONE, HYALGAN, SYNVISC, HYMOVIS, and TRILLURON will be the preferred products. No Prior Authorization needed for preferred products.	<a href="#">SYNVISC (hyaluronan or derivative)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	I7325	SYNVISC ONE - preferred	hyaluronan or derivative	SYNVISC ONE, HYALGAN, SYNVISC, HYMOVIS, and TRILLURON will be the preferred products. No Prior Authorization needed for preferred products.	<a href="#">SYNVISC ONE (hyaluronan or derivative)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q2053	TECARTUS	brexucabtagene autoleucl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">TECARTUS (brexucabtagene autoleucl)</a>	<a href="#">TECARTUS (brexucabtagene autoleucl)</a>	
Medical	Q2053	TECARTUS	brexucabtagene autoleucl	EFFECTIVE 09/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">TECARTUS (brexucabtagene autoleucl)</a>	Coming Soon!	
Medical	J9022	TECENTRIQ	atezolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">TECENTRIQ (atezolizumab)</a>	<a href="#">TECENTRIQ (atezolizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3241	TEPEZZA	teprotumumab-trbw	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Ophthalmologist and Endocrinologist specialist with authorization.	<a href="#">TEPEZZA (teprotumumab-trbw)</a>	<a href="#">TEPEZZA (teprotumumab-trbw)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9273	TIVDAK	tisotumab vedotin-tfv	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncology specialist with authorization.	<a href="#">TIVDAK (tisotumab vedotin-tfv)</a>	<a href="#">TIVDAK (tisotumab vedotin-tfv)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q5116	TRAZIMERA - preferred	trastuzumab-qyyp	Yes, through the Plan Pharmacy Services. Restricted to an Oncology specialist with authorization.	<a href="#">TRAZIMERA (trastuzumab-qyyp)</a>	<a href="#">TRAZIMERA (trastuzumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">TREANDA (bendamustine)</a>	<a href="#">TREANDA (bendamustine)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1443, J1444	TRIFERIC - non-preferred	ferric pyrophosphate citrate solution, powder	EFFECTIVE 08/01/2022: VENOFER, INFED, FERRLECT, and FERACHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">TRIFERIC (ferric pyrophosphate citrate solution, powder)</a>	Coming Soon!	

INJECTABLE MEDICINES				SEARCH TIPS:	PREVEA360 health plan centered around you		
		<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please 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.</p> <p>Updated: 06/01/2022</p>		<p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name</p>			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1445	TRIFERIC AVNU - non-preferred	ferric pyrophosphate citrate	EFFECTIVE 08/01/2022: VENOfer, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">TRIFERIC (ferric pyrophosphate citrate)</a>	<a href="#">Coming Soon!</a>	
Medical	J7332	TRILURON - preferred	sodium hyaluronate	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred products. No Prior Authorization needed for preferred product	<a href="#">TRILURON (sodium hyaluronate)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J7329	TRIVISC - non-preferred	hyaluronan or derivative	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of TRIVISC requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">TRIVISC (hyaluronan or derivative)</a>	<a href="#">TRIVISC (hyaluronan or derivative)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9317	TRODELVY	sacituzumab govitecan-hziy	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">TRODELVY (sacituzumab govitecan-hziy)</a>	<a href="#">TRODELVY (sacituzumab govitecan)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1746	TROGARZO	ibalizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Infectious Disease specialist with authorization.	<a href="#">TROGARZO (ibalizumab)</a>	<a href="#">Coming Soon!</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q5115	TRUXIMA - preferred	rituximab-abbs	TRUXIMA and RUXIENCE will be the preferred rituximab products. Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Transplant, Hematology, Neurology, Dermatology, ENT, Nephrology, or Oncology specialist with authorization.	<a href="#">TRUXIMA (rituximab-abbs)</a>	<a href="#">TRUXIMA (rituximab-abbs)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J2323	TYSABRI	natalizumab injection	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	<a href="#">TYSABRI (natalizumab)</a>	<a href="#">TYSABRI (natalizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5111	UDENYCA - non-preferred	pegfilgrastim-cbqv	FULPHILA and ZIEXTENZO will be the preferred pegfilgrastim products. Coverage of UDENYCA requires a failed trial of FULPHILA and ZIEXTENZO. Restricted to (in at least consultation with) a Hematologist or Oncologist specialist with authorization through the Plan Pharmacy Services.	<a href="#">UDENYCA (pegfilgrastim-cbqv)</a>	<a href="#">UDENYCA (pegfilgrastim-cbqv)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1303	ULTOMIRIS	ravulizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematology, Oncology, or Immunology specialist with authorization.	