

INJECTABLE MEDICINES		PREVEA360 health plan member resources					
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
<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 Prevea 360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</p> <p>Updated: 10/01/2024</p>				<p>SEARCH TIPS:</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>			
Medical	Q2055	ABECMA	itecaborigene vicleucel	Yes, through the Plan Pharmacy Services	ABECMA (itecaborigene vicleucel)	ABECMA (itecaborigene vicleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J5264	ABRAXANE	paclitaxel protein bound	Yes, through the Plan Pharmacy Services	ABRAXANE (paclitaxel protein-bound particles)	ABRAXANE (paclitaxel protein-bound)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	H9296	ACCORD	pegmetresed	Yes, through the Plan Pharmacy Services	ACCORD (pegmetresed)	ACCORD (pegmetresed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3262	ACTEMRA (IV)	tocilizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with an Rheumatology specialist with authorization.	ACTEMRA IV (tocilizumab)	ACTEMRA IV (tocilizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J3262	ACTEMRA (SC)	tocilizumab	Yes, through Navitas. Restricted to (in at least consultation with Rheumatology specialist with authorization.	ACTEMRA SC (tocilizumab)	ACTEMRA SC (tocilizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J0800	ACTHAR GEL	repository corticotropin injection	PHARMACY BENEFIT ONLY. Yes, through Navitas. Refer to members pharmacy benefit formulary for coverage.		ACTHAR GEL (repository corticotropin injection)	
Medical	H0791	ADAKVEO	cizanolizumab-tmca	Yes, through the Plan Pharmacy Services. Restricted to an Hematology specialist with authorization.	ADAKVEO (cizanolizumab-tmca)	ADAKVEO (cizanolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	H9042	ADCTRI5	brentuximab vedotin	Yes, through the Plan Pharmacy Services	ADCTRI5 (brentuximab vedotin)	ADCTRI5 (brentuximab vedotin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	H9029	ADSTILADRIN	radofarigene fradenovec-vmcg	Yes, through the Plan Pharmacy Services	ADSTILADRIN (radofarigene fradenovec-vmcg)	ADSTILADRIN (radofarigene fradenovec-vmcg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0172	ADUHELM	afucanumab	None. Not Covered.	ADUHELM (afucanumab)		
Medical	J7271	ADZYNMA	ADAMTS13 recombinant-krbn	Yes, through the Plan Pharmacy Services	ADZYNMA (ADAMTS13 recombinant-krbn)	ADZYNMA (ADAMTS13 recombinant-krbn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	AHZANTIVE	afibercept	Yes, through the Plan Pharmacy Services	AHZANTIVE (afibercept)	AHZANTIVE (afibercept)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J454	AKYNEZO	fosbretupitant/palonosetron	Yes, through the Plan Pharmacy Services	AKYNEZO (fosbretupitant/palonosetron)	AKYNEZO (fosbretupitant/palonosetron)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	1931	ALDURAZYME	lanridase	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.	ALDURAZYME (lanridase)	ALDURAZYME (lanridase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9305	ALIMTA	pegmetresed	Yes, through the Plan Pharmacy Services	ALIMTA (pegmetresed)	ALIMTA (pegmetresed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	H0557	ALIQOPA	copanlisib	Yes, through the Plan Pharmacy Services	ALIQOPA (copanlisib)	ALIQOPA (copanlisib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2469	ALIXI	palonosetron	EFFECTIVE 02/01/2023 No Prior Authorization is Required	ALIXI (palonosetron)		
Medical	Q5126	ALYMSYS	bevacizumab	As of 03/01/2024, Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymsys, Itevad and Vegfexin prior authorization is required through the Plan Pharmacy Services. **Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	ALYMSYS (bevacizumab)	ALYMSYS (bevacizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J426	AMONDYS	casimersen	None. Not Covered.	AMONDYS (casimersen)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J9999	AMTAGVI	filgrastim	Yes, through the Plan Pharmacy Services	AMTAGVI (filgrastim)	AMTAGVI (filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0225	AMVUTTRA	vutrisiran	Yes, through the Plan Pharmacy Services	AMVUTTRA (vutrisiran)	AMVUTTRA (vutrisiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9999	ANKTIVA	nogspendekin alfa inabicept-pmnl	Yes, through the Plan Pharmacy Services	Anktiva (nogspendekin alfa inabicept-pmnl)	Anktiva (nogspendekin alfa inabicept-pmnl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7275, J7178, J7179, J7280, J7181, J7188, J7285, J7196, J7212	Antihemophilic Factor and Clotting Factors (Coagdex, RUSTAP, Vormenol, Confact, Tretlen, Obitar, Novoseven RT, Feiba NF, Sevenfact)	(coagulation factor X (human), fibrinogen concentrate (human), von Willebrand factor (recombinant), factor XIII concentrate (human), coagulation factor VIII & subunit (recombinant), antihemophilic factor (porcine), coagulation factor VIIa (recombinant), antithrombin coagulant complex, Coagulation factor Vlla (recombinant) (new)	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTHEMOPHILIC FACTOR AND CLOTTING FACTORS	ANTHEMOPHILIC FACTOR AND CLOTTING FACTORS	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7182, J7183, J7185, J7186, J7187, J7190, J7192, J7204, J7205, J7207, J7208, J7249, J7210, J7211, J7214	Antihemophilic Factor VIII (Novovogin, Wilate, Xyntha, Alphanine, Humate-P, Hemofill M, Koate DVI, Advate, Kogenate FS, Recombinate, Esperote, Advilya, Elocate, Advionite, Adv, Rowin, Kovaltry Altiavo)	(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 (recombinant), antihemophilic factor (recombinant), antihemophilic factor (recombinant), Antihemophilic factor (recombinant) glyco-polyated, antihemophilic factor (recombinant) single chain, antihemophilic factor (recombinant), antihemophilic factor (recombinant) pegylated, antihemophilic factor (recombinant) pegylated-aucd, antihemophilic factor (recombinant) human, antihemophilic factor (recombinant))	Yes, through Dean Health Plan Utilization Management Department. Restricted to a Hematology specialist with authorization.	ANTHEMOPHILIC FACTOR VIII	ANTHEMOPHILIC FACTOR VIII	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7193, J7194, J7195, J7200, J7201, J7202, J7203	Antihemophilic Factor IX (Alphanine CD, Mononine, Proflinase, Benefix, Isatiny, Rowibi, Alprolix, IteVion, Rebiny)	(coagulation Factor IX, coagulation Factor IX, factor IX complex, coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), Fc fusion protein, coagulation factor IX (recombinant), human, coagulation factor IX (recombinant), glycopegylated)	Yes, through Dean Health Plan Utilization Management Department. Restricted to Hematology specialist with authorization.	ANTHEMOPHILIC FACTOR IX	ANTHEMOPHILIC FACTOR IX	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J277	APHEXDA	notofarotide	Yes, through the Plan Pharmacy Services	APHEXDA (notofarotide)	APHEXDA (notofarotide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0256	ARALAST NP	alpha-1-proteinase inhibitor (human)	Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	ARALAST NP (alpha-1-proteinase inhibitor)	ARALAST NP (alpha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0881	ARANESP	darbepoetin alpha	Yes, through the Plan Pharmacy services	ARANESP (darbepoetin alpha)	ARANESP (darbepoetin alpha)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

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Medical	C9072	ASCENV (IVIG) - non-preferred	Immune globulin (Human)	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of all other immune globulin products.	ASCENV (IVIG)	ASCENV (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J9035	AVASTIN	bevacizumab	As of 03/01/2024, Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alynxys, Ibrava and Vegtelma prior authorization is required through the Plan Pharmacy Services. **Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYNXYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	AVASTIN (bevacizumab)	AVASTIN (bevacizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	Q5121	AVSOLA - non-preferred	ixiflimab-axiq	Yes, through the Plan Pharmacy Plan after failed trial of RENFLERIX. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialists with authorization.	AVSOLA -non-preferred (ixiflimab-axiq)	AVSOLA (ixiflimab-axiq)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	A9590	AZEDRA	lobeguanine 1-131	Yes, through the Plan Pharmacy Services	AZEDRA (lobeguanine 1-131)	AZEDRA (lobeguanine 131)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9023	BAVENCIO	avelumab	Yes, through the Plan Pharmacy Services	BAVENCIO (avelumab)	BAVENCIO (avelumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9032	BELEODAQ	belinostat	Yes, through the Plan Pharmacy Services	BELEODAQ (belinostat)	BELEODAQ (belinostat)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9036	BELRAPZO	benidamine	Yes, through the Plan Pharmacy Services	BELRAPZO (benidamine)	BELRAPZO (benidamine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9034	BENDEKA	benidamine	Yes, through the Plan Pharmacy Services	BENDEKA (benidamine)	BENDEKA (benidamine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0490	BENLYSTA (IV)	belimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	BENLYSTA IV (belimumab)	BENLYSTA IV (belimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J0490	BENLYSTA (SC)	belimumab	Yes, through Navitas. