						PREVEA360		
		INJECTA	ABLE MEDICINES		SEARCH TIPS:	The alth plan-		
Mathematical   Math		Updated: 05/01/2024	benefit are covered, not covered, or coverage review of any drug lister	r not yet reviewed and whether a prior authorization is required. Fo d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy	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		
Part	Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Control	Medical	Q2055	ABECMA	Idecabtagene vicieucel	Yes, through the Plan Pharmacy Services	ABECMA (Idecabtagene vicleucel)	ABECMA (ledcabtagene vicleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Part	Medical	19264	ABRAXANE	paclitaxel protein bound	Yes, through the Plan Pharmacy Services	ABRAXANE (paciltaxel protein-bound particles)	ABRAXANE (pacitizate) 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, II, MO.
Manual	Medical	19296	ACCORD	pemetrexed	Yes, through the Plan Pharmacy Services	ACCORD (pemetrexed)	ACCORD (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
March   Marc	Medical	13262	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)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Manual	Pharmacy	13262	ACTEMRA (SC)	tocilizumab		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
Mathematical Content	Pharmacy	10800	ACTHAR GEL	repository corticotripin injection	PHARMACY BENEFIT ONLY. Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		ACTHAR GEL (repository conticotripin injection)	
Mathematical   Math	Medical	J0791	ADAKVEO	crizanlizumab-tmca		ADAKVEO (crizanlizumab-tmca)	ADAKVEO (crizanlizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
March   Marc	Medical	J9042	ADCETRIS	brentuximab vedotin	Yes, through the Plan Pharmacy Services	ADCETRIS (brentuximab vedotin)	ADCETRIS (brentuximab vedotin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Second   S	Medical	19029	ADSTILADRIN	nadofaragene firadenovec-vncg	Yes, through the Plan Pharmacy Services	ADSTILADRIN (nadofaragene firadenovec-vncg)	ADSTILADRIN (nadofaragene firadenovec-vnog)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs.
	Medical	J0172	ADUHELM	aducanumab	None. Not Covered.	ADUHELM (aducanumab)		
Part	Medical	C9167	ADZYNMA	ADAMTS13, recombinant-krhn	Yes, through the Plan Pharmacy Services	ADZYNMA (ADAMTS13, recombinant-krhn)	ADZYNMA (ADAMTS13, recombinant-krhn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Section   Sect	Medical	J1454	AKYNEZO	fosbetupitant/palonosetron	Yes, through the Plan Pharmacy Services	AKYNEZO (fosbetupitant/palonosetron)	AKYNEZO (fosbetupitant/palonosetron)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
March   Marc	Medical	J1931	ALDURAZYME	laronidase	consultation with) medical geneticist or other prescriber specialized in	ALDURAZYME (Jaronidase)	ALDURAZYME (laronidase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Section 1	Medical	19305	ALIMTA	pemetrexed	Yes, through the Plan Pharmacy Services	ALIMTA (pernetrexed)	ALMITA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
A MINISTER STATE OF THE PROPERTY OF THE PROPER	Medical	19057	ALIQOPA	copanlisib	Yes, through the Plan Pharmacy Services	ALIQOPA (copanisib)	AUQOPA (copanlisib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologiculs for drugs
Heavy Services and the services of the service	Medical	12469	ALOXI	palonosetron	EFFECTIVE 02/01/2023 No Prior Authorization is Required	ALOXI (palonosetron)		
Market of the Control	Medical	Q5126	ALYMSYS	bevacizumab	does not require prior authorization. Avastin, Alymays, Mxssl and Vegzelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacitumab is not required when used for ophtalmological indications.*** See the ALYMSYS (bevacitumab) Policy for a list of applicable ophthalmological	ALYMOYS (bevicoumab)	ANTANYS (benaclaumab)	MAPD Fror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Artisdictions WI, II, MO.
Mode 277 August 1972 August 19	Medical	J1426	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.