<a href="#">ULTOMIRIS (ravulizumab)</a>	<a href="#">ULTOMIRIS (ravulizumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9999	UNITUXIN	dinutuximab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">UNITUXIN (dinutuximab)</a>	<a href="#">UNITUXIN (dinutuximab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3490	UPTRAVI-IV	selexipag	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a cardiologist or pulmonologist with authorization.	<a href="#">UPTRAVI-IV (selexipag)</a>	<a href="#">UPTRAVI-IV (selexipag)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Pharmacy	J3490	UPTRAVI	selexipag	Yes, through Navitus. Restricted to (in at least consultation with) a cardiologist or pulmonologist with authorization.	<a href="#">UPTRAVI (selexipag)</a>	<a href="#">UPTRAVI (selexipag)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">VECTIBIX (panitumumab)</a>	<a href="#">VECTIBIX (panitumumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9041, J9044	VELCADE	bortezomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">VELCADE (bortezomib)</a>	<a href="#">VELCADE (bortezomib)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J1756	VENOfer - preferred	iron sucrose	VENOfer, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER and MONOFERRIC are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">VENOfer (iron sucrose)</a>		
Medical	J1756	VENOfer - preferred	iron sucrose	EFFECTIVE 08/01/2022: VENOfer, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">VENOfer (iron sucrose)</a>		
Medical	J1427	VILTEPSO	viltolarsen	None. Not Covered.	<a href="#">VILTEPSO (viltolarsen)</a>		
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.	<a href="#">VIMIZIM (elosulfase)</a>	<a href="#">VIMIZIM (elosulfase)</a>	Medicare Prior Authorization is required. See Medical Policy.

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Updated: 06/01/2022							
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J7321	VISCO-3 - non-preferred	hyaluronan or derivative	HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred product. Coverage of VISCO-3 requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">VISCO-3 (hyaluronan or derivative)</a>	<a href="#">VISCO-3 (hyaluronan or derivative)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3396	VISUDYNE	verteporfin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Ophthalmologist specialist with authorization.	<a href="#">VISUDYNE (verteporfin)</a>	<a href="#">VISUDYNE (verteporfin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3385	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.	<a href="#">VPRIV (velaglucerase alfa)</a>	<a href="#">VPRIV (velaglucerase alfa)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3032	VYEPTI	eptinezumab-jjmr	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurologist specialist with authorization.	<a href="#">VYEPTI (eptinezumab-jjmr)</a>	<a href="#">VYEPTI (eptinezumab-jjmr)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J3032	VYEPTI	eptinezumab-jjmr	EFFECTIVE 07/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurologist specialist with authorization.	<a href="#">VYEPTI (eptinezumab-jjmr)</a>	Coming Soon!	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1429	VYONDYS 53	golodirsen	None. Not Covered.	<a href="#">VYONDYS 53 (golodirsen)</a>		
Pharmacy		VYZULTA	latanoprostene bunod	PHARMACY BENEFIT ONLY. Yes, through Navitus.	<a href="#">VYZULTA (latanoprostene bunod)</a>	<a href="#">VYZULTA (latanoprostene bunod)</a>	
Medical	J1558	XEMBIFY	immune globulin	Yes, through the Plan Pharmacy Services.	<a href="#">XEMBIFY (Immune Globulin)</a>	<a href="#">XEMBIFY (Immune Globulin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1558	XEMBIFY (SCIG)	immune globulin	EFFECTIVE 08/01/2022: Yes, through the Plan Pharmacy Services.	<a href="#">XEMBIFY (SCIG)</a>	Coming Soon!	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0588	XEOMIN	incobotulinumtoxinA	No prior authorization is required.	<a href="#">XEOMIN (incobotulinumtoxinA)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J2357	XOLAIR	omalizumab, 5mg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	<a href="#">XOLAIR (omalizumab)</a>	<a href="#">XOLAIR (omalizumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J9228	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology or Dermatology specialist with authorization.	<a href="#">YERVOY (ipilimumab)</a>	<a href="#">YERVOY (ipilimumab)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q2041	YESCARTA	axicabtagene ciloleuce	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">YESCARTA (axicabtagene ciloleuce)</a>	<a href="#">YESCARTA (axicabtagene ciloleuce)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q2041	YESCARTA	axicabtagene ciloleuce	EFFECTIVE 09/01/2022: Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">YESCARTA (axicabtagene ciloleuce)</a>	Coming Soon!	