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	BENLYSTA SC (belimumab)	BENLYSTA SC (belimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0179	BEDEVU	broliciciumab-dbl	Yes, through the Plan Pharmacy Services	BEDEVU (broliciciumab-dbl)	BEDEVU (broliciciumab-dbl)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J9229	BESPONSA	botocumab coqagmncf	Yes, through the Plan Pharmacy Services	BESPONSA (botocumab coqagmncf)	BESPONSA (botocumab-dbl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3900	BEQVEZ	fidanacogene elagarevvec-dakt	Yes, through the Plan Pharmacy Services	Beqvez (fidanacogene elagarevvec-dakt)	Beqvez (fidanacogene elagarevvec-dakt)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J1556	BIVIGAM (IVIG), IMMUNE GLOBULIN	Immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	BIVIGAM (IVIG)	BIVIGAM (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J3590	BKEMV	eculizumab	Yes, through the Plan Pharmacy Services	BKEMV (eculizumab)	BKEMV (eculizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services	BLINCYTO (blinatumomab)	BLINCYTO (blinatumomab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9222	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	BLUEPOINT (pemetrexed)	BLUEPOINT (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9044	BORTEZOMIB	bortezomib - preferred	Yes, through the Plan Pharmacy Services	BORTEZOMIB	BORTEZOMIB	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0585	BOTOX	onabotulinumtoxin	No prior authorization is required.	BOTOX (onabotulinumtoxinA)	BOTOX (onabotulinumtoxinA)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q2054	BREYANZ	lisocabtagene maraleucel	Yes, through the Plan Pharmacy Services	BREYANZ (lisocabtagene maraleucel)	BREYANZ (lisocabtagene maraleucel)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3229	BRIUMVI	ublituximab-sly	Yes, through the Plan Pharmacy Services	BRIUMVI** (ublituximab-sly)	BRIUMVI** (ublituximab-sly)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0667, C9014	BRINEURA	cerliponase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the Late infantile Ceroid lipofuscinosis with authorization.	BRINEURA (cerliponase alfa)	BRINEURA (cerliponase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5124	BYOCVIZ	ranibizumab	Yes, through the Plan Pharmacy Services	BYOCVIZ (ranibizumab)	BYOCVIZ (ranibizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J9043	CABAZITAXEL	Cabazitaxel (levians)	Yes, through the Plan Pharmacy Services	CABAZITAXEL (levians)	CABAZITAXEL (levians)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C2056	CARVYKT	ciltacabtagene autovecel	Yes, through the Plan Pharmacy Services	CARVYKT (ciltacabtagene autovecel)	CARVYKT (ciltacabtagene autovecel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	CASEVY	exagamgogene autotemcel	Yes, through the Plan Pharmacy Services	CASEVY (exagamgogene autotemcel)	CASEVY (exagamgogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1786	CEREZYME	imglucerase (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 DK with authorization.	CEREZYME (imglucerase) (intravenous)	CEREZYME (imglucerase) (intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5128	CIMERLI	ranibizumab	Yes, through the Plan Pharmacy Services	CIMERLI (ranibizumab)	CIMERLI (ranibizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Pharmacy	J0717	CIMZIA	certolizumab pegol	PHARMACY BENEFIT ONLY - Verify prior authorization requirements by accessing the members formulary.	CIMZIA (certolizumab pegol)	CIMZIA (certolizumab pegol)	
Medical	J2786	CINQAIR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	CINQAIR (reslizumab)	CINQAIR (reslizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	J1932	CIPLA	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	CIPLA (lanreotide depot)	CIPLA (lanreotide depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	J9286	COLUMVI	gloftamab-gbmn	Yes, through the Plan Pharmacy Services.	COLUMVI** (gloftamab-gbmn)	COLUMVI** (gloftamab-gbmn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	J1448	COSELA	triliciclib	Yes, through the Plan Pharmacy Services	COSELA (triliciclib)	COSELA (triliciclib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	8347	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	COSENTYX IV (secukinumab)	COSENTYX IV (secukinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8584	CRYSVITA	busosumab	Yes, through the Plan Pharmacy Services. Restricted to Endocrinologist, Nephrologist, Medical Geneticist, or Specialist experienced in treatment of Metabolic Bone Disorders with authorization.	CRYSVITA (busosumab)	CRYSVITA (busosumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	1555	CUVITRU (SOIG), IMMUNE GLOBULIN	immune globulin (cuvtru)	Yes, through the Plan Pharmacy Services	CUVITRU (SOIG)	CUVITRU (SOIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	8908	CYRAMZA	ramucicamab	Yes, through the Plan Pharmacy Services	CYRAMZA (ramucicamab)	CYRAMZA (ramucicamab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	8948	DANYELZA	naftamab	Yes, through the Plan Pharmacy Services	DANYELZA (naftamab)	DANYELZA (naftamab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	8945	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services	DARZALEX (daratumumab)	DARZALEX (daratumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	8944, C962	DARZALEX FASPRO	daratumumab/hyaluronidase-fihj	Yes, through the Plan Pharmacy Services	DARZALEX FASPRO (daratumumab/hyaluronidase-fihj)	DARZALEX FASPRO (daratumumab/hyaluronidase-fihj)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	8589	DAVIFY	daxibotulinumtoxinA	None. Please see attached policy for criteria.	DAVIFY™ (daxibotulinumtoxinA)	DAVIFY™ (daxibotulinumtoxinA)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	77318	DURDLANE - non-preferred	sodium hyaluronate	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of DURDLANE 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.	DURDLANE - non-preferred (sodium hyaluronate)	DURDLANE (sodium hyaluronate)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	8586	DYSPORT	abobotulinumtoxinA	No prior authorization is required.	DYSPORT (abobotulinumtoxinA)	DYSPORT (abobotulinumtoxinA)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	8904	EAGLE	gemtrevird	Yes, through the Plan Pharmacy Services	EAGLE (gemtrevird)	EAGLE (gemtrevird)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8963	ELAHERE	nirxetumab soravastatin-glyx	EFFECTIVE 04/01/2023. Yes, through the Plan Pharmacy Services	ELAHERE (nirxetumab soravastatin-glyx)	ELAHERE (nirxetumab soravastatin-glyx)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11743	ELAPRASE	idarubicin (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis II with authorization.	ELAPRASE (idarubicin)	ELAPRASE (idarubicin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	14113	ELEVIDYS	delandistrogene moxeparvececeol	None. Not Covered.	ELEVIDYS (delandistrogene moxeparvececeol)	ELEVIDYS (delandistrogene moxeparvececeol)	
Medical	8360	ELELYSO	talligucerase 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 DI with authorization.	ELELYSO (talligucerase alfa)	ELELYSO (talligucerase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8580	ELFABRIO	pegunigalsidase alfa-1wq	Yes, through the Plan Pharmacy Services	ELFABRIO™ (pegunigalsidase alfa-1wq)	ELFABRIO™ (pegunigalsidase alfa-1wq)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8323	ELREXFO	elranatamab-bcmn	Yes, through the Plan Pharmacy Services	ELREXFO™ (elranatamab-bcmn)	ELREXFO™ (elranatamab-bcmn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	89269	ELZONRIS	tagraxofup-ers	Yes, through the Plan Pharmacy Services	ELZONRIS (tagraxofup-ers)	ELZONRIS (tagraxofup-ers)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	89176	EMPLICITI	elotuzumab	Yes, through the Plan Pharmacy Services	EMPLICITI (elotuzumab)	EMPLICITI (elotuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	89358	ENHERTU	fam-trastuzumab deruxtecan-nxli	Yes, through the Plan Pharmacy Services	ENHERTU (fam-trastuzumab deruxtecan-nxli)	ENHERTU (fam-trastuzumab deruxtecan-nxli)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8302	ENJAYMO	sutimlimab	Yes, through Plan Pharmacy Services	ENJAYMO (sutimlimab-joje)	ENJAYMO (sutimlimab-joje)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8399, 8390	ENSPRYNG	satralizumab-mwge	Yes, Through the Plan Pharmacy Services	ENSPRYNG™ (satralizumab-mwge)	ENSPRYNG™ (satralizumab-mwge)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8380	ENTYVIO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	ENTYVIO (vedolizumab)	ENTYVIO (vedolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	89321	EPKINLY	epcoritamab-bygp	Yes, through the Plan Pharmacy Services.	