Hold (73, 173, 173, 173, 173, 173, 173, 173, 1	Medical	19999	AMTAGVI	lifileucel	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services			
The control of the co	Medical	10225	AMVUTTRA	viutisiran	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
Fig. 2753, 1755.  And Conformation for the Teach of the T	Medical	J7180, J7181, J7188,	Clotting Factors (Coagadex, RiaSTAP, Vonvendi, Corifact, Tretten, Obizur, Novoseven RT,	(human), von Willebrand Factor (recombinant), factor XIII concentrate (human), coagulation factor XIII A-subunit (recombinant), antihemophilic factor (porcine), coagulation factor VIIa (recombinant), antiinhibitor coagulant complex,	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTISEMOPHRILA FACTOR AND CLOTTING FACTORS	ANTHEMOPHILIA 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
1733_1774_178_178_1   1734_17	Medical	J7186, J7187, J7190, J7192, J7204, J7205, J7207, J7208, J7209,	(Novoeight, Wilate, Xyntha, Alphanate, Humate-P, Hemofil M, Koate-DVI, Advate, Kogenate FS, Recombinate, Esperoct, Afstyla, Eloctate, Adynovate, Jivi, Nuwiq,	factor/coagulation factor Viti complex (human), archemophilic factor (recombinant), archemophilic factor (recombinant), archemophilic factor (recombinant), archemophilic factor (human), arthemophilic factor (human), arthemophilic factor (recombinant), archemophilic factor (recombinant) applicated, arthemophilic factor (recombinant) applicated, arthemophilic factor (recombinant) applicated, arthemophilic factor (recombinant) applicated, arthemophilic factor (recombinant) applicated and, archemophilic factor	Yes, through Den Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTHEMOPHISIC FACTORVIE	ANTHEMOTRES CENTRAL VIEW	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical ADS6 ARAAST NP alpha 5 proteinase inhibitor (human) Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.  Medical ADS81 ARAAST NP durportina inhibitor (human) Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.  Medical ADS81 ARAAST NP durportina inhibitor (human) Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.  MARKET Restriction inhibitor (human) MARKET Restriction inhibitor (human) (hum	Medical		(Alphanine SD, Mononine, Profilnine, Benefix, Ixinity, Rixubis, Alprolix, Idelvion,	complex, coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), fc fusion protein, coagulation factor IX (recombinant), human, coagulation	Yes, through Dean Health Plan Utilization Management Department. Restricted to Hematology specialist with authorization.	ANTHEMPHILIC FACTOR IX	ANTHEMOPHIC FACTOR IX	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical 10831 ARANESP derbeposetin alpha Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy services requiring a failed trial or Ves, through the Plan Pharmacy se	Medical	12277	APHEXDA	mothafortide	Yes, through the Plan Pharmacy Services	APPEXIXA (motivafortide)	APHEXDA (motivafortide)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical DB31 ADAREP derbegoetin siphs Yes, through the Plan Tharmacy services ABASET (Independent siphs)  Yes, through the Plan Tharmacy Services requiring a filled trial or yes, through the Plan Tharmacy Services requiring a filled trial or yes, through the Plan Tharmacy Services requiring a filled trial or yes.	Medical	10256	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		ARANSEP (darbepoetin alpha)	ARANSEP (darbepoetin alpha)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
	Medical	C9072	ASCENIV (IVIG) - non-preferred	immune globulin (Human)		ASCENIV (IVIG)	ASCENIW (IVIG)	MAPO 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.

	INJECTABLE MEDICINES				PREVEA360		
		This reference guide is a partial	l listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	centered around yes		
		benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review or ayout, listed as not covered, please complete the Exception to Coverage form found on the Prevea360 website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.		This is a large document, but you can search quickly and easily by clicking or type in the name of drug you want to locate. If you do not know the correc n	n the binocular icon on your toolbar. It will then display a search box for you to it spelling, you can start your search by entering just the first few letters of the arme		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19035	AVASTIN	bevacizumab	As of 30/1/2024: Zirabev is the preferred Bevaciumab product and does not require prior authorization. Avastin, Alymays, Mussi and Vegetima prior authorization is required through the Plan Pharmacy Services. "**Prior authorization for bevaciumab is not required whe used for ophthalmological indications."* See the ALYMOSIO (bevacicumab) Policy for a list of applicable ophthalmological diagnoses.	n AVASTIN (bevacioumab)	AVASTIN (bevacioumsb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Artisdictions Wt, II, MO.
Medical	Q5121	AVSOLA - non-preferred	infliximab-axxq	Yes, through the Plan Pharmacy Plan after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialists with authorization.	AVSOLA - non-preferred (infliximals-axis)	AVSOLA (influimab-awa)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictons WI, II, MO.