Medical	J9400	ZALTRAP	ziv-aflibercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ZALTRAP (ziv-aflibercept)</a>	<a href="#">ZALTRAP (ziv-aflibercept)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J0256	ZEMAIRA/PROLASTIN-C	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	<a href="#">ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)</a>	<a href="#">ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ZEPZELCA (lurbinectedin)</a>	<a href="#">ZEPZELCA (lurbinectedin)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	Q5120	ZIEXTENZO - preferred	pegfilgrastim-bmez	PREFERRED PEGFILGRASTIM PRODUCT. No prior authorization required. Restricted to (in at least consultation with) a Oncology or Hematology specialist.	<a href="#">ZIEXTENZO (pegfilgrastim-bmez)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J0565	ZINPLAVA	bezlotoxumab	Yes, through the Plan Pharmacy Services. Restricted to a Infectious Disease or Gastroenterology specialist with authorization.	<a href="#">ZINPLAVA (bezlotoxumab)</a>	<a href="#">ZINPLAVA (bezlotoxumab)</a>	See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	Q5118	ZIRABEV - preferred	bevacizumab-bvzr	MVASI and ZIRABEV will be the preferred bevacizumab products. No prior authorization required. Please see attached policy for criteria.	<a href="#">ZIRABEV (bevacizumab-bvzr)</a>		See CMS Guidance for Jurisdictions of WI, IL, MO.
Medical	J3399	ZOLGENSMA	onasemnogene abeparvovic-xioi	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.	<a href="#">ZOLGENSMA (onasemnogene abeparvovic-xioi)</a>	<a href="#">ZOLGENSMA (onasemnogene abeparvovic)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J1632	ZULRESSO	brexanolone	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Psychiatrist or an Obstetrician-Gynecologist specialist with authorization.	<a href="#">ZULRESSO (brexanolone)</a>	<a href="#">ZULRESSO (brexanolone)</a>	Medicare Prior Authorization is required. See Medical Policy.
Medical	J9999	ZYNLONTA	loncastuximab tesirine	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">ZYNLONTA (loncastuximab tesirine)</a>	<a href="#">ZYNLONTA (loncastuximab tesirine)</a>	

INJECTABLE MEDICINES				PREVEA360 health plan™ centered around you			
		<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please 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.</p> <p>Updated: 06/01/2022</p>		<p><b>SEARCH TIPS:</b></p> <p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name</p>			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
	Notes:						
			<p>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.</p>	<p>There are claim specific edits for many of these drugs. The edits limit the uses of these drugs to approved indications and dosages. In addition, Prevea360 Health Plan has payment restrictions consistent with Prevea360 Health Plan Medical or Drug Policies.</p>		<p>The Health Plan will not cover U.S. Food and Drug Administration (FDA) approved drugs that are new to the market until the Pharmacy and Therapeutics (P&amp;T) Committee formally reviews and grants approval, within a maximum timeframe of 1 year from FDA approval. If a provider believes that use of a new drug is medically necessary prior to P&amp;T Committee approval, they may submit an exception to coverage form request.</p>	
			<p>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</p>	<p>Any drug submitted under either J3590 or J3490 with a cost of \$750 or greater will be reviewed post-claim by Prevea360 Health Plan.</p>	<p>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.</p>	<p><a href="#">Pharmacy Drug Exception to Coverage Request Form</a></p> <p><a href="#">Medical Injectable Drug Exception to Coverage Request Form</a></p>	