EPKINLY™ (epcoritamab-bygp)	EPKINLY™ (epcoritamab-bygp)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8885	EPOGEN	epoetin alfa, (for non-esrd use)	As of 01/01/2023: Retacir is the preferred Epoetin Alfa products and does not require prior authorization. Epopgen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	EPOGEN (epoetin alfa)	EPOGEN (epoetin alfa)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	8390	EPYSQIU	eculsiumab	Yes, through the Plan Pharmacy Services	EPYSQIU (eculsiumab)	EPYSQIU (eculsiumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	89055	ERBITUX	cetuximab	Yes, through the Plan Pharmacy Services	ERBITUX (cetuximab)	ERBITUX (cetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	7723	EUFLEXA - non-preferred	sodium hyaluronate, 1%	As of 08/01/2022 HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of EUFLEXA 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.	EUFLEXA (sodium hyaluronate, 1%)	EUFLEXA (sodium hyaluronate, 1%)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	83111	EVENTY	romosozumab-aqqg	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinology or Rheumatology specialists with authorization.	EVENTY (romosozumab-aqqg)	EVENTY (romosozumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	8305	EVKEEZA	evinacumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Cardiologist, Lipidologist, or Endocrinologist specialist with authorization.	EVKEEZA (evinacumab)	EVKEEZA (evinacumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		EVRYSDI	risdiplam	Yes, through Novitas. Restricted to a pediatric neurologist at a Muscular Dystrophy Association care center with authorization.	EVRYSDI (risdiplam)	EVRYSDI (risdiplam)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	8428	EXONDYS 51	eteplirsen	None. Not Covered.	EXONDYS 51 (eteplirsen)	EXONDYS 51 (eteplirsen)	

INJECTABLE MEDICINES		PREVEA 360 health plan commercial/member/plan					
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
		<p>SEARCH TIPS:</p> <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 Prevea 360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</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>					
Medical	0178	EYLEA	afibercept	Yes, through the Plan Pharmacy Services	EYLEA (afibercept)	EYLEA (afibercept)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0177	EYLEA HD	afibercept	Yes, through the Plan Pharmacy Services	EYLEA HD (afibercept)	EYLEA HD (afibercept)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0180	FABRYZYME	agalsidase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with a medical geneticist or other prescriber specified in the treatment of Fabry DX with authorization.	FABRYZYME (agalsidase)	FABRYZYME (agalsidase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0517	FASENRA	benralizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	FASENRA (benralizumab)	FASENRA (benralizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q0136, Q0139	FERAHEME - preferred	ferumoxytol	As of 08/01/2022 VENOFER, INEED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERRIC, and TRIFERRIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERAHEME (ferumoxytol)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	Z916	FERRELECT - preferred	sodium ferrous gluconate complex	As of 08/01/2022 VENOFER, INEED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERRIC, and TRIFERRIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERRELECT (sodium ferrous gluconate complex)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	11744	FIRAZYR	icatibant	Yes, through the Plan Pharmacy Services.	FIRAZYR® (icatibant)	FIRAZYR® (icatibant)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11572	FLEBOGAMMA/FLEBOGAMMA DF (IVIG), IMMUNE GLOBULIN	febogamma	Yes, through the Plan Pharmacy Services	FLEBOGAMMA/FLEBOGAMMA DF (IVIG)	FLEBOGAMMA/FLEBOGAMMA DF (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	Q5108	FULPHLA	pegfilgrastim-imbj	EFFECTIVE 01/01/2024: FULPHLA and NVVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZENXENZO AND FULPHLA before coverage of Neulasta. UDCENYCA, FULNETRA, STIMUFEND and ZENXENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	FULPHLA (pegfilgrastim-imbj)	FULPHLA (pegfilgrastim-imbj)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0641	FUSILEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	FUSILEV (levoleucovorin)	FUSILEV (levoleucovorin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0931	FYARRO	sirilimus albumin-bound	Yes, through the Plan Pharmacy Services	FYARRO (sirilimus albumin-bound)	FYARRO (sirilimus albumin-bound)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5130	FULNETRA - non-preferred	pegfilgrastim-pbbk	EFFECTIVE 01/01/2024: FULPHLA and NVVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZENXENZO AND FULPHLA before coverage of Neulasta. UDCENYCA, FULNETRA, STIMUFEND and ZENXENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	FULNETRA (pegfilgrastim-pbbk)	FULNETRA (pegfilgrastim-pbbk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0910	GAMFANT	emapalumab-lzg	Yes, through the Plan Pharmacy Services	GAMFANT™ (emapalumab-lzg)	GAMFANT™ (emapalumab-lzg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11569	GAMMAGARD (SCIG), IMMUNE GLOBULIN	immune globulin (gammagard liquid)	Yes, through the Plan Pharmacy Services	GAMMAGARD (SCIG)	GAMMAGARD (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11557	GAMMAPLEX (IVIG), IMMUNE GLOBULIN	immune globulin (gammalex liquid)	Yes, through the Plan Pharmacy Services	GAMMAPLEX (IVIG)	GAMMAPLEX (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	11561	GAMUNEX-C/GAMMAKED (SCIG), IMMUNE GLOBULIN	gamunex injection	Yes, through the Plan Pharmacy Services	GAMUNEX-C/GAMMAKED (SCIG)	GAMUNEX-C/GAMMAKED (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0901	GAZYVA	obintuzumab	Yes, through the Plan Pharmacy Services	GAZYVA (obintuzumab)	GAZYVA (obintuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	07326	GEL-ONE - non-preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym-3, Visco-3, sodium hyaluronate, TriVisc, Orthovic, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GEL-ONE (hyaluronate sodium)	GEL-ONE (hyaluronate sodium)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	07328	GELSYN-3 - non-preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym-3, Visco-3, sodium hyaluronate, TriVisc, Orthovic, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GELSYN-3 (hyaluronate sodium)	GELSYN-3 (hyaluronate sodium)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	07320	GENVISC 850 - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelym-3, Visco-3, sodium hyaluronate, TriVisc, Orthovic, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GENVISC 850 (hyaluronan or derivative)	GENVISC 850 (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0223	GIVLAARI	givrosan	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.	GIVLAARI (givrosan)	GIVLAARI (givrosan)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialists with authorization.	GLASSIA (alpha-1-proteinase inhibitor)	GLASSIA (alpha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11447	GRANIX	tbody-filgrastim	EFFECTIVE 01/01/2023: Invectym and Zavisio are the preferred Filgrastim products and do not require prior authorization. Please see Medical Policy for criteria.	GRANIX (tbody-filgrastim)	GRANIX (tbody-filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11411	HEMGENIX	etranacogene-deasparovoc-dfzb	Yes through the Plan Pharmacy Services	HEMGENIX (etranacogene-deasparovoc-dfzb)	HEMGENIX (etranacogene-deasparovoc-dfzb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	07170	HEMLIBRA	emicizumab	Yes, through Navitas. Refer to members pharmacy benefit formulary for coverage.		HEMLIBRA (emicizumab)	
Medical	09248	HEPZATO	mephalan hydrochloride	Yes, through the Plan Pharmacy Services	HEPZATO (mephalan hydrochloride)	HEPZATO (mephalan hydrochloride)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	09355	HERCEPTIN	trastuzumab injection	Heruzma and Trastuzera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Opdivi, Kanjanti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HERCEPTIN (trastuzumab injection)	HERCEPTIN (trastuzumab injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

INJECTABLE MEDICINES		PREVEA 360 health plan							
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD		
<p>SEARCH TIPS:</p> <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 Prevea 360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</p> <p>Updated: 10/01/2024</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>					
Medical	89356	HERCEPTIN HYLECTA	trastuzumab and hyaluronidase-oyk	Yes, through the Plan Pharmacy Services	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oyk)	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oyk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	Q5113	HERZUMA	trastuzumab-pkrb	Herzuma and Trastizera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Opdivi, Kanjini and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HERZUMA (trastuzumab-pkrb)	HERZUMA (trastuzumab-pkrb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	11559	HIZENTRA (SCIG), IMMUNE GLOBULIN	immune globulin (hizentra)	Yes, through the Plan Pharmacy Services	HIZENTRA (SCIG)	HIZENTRA (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89294	HOSPIRA	pegretaxel	Yes, through the Plan Pharmacy Services	HOSPIRA (pegretaxel)	HOSPIRA (pegretaxel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	17321	HYALGAN - preferred	hyaluronate or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelyin-3, Visco-3, sodium hyaluronate, TRIVIC, Orthovic, Supartz FX, and GenVisco50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HYALGAN (hyaluronate or derivative)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	89351	HYCAMTIN	topotecan	IV dosage form does not require PA Oral dosage form requires PA - Restricted to Oncologists with authorization through the Plan Pharmacy Services.		HYCAMTIN (topotecan)			
Medical	17322	HYMOVIS - preferred	hyaluronan	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Durolane, Gel-One, Euflexa, Gelyin-3, Visco-3, sodium hyaluronate, TRIVIC, Orthovic, Supartz FX, and GenVisco50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HYMOVIS (hyaluronan)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	11575	HYQVIA (SCIG), IMMUNE GLOBULIN	immune globulin (hyqvia)	Yes, through the Plan Pharmacy Services	HYQVIA (SCIG)	HYQVIA (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	13245	ILUMYA	hidraluzumab-asnm	Yes, through the Plan Pharmacy Services	ILUMYA (hidraluzumab-asnm)	ILUMYA (hidraluzumab-asnm)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89173	IMFINZI	durvalumab	Yes, through the Plan Pharmacy Services	IMFINZI (durvalumab)	IMFINZI (durvalumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89347	IMLUDO	tremlimumab-actl	Yes, through the Plan Pharmacy Services	IMLUDO (tremlimumab-actl)	IMLUDO (tremlimumab-actl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89325	IMALYGIC	talimogene laherparepvec	Yes, through the Plan Pharmacy Services	IMALYGIC (talimogene laherparepvec)	IMALYGIC (talimogene laherparepvec)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89999	IMDELLTRA	tarlatamab-dtll	EFFECTIVE 09/01/2024. Yes, through the Plan Pharmacy Services	IMDELLTRA (tarlatamab-dtll)	IMDELLTRA (tarlatamab-dtll)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	11750	INFED - preferred	iron dextran	As of 08/01/2022 VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERRIC, and TRIFERRIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	INFED (iron dextran)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	Q5103	INFLECTA - 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.	INFLECTA (infliximab-dyyb)	INFLECTA (infliximab-dyyb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	89198	INFUGEM	premixed penciclovine in sodium chloride solution	Yes, through the Plan Pharmacy Services	INFUGEM (premixed penciclovine in sodium chloride solution)	INFUGEM (premixed penciclovine in sodium chloride solution)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	11439	INJECTAFER - non-preferred	ferric carboxymaltose	As of 08/01/2022 VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERRIC, and TRIFERRIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	INJECTAFER (ferric carboxymaltose)	INJECTAFER (ferric carboxymaltose)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan (Utilization Management Department. MAPD ONLY)	INSULIN PUMPS	INSULIN PUMPS			
Medical	11566	IVIG IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NF)	Immune globulin, powder	Yes, through the Plan Pharmacy Services	IVIG Immune Globulin	IVIG Immune Globulin	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	11599	IVIG IMMUNE GLOBULIN	Immune globulin, liquid	Yes, through the Plan Pharmacy Services	IVIG Immune Globulin	IVIG Immune Globulin	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	Q5109	IXIFI	infliximab-gtbs	Yes, through the Plan Pharmacy Services after failed trial of AVSOLA. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	IXIFI (infliximab-gtbs)	IXIFI (infliximab-gtbs)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	12782	IZERVAY	avacicaptad pegol	Yes, through the Plan Pharmacy Services	IZERVAY (avacicaptad pegol)	IZERVAY (avacicaptad pegol)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89281	JELMYTO	mitomycin	Yes, through the Plan Pharmacy Services	JELMYTO (mitomycin)	JELMYTO (mitomycin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89272	JEMPERLI	doxorubicin	Yes, through the Plan Pharmacy Services	JEMPERLI (doxorubicin-gly)	JEMPERLI (doxorubicin-gly)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	89043	JEVYANA	sabaxitaxel	Yes, through the Plan Pharmacy Services	JEVYANA (sabaxitaxel)	JEVYANA (sabaxitaxel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	8390	JIBBONTI	denosumab	Yes, through the Plan Pharmacy Services	JIBBONTI (denosumab)	JIBBONTI (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.		
Medical	89354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services	KADCYLA (ado-trastuzumab emtansine)	KADCYLA (ado-trastuzumab emtansine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	11290	KALBITOR	kalbitor (ecalcitriol)	Yes, through the Plan Pharmacy Services	KALBITOR (ecalcitriol)	KALBITOR (ecalcitriol)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	Q5117	KANINTI	trastuzumab-anns	Herzuma and Trastizera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Opdivi, Kanjini and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	KANINTI (trastuzumab-anns)	KANINTI (trastuzumab-anns)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	12840	KANUMA IV	sebelipase-afib	Yes, through the Plan Pharmacy Services	KANUMA IV (sebelipase-afib)	KANUMA IV (sebelipase-afib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		
Medical	13490	KETAMINE For Chronic Pain and Mental Health and Substance Related Disorder	ketamine	None. Not Covered.	KETAMINE FOR CHRONIC PAIN				
Medical	89271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	KEYTRUDA (pembrolizumab)	KEYTRUDA (pembrolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs		

INJECTABLE MEDICINES		SEARCH TIPS		PREVEA 360 health plan member resources			
<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 Prevea 360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</p> <p>Updated: 10/01/2024</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	J0175	KISUNLA	donanemab-azbt	EFFECTIVE 11/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9274	KIMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	KIMTRAK (tebentafusp-tebn)	KIMTRAK (tebentafusp-tebn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	KRYSTEXXA (pegloticase)	KRYSTEXXA (pegloticase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q2042	KYMRIAH	tisagenlecleucel	Yes, through the Plan Pharmacy Services	KYMRIAH (tisagenlecleucel)	KYMRIAH (tisagenlecleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9047	KYPROLIS	carfilzomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	KYPROLIS (carfilzomib)	KYPROLIS (carfilzomib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0217	LAMZEDE	velmanase alfa-tycv	Yes, through the Plan Pharmacy Services	LAMZEDE (velmanase alfa-tycv)	LAMZEDE (velmanase alfa-tycv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J490, C9399	LANREOTIDE	somatuline depot	Yes, through the Plan Pharmacy Services	LANREOTIDE (somatuline depot)	LANREOTIDE (somatuline depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3590	LANTIDRA	donisicel-jujn	Yes, through the Plan Pharmacy Services	LANTIDRA (donisicel-jujn)	LANTIDRA (donisicel-jujn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0202	LEMTRADA	alemtuzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialist with authorization. Infusions must be administered at a facility certified for LEMTRADA infusions.	LEMTRADA (alemtuzumab)	LEMTRADA (alemtuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3590	LENMELDY	afidasagene autotemcel	Yes, through the Plan Pharmacy Services	LENMELDY (afidasagene autotemcel)	LENMELDY (afidasagene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0174	LEQEMBI	lecanemab-imb	Yes, through the Plan Pharmacy Services	LEQEMBI (lecanemab-imb)	LEQEMBI (lecanemab-imb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1306	LEQVIO	incisiran	None. Not covered.	LEQVIO (incisiran)		
Medical	J0641, J0642	LEVOLUCOVORIN	fusler khazopy	Yes, through the Plan Pharmacy Services	LEVOLUCOVORIN	LEVOLUCOVORIN (fusler khazopy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0650	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INJECTION (INTRAVENOUS)	LEVOTHYROXINE INJECTION (INTRAVENOUS)	
Medical	J9119	LIFTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	LIFTAYO (cemiplimab-cvcl)	LIFTAYO (cemiplimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2001	LIDOCAINE for Chronic Pain	lidocaine	None. Not Covered.	LIDOCAINE FOR CHRONIC PAIN		
Medical	J3263	LIQTORZI	toripalimab-tpzl	Yes, through the Plan Pharmacy Services	LIQTORZI (toripalimab-tpzl)	LIQTORZI (toripalimab-tpzl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2778	LUCENTIS	ranibizumab	Yes, through the Plan Pharmacy Services	LUCENTIS (ranibizumab)	LUCENTIS (ranibizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, IL, MO
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 Dis with authorization.	LUMIZYME (alglucosidase alfa) (Intravenous)	LUMIZYME (alglucosidase alfa) (Intravenous)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.
Medical	J9113	LUMOMITI	inowatumab pasodotax-ldff	Yes, through the Plan Pharmacy Services	LUMOMITI (inowatumab pasodotax-ldff)	LUMOMITI (inowatumab pasodotax)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.
Medical	J9550	LUNSUMIO	nosunetuzumab-aagb	Yes, through the Plan Pharmacy Services	LUNSUMIO (nosunetuzumab-aagb)	LUNSUMIO (nosunetuzumab-aagb)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.
Medical	A9513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services	LUTATHERA (lutetium Lu 177)	LUTATHERA (lutetium Lu 177)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.
Medical	J3398	LUXTRUNA	voretigene neparivec-cryl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the retinal dystrophy with authorization.	LUXTRUNA (voretigene neparivec-cryl)	LUXTRUNA (voretigene neparivec-cryl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3394	LYFGENIA	lovotibeglogene autotemcel	Yes, through the Plan Pharmacy Services	LYFGENIA (lovotibeglogene autotemcel)	LYFGENIA (lovotibeglogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9553	MARGENZA	margetuximab	Yes, through the Plan Pharmacy Services	MARGENZA (margetuximab)	MARGENZA (margetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3397	MEPSEVI	vestronidase alfa-vbka (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.	MEPSEVI (vestronidase alfa-vbka) (Intravenous)	MEPSEVI (vestronidase alfa-vbka) (Intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9340	MONJUVI	talafitamab-cxix	Yes, through the Plan Pharmacy Services	MONJUVI (talafitamab-cxix)	MONJUVI (talafitamab-cxix)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J437	MONOFERRIC - non-preferred	feric derisomaltose	As of 08/01/2022: VENOFER, INFED, FERLECHT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, FERRIC, and TRIFERRIC AVALI are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	MONOFERRIC (feric derisomaltose)	MONOFERRIC (feric derisomaltose)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J7327	MONOVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovic, Duronic, Gel-One, Euflexa, Gelyin-3, Visc-3, sodium hyaluronate, TRIVISC, Orthovic, Supartz FX, and GenViscB50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	MONOVISC (hyaluronan or derivative)	MONOVISC (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, IL, MO.
Medical	Q5107	MVASI	bevacizumab-awwb	As of 03/01/2024: Zirahev is the preferred bevacizumab product and does not require prior authorization. Avastin, Alymsy, Mvasi and Vegemta prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	MVASI (bevacizumab-awwb)	MVASI (bevacizumab-awwb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, IL, MO.
Medical	J9203	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	MYLOTARG (gemtuzumab ozogamicin)	MYLOTARG (gemtuzumab ozogamicin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, IL, MO.
Medical	J0587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	MYOBLOC (rimabotulinumtoxinB)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, IL, MO.
Medical	J1458	NAGLAZYME	galafuse (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VI with authorization.	NAGLAZYME (galafuse) (Intravenous)	NAGLAZYME (galafuse) (Intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

INJECTABLE MEDICINES				PREVEA360 health plan commercial/member/don			
		SEARCH TIPS:					
Updated: 10/01/2024		<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>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	J233	NATALIZUMAB	tyabri	Yes, through the Plan Pharmacy Services	NATALIZUMAB (Tyabri-Tanbe)	NATALIZUMAB (Tyabri-Tanbe)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J206	NEULASTA	pegfilgrastim	EFFECTIVE 01/01/2024: FULPHILA and NIVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCTA, FYLNTRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEULASTA (pegfilgrastim)	NEULASTA (pegfilgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	J206	NEULASTA	pegfilgrastim	Yes, through Navitus	NEULASTA (pegfilgrastim)	NEULASTA (pegfilgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1442	NEUPOGEN	filgrastim	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Graniv, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEUPOGEN (filgrastim)	NEUPOGEN (filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW	New to Market Medical Pharmacy Products currently under clinical review	New policy regarding Medical Pharmacy products under current clinical review	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW		
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS	New to Market Medical Pharmacy Products	New policy regarding New to Market Medical Products	NEW TO MARKET MEDICAL PHARMACY PRODUCTS		
Medical	J0219	NEXYAZYME	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.	NEXYAZYME (avalglucosidase alfa)	NEXYAZYME (avalglucosidase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q510	NIVESTYM	filgrastim-afii	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Graniv, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NIVESTYM (filgrastim-afii)	NIVESTYM (filgrastim-afii)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2796	NPLATE	romipostin	Yes, through the Plan Pharmacy Services	NPLATE (romipostin)	NPLATE (romipostin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2182	NUCALA	mepolizumab	Yes, through the Plan Pharmacy Services. Eosinophilic asthma: Restricted to Pulmonology, Allergy, and Immunology specialists with authorization. Eosinophilic granulomatosis with polyangiitis (EGPA): Restricted to a Pulmonology, Immunology, Allergy or Rheumatology specialist with authorization.	NUCALA (mepolizumab)	NUCALA (mepolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1490, C9399	NULIBRY	fosdenopterin	Yes, through the Plan Pharmacy Services. Restricted to a neurologist, medical geneticist, or a provider who specializes in management of fibron errors of metabolism with authorization.	NULIBRY (fosdenopterin)	NULIBRY (fosdenopterin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3590	NYPOD	filgrastim-bid	Yes, through the Plan Pharmacy Services	NYPOD (filgrastim-bid)	NYPOD (filgrastim-bid)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5122	NYVEPRIA	pegfilgrastim-afgf	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCTA, NYVEPRIA, FYLNTRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NYVEPRIA (pegfilgrastim-afgf)	NYVEPRIA (pegfilgrastim-afgf)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2350	OCRELVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	OCRELVUS (ocrelizumab)	OCRELVUS (ocrelizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1568	OCTAGAM (IVIG), IMMUNE GLOBULIN	Immune globulin (octagam liquid)	Yes, through the Plan Pharmacy Services	OCTAGAM (IVIG)	OCTAGAM (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q5114	OGIVRI	trastuzumab-dkst	Heruzma and Trastuzera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	OGIVRI (trastuzumab-dkst)	OGIVRI (trastuzumab-dkst)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3590	OMISIRGE	omidubicel-only	Yes, through the Plan Pharmacy Services	OMISIRGE* (omidubicel-only)	OMISIRGE* (omidubicel-only)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J2267	OMVOH	mirkizumab-mrzk	Yes, through the Plan Pharmacy Services	OMVOH (mirkizumab-mrzk)	OMVOH (mirkizumab-mrzk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9205	ONIVYDE	irinotecan liposome injection	Yes, through the Plan Pharmacy Services	ONIVYDE (irinotecan liposome injection)	ONIVYDE (irinotecan liposome injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0222	ONPATRO	patisiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Hematology or Neurology specialist with authorization.	ONPATRO (patisiran)	ONPATRO (patisiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5112	ONTRUZANT	trastuzumab-dtbt	Heruzma and Trastuzera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ONTRUZANT (trastuzumab-dtbt)	ONTRUZANT (trastuzumab-dtbt)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9299	OPIOVO	nivolumab	Yes, through the Plan Pharmacy Services	OPIOVO (nivolumab)	OPIOVO (nivolumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9298	OPDUALAG	nivolumab/relatlimab-mrbw	Yes, through the Plan Pharmacy Services	OPDUALAG (nivolumab/relatlimab-mrbw)	OPDUALAG (nivolumab/relatlimab-mrbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0129	ORENCIA (IV)	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	ORENCIA IV (abatacept)	ORENCIA IV (abatacept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	J0129	ORENCIA (SC)	abatacept	Yes, through Navitus. Restricted to an Rheumatology specialist with authorization.	ORENCIA SC (abatacept)	ORENCIA SC (abatacept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J724	ORTHOSYS - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronan acid products and do not require prior authorization. Monovisc, Duronera, Galf One, Lullnexa, Gelpin 3, Visco 3, Iodun hyaluronate, TRIVIS, Orthovisc, Squartz FX, and GenVisco50 are the non-preferred hyaluronan acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ORTHOSYS (hyaluronan or derivative)	ORTHOSYS (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0224	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	OXLUMO (lumasiran)	OXLUMO (lumasiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9259	PACTAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services	PACTAXEL PROTEIN-BOUND PARTICLES	PACTAXEL PROTEIN-BOUND PARTICLES	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9177	PADCEV	enfortumab vedotin-efyv	Yes, through the Plan Pharmacy Services	PADCEV (enfortumab vedotin-efyv)	PADCEV (enfortumab vedotin-efyv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

INJECTABLE MEDICINES				PREVEA360 health plan member resources			
		SEARCH TIPS:					
<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 Navitas.</p> <p>Updated: 10/01/2024</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	0208	PEDMARK	sodium thiosulfate	Yes, through the Plan Pharmacy Services.	PEDMARK (sodium thiosulfate)	PEDMARK (sodium thiosulfate)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0904	PEMFEXY	penmetrexed	Yes, through the Plan Pharmacy Services	PEMFEXY (penmetrexed)	PEMFEXY (penmetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09247	PEPAXTO	(melphalan flufenamide	Yes, through the Plan Pharmacy Services	PEPAXTO* (melphalan flufenamide)	PEPAXTO* (melphalan flufenamide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0906	PERJETA	pertuzumab	Yes, through the Plan Pharmacy Services	PERJETA (pertuzumab)	PERJETA (pertuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1390	PIASKY	crizotinib-akz	EFFECTIVE 11/01/2024. Yes, through the Plan Pharmacy Services	Crizotinib Akzo	Crizotinib Akzo	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	PHESGO (pertuzumab)	PHESGO (pertuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09099	PLUVICTO	lumectin Lu 177 vipivotide tetraxetan	Yes, through the Plan Pharmacy Services	PLUVICTO (lumectin Lu 177 vipivotide tetraxetan)	PLUVICTO (lumectin Lu 177 vipivotide tetraxetan)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0909	POLIVY	polatuzumab vedotin-piq	Yes, through the Plan Pharmacy Services	POLIVY (polatuzumab vedotin-piq)	POLIVY (polatuzumab vedotin-piq)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11203	POMBUTU	cpagluxotinidase alpha-afga	Yes, through the Plan Pharmacy Services	POMBUTU (cpagluxotinidase alpha-afga)	POMBUTU (cpagluxotinidase alpha-afga)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09295	PORTRAZZA	rectutumab	Yes, through the Plan Pharmacy Services	PORTRAZZA (rectutumab)	PORTRAZZA (rectutumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09204	POTLEGO	roganmilzumab-tpkic	Yes, through the Plan Pharmacy Services	POTLEGO (roganmilzumab-tpkic)	POTLEGO (roganmilzumab-tpkic)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11459	PRIVIGEN (IVIG), IMMUNE GLOBULIN	privigen	Yes, through the Plan Pharmacy Services	PRIVIGEN (IVIG)	PRIVIGEN (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Pharmacy	0885	PROCRIT - non-preferred	epoetin alfa, (for non-esrd use)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	PROCRIT (epoetin alfa)	PROCRIT (epoetin alfa)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	0885, 04082	PROCRIT	epoetin alfa, (for non-esrd use)	As of 01/01/2023, Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epegen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	PROCRIT (epoetin alfa, (for non-esrd use))	PROCRIT (epoetin alfa)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	09015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services	PROLEUKIN (aldesleukin)	PROLEUKIN (aldesleukin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	08097	PROLIA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	PROLIA (denosumab)	PROLIA (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	02043	PROVENGE	tipivulcei-T	Yes, through the Plan Pharmacy Services	PROVENGE (tipivulcei-T)	PROVENGE (tipivulcei-T)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	11304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	QALSODY** (tofersen)	QALSODY** (tofersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11301	RADICAVA	edaravone	Yes, through the Plan Pharmacy Services. Restricted to a Neurology specialist with authorization.	RADICAVA (edaravone)	RADICAVA (edaravone)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0896	REBLOZYL	luspatercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	REBLOZYL (luspatercept-aamt)	REBLOZYL (luspatercept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05125	RELUKO	fligrastrin-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarzio are the preferred Fligrastrin products and do not require prior authorization. Neupogen, Retacrit and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RELUKO (fligrastrin-ayow)	RELUKO (fligrastrin-ayow)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11745	REMICADE - non preferred	infliximab	Yes, through the Plan Pharmacy Services after failed trial of RENLEFOS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	REMICADE (infliximab)	REMICADE (infliximab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	03285	REMODULIN IV	treprostinil	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.	REMODULIN IV (treprostinil)	REMODULIN IV (treprostinil)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05104	RENFLEXIS - preferred infliximab product	infliximab-abda	As of 10/01/2019 Prior authorization for the preferred infliximab product will only require provider attestation to an appropriate indication through the Plan Pharmacy Services. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	RENFLEXIS (infliximab-abda)	RENFLEXIS (infliximab-abda)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Pharmacy	05105	RETACRIT - preferred	epoetin alfa-epbx	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	RETACRIT (epoetin alfa-epbx)	RETACRIT (epoetin alfa-epbx)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	05106	RETACRIT	epoetin alfa-epbx	As of 01/01/2023, Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epegen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RETACRIT (epoetin alfa-epbx)	RETACRIT (epoetin alfa-epbx)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	07311	RETSERT	fluciclonolone acetamide intravitreal implant	None. Not Covered.	RETSERT (fluciclonolone acetamide intravitreal implant)	RETSERT (fluciclonolone acetamide intravitreal implant)	
Medical	13590	BETHYMIC	allogenic processed thymus tissue agdc	Yes, through the Plan Pharmacy Services	BETHYMIC (allogenic processed thymus tissue agdc)	BETHYMIC (allogenic processed thymus tissue agdc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals
Medical	0950, C9399	REVOCOV	elapagademase-hlr	Yes, through the Plan Pharmacy Services.	REVOCOV** (elapagademase-hlr)	REVOCOV** (elapagademase-hlr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitas.	RHOPRESSA (netarsudil)	RHOPRESSA (netarsudil)	
Medical	05123	RIABNI	rituximab-arx	As of 01/01/2023, Rituxane and Truxima are the preferred Rituximab products and does not require prior authorization. Riabni and Riuxan prior authorization is required. Please see medical policy for criteria	RIABNI (rituximab-arx)	RIABNI (rituximab-arx)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	13490	RIVFLOZA	redoiran	Yes, through the Plan Pharmacy Services	RIVFLOZA (redoiran)	RIVFLOZA (redoiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09312	RITUXAN	rituximab	As of 01/01/2023, Rituxane and Truxima are the preferred Rituximab products and does not require prior authorization. Riabni and Riuxan prior authorization is required. Please see medical policy for criteria	RITUXAN (rituximab)	RITUXAN (rituximab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	09311	RITUXAN HYCELA	rituximab and hyaluronidase human	Yes, through the Plan Pharmacy Services	RITUXAN HYCELA (rituximab and hyaluronidase human)	RITUXAN HYCELA (rituximab and hyaluronidase human)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	09312	RITUXIMAB IV	rituxan, truxima, nusencen-riabni	Yes, through the Plan Pharmacy Services	RITUXIMAB IV (rituxan, truxima, nusencen-riabni)	RITUXIMAB IV (rituxan, truxima, nusencen-riabni)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.
Medical	13412	RICTAVIAN	haloctenogene mesoporphyrin-oxal	Yes, through the Plan Pharmacy Services	RICTAVIAN** (haloctenogene mesoporphyrin-oxal)	RICTAVIAN** (haloctenogene mesoporphyrin-oxal)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.

INJECTABLE MEDICINES		PREVEA360 health plan commercial/member/plan						
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD	
				SEARCH TIPS: 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 Navitas. Updated: 10/01/2024				
Medical	J1449	ROLVEDON	efapegrastim-ansf	Yes, through the Plan Pharmacy Services.	ROLVEDON™ (efapegrastim-ansf)	ROLVEDON™ (efapegrastim-ansf)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals	
Medical	Q5119	RUXIENCE	rituximab-pwvr	As of 02/01/2023: Ruxience and Truxima are the preferred Rituximab products and does not require prior authorization. Rituxi and Rituxa prior authorization is required. Please see medical policy for criteria	RUXIENCE (rituximab-pwvr)	RUXIENCE (rituximab-pwvr)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.	
Medical	J9061	RYBREVANT	amivantamab-vmjw	Yes, through the Plan Pharmacy Services	RYBREVANT (amivantamab-vmjw)	RYBREVANT (amivantamab-vmjw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2998	RYPLAZIM	plasmingogen, human-tymh	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Hematologist or MD specializing in plasmingogen deficiency (PLGD) with authorization.	RYPLAZIM (plasmingogen, human-tymh)	RYPLAZIM (plasmingogen, human-tymh)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9333	RYSTIGGO	rozanoliszumab-noll	Yes, through the Plan Pharmacy Services	RYSTIGGO® (rozanoliszumab-noll)	RYSTIGGO® (rozanoliszumab-noll)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9999	RYTELO	imebelstat	Yes, through the Plan Pharmacy Services	Ryteb (imebelstat)	Ryteb (imebelstat)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD	
Medical	J9361	RYZNEUTA	efbemaleograstim alfa-vvuv	Yes, through the Plan Pharmacy Services	RYZNEUTA (efbemaleograstim alfa-vvuv)	RYZNEUTA (efbemaleograstim alfa-vvuv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Pharmacy		SANDOSTATIN	octreotide	Yes, through Navitas. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or Gastroenterologist specialist with authorization.		SANDOSTATIN (octreotide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2353	SANDOSTATIN LAR	octreotide suspension	Yes, through the Plan Pharmacy Services	SANDOSTATIN (octreotide suspension)	SANDOSTATIN LAR (octreotide suspension)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2354	SANDOSTATIN	octreotide suspension (non-depot form)	Yes, through the Plan Pharmacy Services	SANDOSTATIN (octreotide suspension (non-depot form))	SANDOSTATIN (octreotide suspension (non-depot form))	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Services	SANDOZ (pemetrexed)	SANDOZ (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J0491	SAPHNELO	janfrolumab-fria	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	SAPHNELO (janfrolumab-fria)	SAPHNELO (janfrolumab-fria)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9227	SARCLISA	latsustumab-irfc	Yes, through the Plan Pharmacy Services	SARCLISA (latsustumab-irfc)	SARCLISA (latsustumab-irfc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
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.	SCENESSE (afamelanotide)	SCENESSE (afamelanotide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Pharmacy		SELF-ADMINISTERED DRUGS		PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.	SELF-ADMINISTERED DRUGS			
Medical	J2502	SIGNIFOR LAR	pasireotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist specialist with authorization.	SIGNIFOR LAR (pasireotide)	SIGNIFOR LAR (pasireotide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J1602	SIMPONI ARIA	golimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (golimumab)	SIMPONI ARIA (golimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Pharmacy	J1602	SIMPONI ARIA	golimumab	Yes, through Navitas. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (golimumab)	SIMPONI ARIA (golimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical		SITE OF SERVICE		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.	SITE OF SERVICE			
Medical	J2327	SKYRIZI IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterology specialist with authorization.	SKYRIZI IV (risankizumab IV)	SKYRIZI IV (risankizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J3590	SKYSONA	elivaldogene autotemcel	Yes, through the Plan Pharmacy Services.	SKYSONA® (elivaldogene autotemcel)	SKYSONA® (elivaldogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J1300	SOLIRS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Neuro-Ophthalmologist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	SOLIRIS (eculizumab)	SOLIRIS (eculizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD	
Medical	J1930	SOMATULINE	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	SOMATULINE (lanreotide depot)	SOMATULINE (lanreotide depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J1747	SPEVIGO	spepsimab	Yes, through the Plan Pharmacy Services	SPEVIGO® (spepsimab)	SPEVIGO® (spepsimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2326	SPINRAZA	nusinersen	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurology specialist with expertise in SMA treatment with authorization.	SPINRAZA (nusinersen)	SPINRAZA (nusinersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	50013	SRAVATO	esketamine	Yes, through Plan Pharmacy Services	SRAVATO (esketamine)	SRAVATO (esketamine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J3358	STELARA (IV)	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	STELARA IV (ustekinumab)	STELARA IV (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Pharmacy	J3358	STELARA (SC)	ustekinumab	Yes, through Navitas. Restricted to an Gastroenterology specialist with authorization.	STELARA SC (ustekinumab)	STELARA SC (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J3590	STIMUFEND	pegfilgrastim-pbbk	EFFECTIVE 01/01/2024: FULPHILA and NIVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTEND AND FULPHILA before coverage of Neulasta. UDENACIA, FYLENTRA, STIMUFEND and ZIEXTENDZ require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	STIMUFEND (pegfilgrastim-pbbk)	STIMUFEND (pegfilgrastim-pbbk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Pharmacy		Sublingual Immunotherapy (SIT) for ALLERGY products	GRASSTEK (Timothy grass pollen allergen extract), ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollen allergen extract), ODCATRA (House Dust Mite allergen extract)	Yes, through Navitas. 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	SIT for Allergy Products			

INJECTABLE MEDICINES		PREVEA 360 health plan commercial member plan						
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD	
				SEARCH TIPS: 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 Prevea 360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas. Updated: 10/01/2024	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.			
Medical	J7321	SUPARTZ FX - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexa, Gelysyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	SUPARTZ FX (hyaluronan or derivative)	SUPARTZ FX (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO	
Medical	J1627	SUSTOL	granisetron extended-release	Yes, through the Plan Pharmacy Services	SUSTOL (granisetron extended-release)	SUSTOL (granisetron extended-release)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2781	SYFOVRE	pegcetacoplan	No. Please see medical policy for criteria.	SYFOVRE (pegcetacoplan)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2860	SYLVANT	siltuximab	Yes, through the Plan Pharmacy Services	SYLVANT (siltuximab)	SYLVANT (siltuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	90378	SYNAGIS	pallivumab	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.	SYNAGIS (pallivumab)	SYNAGIS (pallivumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.	
Medical	J7325	SYNVISC - preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexa, Gelysyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	SYNVISC (hyaluronan or derivative)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO	
Medical	J7325	SYNVISC ONE - preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexa, Gelysyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	SYNVISC ONE (hyaluronan or derivative)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO	
Medical	J3055	TALVEY	talquetamab-tqys	Yes, through the Plan Pharmacy Services	TALVEY** (talquetamab-tqys)	TALVEY** (talquetamab-tqys)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	Q2063	TECARTUS	brexucabtagene autoleucel	Yes, through the Plan Pharmacy Services	TECARTUS (brexucabtagene autoleucel)	TECARTUS (brexucabtagene autoleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9022	TECENTRIQ	atezolizumab	Yes, through the Plan Pharmacy Services	TECENTRIQ (atezolizumab)	TECENTRIQ (atezolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	C9148	TECVAYI	teclistamab-cqyv	Yes, through the Plan Pharmacy Services	TECVAYI (teclistamab-cqyv)	TECVAYI (teclistamab-cqyv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
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.	TEPEZZA (teprotumumab-trbw)	TEPEZZA (teprotumumab-trbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9314	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	TEVA (pemetrexed)	TEVA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9999, C9399	TEVMBRA	tislelizumab-jqyr	Yes, through the Plan Pharmacy Services	TEVMBRA (tislelizumab-jqyr)	TEVMBRA (tislelizumab-jqyr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2356	TEZSPIRE	tezepelumab	Yes, through the Plan Pharmacy Services	TEZSPIRE (tezepelumab)	TEZSPIRE (tezepelumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9273	TIVDAK	tivotumab vedotin-tfvy	Yes, through the Plan Pharmacy Services	TIVDAK (tivotumab vedotin-tfvy)	TIVDAK (tivotumab vedotin-tfvy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	Q5133	TOPIDENCE	tocilizumab-bawi	Yes, through the Plan Pharmacy Services	TOPIDENCE (tocilizumab-bawi)	TOPIDENCE (tocilizumab-bawi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	Q5116	TRAZIMERA	trastuzumab-ayyp	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Opdivi, Karlini and Dituzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	TRAZIMERA (trastuzumab-ayyp)	TRAZIMERA (trastuzumab vedotin-tfvy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J9033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services	TREANDA (bendamustine)	TREANDA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J7332	TRILURON - preferred	sodium hyaluronate	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred products. No Prior Authorization needed for preferred product	TRILURON (sodium hyaluronate)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO	
Medical	J7329	TRIVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexa, Gelysyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	TRIVISC (hyaluronan or derivative)	TRIVISC (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO	
Medical	J9317	TRODELVY	sacituzumab govitecan-hzly	Yes, through the Plan Pharmacy Services	TRODELVY (sacituzumab govitecan-hzly)	TRODELVY (sacituzumab govitecan-hzly)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J1746	TROGARZO	ibalizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Infectious Disease specialist with authorization.	TROGARZO (ibalizumab)	TROGARZO (ibalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	Q5115	TRUXIMA	rituximab-abbs	As of 01/01/2023: Ruixence and Truxima are the preferred Rituximab products and does not require prior authorization. Riabni and Rituxan prior authorization is required. Please see medical policy for criteria	TRUXIMA (rituximab-abbs)	TRUXIMA (rituximab-abbs)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.	
Medical	Q5134	TRUKO	rituximab	Yes, through the Plan Pharmacy Services	TRUKO (rituximab)	TRUKO (rituximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	J2323	TYSABRI	natalizumab injection	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	TYSABRI (natalizumab)	TYSABRI (natalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	C9149	TZIELD	teplizumab-mxwv	Yes, through the Plan Pharmacy Services.	TZIELD (teplizumab-mxwv)	TZIELD (teplizumab-mxwv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	
Medical	Q5111	UDENYCA	pegfilgrastim-cbqv	EFFECTIVE 01/01/2024: FULLPHLA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZENXEND and FULLPHLA before coverage of Udenyca. UDENYCA, FULNETRA, STIMUFEND and ZIEXTEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	UDENYCA (pegfilgrastim-cbqv)	UDENYCA (pegfilgrastim-cbqv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs	

INJECTABLE MEDICINES		SEARCH TIPS:		PREVEA360 health plan commercial member plan			
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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	1103	ULTOMIRIS	revulsimab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a hematology, Oncology, or Immunology specialist with authorization.	ULTOMIRIS (revulsimab)	ULTOMIRIS (revulsimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11823	UPLIZNA	imebilizumab-ctdon	Yes, through the Plan Pharmacy Services	UPLIZNA® (imebilizumab-ctdon)	UPLIZNA® (imebilizumab-ctdon)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	18499	UPTRAVI-IV	selexipag	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI-IV (selexipag)	UPTRAVI-IV (selexipag)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		UPTRAVI	selexipag	Yes, through Navitas. Restricted to (in at least consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI (selexipag)	UPTRAVI (selexipag)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12777	VABYSMO	faricimab-ovoa	Yes, through the Plan Pharmacy Services	VABYSMO (faricimab-ovoa)	VABYSMO (faricimab-ovoa)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	19303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	VECTIBIX (panitumumab)	VECTIBIX (panitumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	VELCADE (bortezomib)	VELCADE (bortezomib)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	05129	VEGELMA	bevacizumab-afdf	As of 08/01/2024, Zivabev is the preferred bevacizumab product and does not require prior authorization. Avastin, Aylmys, Mvsi and Vegalma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	VEGELMA (bevacizumab-afdf)	VEGELMA (bevacizumab-afdf)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	11756	VENOFER - preferred	iron sucrose	As of 08/01/2022, VENOFER, INFED, FERBLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC IV/IV are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	VENOFER (iron sucrose)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19376	VEOPOZ	pozelimab-bbfg	Yes, through the Plan Pharmacy Services	VEOPOZ® (pozelimab-bbfg)	VEOPOZ® (pozelimab-bbfg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11427	VILTEPSO	viltolarsen	None. Not Covered.	VILTEPSO (viltolarsen)		
Medical	11323	VIMZIM	elisuifase (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.	VIMZIM (elisuifase)	VIMZIM (elisuifase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	17321	VISCO-3 - non-preferred	hyaluronan or derivative	As of 08/01/2022, HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexa, Gelym-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Sugartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	VISC0-3 (hyaluronan or derivative)	VISC0-3 (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	19999	VIVIMUSTA	bendamustine	EFFECTIVE 05/01/2023. Yes, through the Plan Pharmacy Services	VIVIMUSTA (bendamustine)	VIVIMUSTA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13385	VPRIV	velaglucerase alfa (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX with authorization.	VPRIV (velaglucerase alfa)	VPRIV (velaglucerase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13032	VYEPTI	eptinezumab-jjmr	Yes, through the Plan Pharmacy Services	VYEPTI (eptinezumab)	VYEPTI (eptinezumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13401	VYLVEK	beremagene gepargene-ovdt	Yes, through the Plan Pharmacy Services	VYLVEK™ (beremagene gepargene-ovdt)	VYLVEK™ (beremagene gepargene-ovdt)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11429	VYONDYS 52	golodirsen	None. Not Covered.	VYONDYS 52 (golodirsen)		
Medical	19332	VYVGART	efgartigimod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	VYVGART (efgartigimod)	VYVGART (efgartigimod alfa-fcab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19334	VYVGART-HYTRULO	efgartigimod alfa-fcab and hyaluronidase-qyfc	Yes, through the Plan Pharmacy Services.	VYVGART™ Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qyfc)	VYVGART™ Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qyfc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19153	VYXEOS	daunorubicin and cytarabine - liposome	Yes, through the Plan Pharmacy Services	VYXEOS (daunorubicin and cytarabine - liposome)	VYXEOS (daunorubicin and cytarabine liposome)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13590	WEZLANA	ustekinumab	Yes, through the Plan Pharmacy Services	WEZLANA (ustekinumab)	WEZLANA (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13590	WYOST	denosumab	Yes, through the Plan Pharmacy Services	WYOST (denosumab)	WYOST (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	11558	XEMBYF (SCIG)	Immune globulin	Yes, through the Plan Pharmacy Services	XEMBYF (SCIG)	XEMBYF (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10218	XENPOZYME	olipudase alfa	Yes, through the Plan Pharmacy Services.	XENPOZYME™ (olipudase alfa)	XENPOZYME™ (olipudase alfa)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	10588	XEOMN	incobotulinumtoxinA	No prior authorization is required.	XEOMN (incobotulinumtoxinA)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	10897	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.	XGEVA (denosumab)	XGEVA (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	13299	XIPERE	triamcinolone acetonide injectable suspension	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an ophthalmologist specialist with authorization.	XIPERE (triamcinolone acetonide injectable suspension)	XIPERE (triamcinolone acetonide injectable suspension)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	12357	XOLAIR	omalizumab, 5mg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	XOLAIR (omalizumab)	XOLAIR (omalizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	19228	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services	YERVOY (ipilimumab)	YERVOY (ipilimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	02041	YESCARTA	axicabtagene ciloleucel	Yes, through the Plan Pharmacy Services	YESCARTA (axicabtagene ciloleucel)	YESCARTA (axicabtagene ciloleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

INJECTABLE MEDICINES				PREVEA360 Health Plan Member Information			
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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9352	YONDELIS	trabectedin	Yes, through the Plan Pharmacy Services	YONDELIS (trabectedin)	YONDELIS (trabectedin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5101	ZARXIO	figlirastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Figlirastim products and do not require prior authorization. Neupogen, Rebuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ZARXIO (figlirastim-ayow)	ZARXIO (figlirastim-ayow)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0256	ZEMARA/PROLASTIN-C	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to a Pulmonologist specialist with authorization.	ZEMARA/PROLASTIN-C (alpha-1-proteinase inhibitor)	ZEMARA/PROLASTIN-C (alpha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	H9223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	ZEPZELCA (lurbinectedin)	ZEPZELCA (lurbinectedin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5120	ZEXTENZO	pegfiglirastim-bmez	EFFECTIVE 01/01/2024: FULPHILA and NVVPRISA are the preferred Pegfiglirastim products and do not require prior authorization. Must have a failed trial of ZEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYTA, FYLNETRA, STIMUFEND and ZEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	ZEXTENZO (pegfiglirastim-bmez)	ZEXTENZO (pegfiglirastim-bmez)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5118	ZIRABEV	bevacizumab-bwr	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Aylmsys, Mvasi and Vegalma prior authorization is required through the Plan Pharmacy Services. **Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYNAYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	ZIRABEV (bevacizumab-bwr)	ZIRABEV (bevacizumab-bwr)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	C9399, J3590	ZOLGENSMA	onasemnogene apegarvovic-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.	ZOLGENSMA (onasemnogene apegarvovic-xioi)	ZOLGENSMA (onasemnogene apegarvovic-xioi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9359	ZYNLONTA	loncastuximab tesirine	Yes, through the Plan Pharmacy Services	ZYNLONTA (loncastuximab)	ZYNLONTA (loncastuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3393	ZYNTEGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	ZYNTEGLO® (betibeglogene autotemcel)	ZYNTEGLO® (betibeglogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J9345	ZYNZ	retifanlimab-dlwr	EFFECTIVE 08/01/2023. Yes, through the Plan Pharmacy Services	ZYNZ (retifanlimab-dlwr)	ZYNZ (retifanlimab-dlwr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
			These drugs are all medical injectable drugs, and are not listed on the Prevea360 Health Plan drug formulary. The on-line formulary only lists drugs covered by the pharmacy benefit.	There are claim specific edits for many of these drugs. The edits limit the use 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.		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 (PAT) 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 PAT Committee approval, they may submit an exception to coverage form request.	
			J3590 and J3490 are miscellaneous codes used for drugs that do not have a code assigned by the FDA. New drugs may take between 12-18 months to get a code assigned	Any drug submitted under either J3590 or J3490 with a cost of \$750 or greater will be reviewed post-claim by Prevea360 Health Plan.	It is recommended that any use of the miscellaneous codes be pre-approved ahead of time through Prevea360 Health Plan Utilization Management, especially for off-label uses from FDA indications.	Pharmacy Drug Exception to Coverage Request Form Medical Injectable Drug Exception to Coverage Request Form	