Medical	A9590	AZEDRA	iobenguane I-131	Yes, through the Plan Pharmacy Services	AZEDRA (iobenguane-l-131)	AZEDRA (lobenguanel -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)	<u>BAVENCIO (avelumab)</u>	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	19036	BELRAPZO	bendamustine	Yes, through the Plan Pharmacy Services	8ELRAPZO (bendamustine)	BELPRAZO (bendamustine)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19034	BENDEKA	bendamustine	Yes, through the Plan Pharmacy Services	BENDEKA (bendamustine)	BENDEKA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10490	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)	SENLYSTA IV (belimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pvb. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	10490	BENLYSTA (SC)	belimumab	Yes, through Navitus. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	BENLYSTA SC (belimumab)	BENLYSTA SC (beilmumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J0179	BEOVU	brolucizumab-dbll	None. Please see attached policy for criteria.	BEOVU (broluctrumab dbll)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J0179	BEOVU	brolucizumab-dbll	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	19229	BESPONSA	inotuzumab ozogamicin	Yes, through the Plan Pharmacy Services	BESPONSA (inotuzumab ozogamicin)	BESPONSA (inotuzumab-dbll)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1556	BIVIGAM (IVIG), IMMUNE GLOBULIN	immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	BIVIGAM (VIG)	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, II, MO.
Medical	19039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services	BLINCYTO (blinatumomab)	BLINCYTO (blinatumomab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19322	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	BLUEPOINT (pemetrexed)	BLUEPOINT (pemetrexed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19044	BORTEZOMIB	bortezomib - preferred	Yes, through the Plan Pharmacy Services	BORTEZOMIB.	BORTEZOMIB	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	10585	вотох	onabotulinumtoxin	No prior authorization is required.	BOTOX (onabotulinumtoxinA)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for jurisdictions Wi, II, MO
Medical	Q2054	BREYANZI	lisocabtagene maraleucel	Yes, through the Plan Pharmacy Services	SREYANZI (lisocabtagene maraleucel)	BREYANZI (lisocabtagene maraleuce!)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	J2329	BRIUMVI	ublituximab-xily	Yes, through the Plan Pharmacy Services	BRIUMVI™ (ublituximab-xiiy)	BRIUMVI™ (ublituximab siiy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0567, C9014	BRINEURA	ceriponase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the Late infantile Ceroid lipofucinosis with authorization.	BRINEURA (cerli ponase alfa)	BRINEURA (cerliponase aifa)	MAPO Prior Authorisation needed audined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5124	BYOOVIZ	ranibizumab	No. No prior authorization required	SYOOVIZ™ (rainibizumab)	BYOOVIZ*** (rainibizumab)	MARTO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for surisdictions Wi, II, MO
	Q5124	BYOOVIZ	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	19043	CABAZITAXEL	Cabazitaxel (Jevtana)	Yes, through the Plan Pharmacy Services	CABAZITAXELIJevtana)	CABAZITAXEL(Jevtana)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C2056	CARVYKTI	ciltacabtagene autoleucel	Yes, through the Plan Pharmacy Services	CARVYKTI (ciltacabtagene autoleucel)	CARVYKTI (citacabtagene autoleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	CASGEVY	exagamglogene autotemcel	Yes, through the Plan Pharmacy Services	CASGEVY (exagamglogene autotemcel)	CASGEVY (exagamglogene autotemcel)	
Medical	J1786	CEREZYME	imiglucerase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX. with authorization.	CEREZYME (Imiglucerase) (Intravenous)	CEREZYME (imiglucerase) (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	No. No prior authorization required	CIMERU (canbizumab)		MAPD Prior Authorization based on Mational Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
	Q5128	CIMERLI	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Seen	
Pharmacy	10717	CIMZIA	certolizumab pegol	PHARMACY BENEFIT ONLY. Verify prior authorization requirements b accessing the members formulary.	y		
Medical	12786	CINQAIR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology Allergy, and Immunology specialist with authorization.	CMQAIR (redizumab)	CINQAIR (redizumab)	MAM'S Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 500 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 (somatuline depot)	CIPLA (lanreotide depot)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	19286	COLUMVI	glofitamab-gxbm	Yes, through the Plan Pharmacy Services.	COLUMVI** (glofitamab-gobm)	COLUMVI** (glofitamab-gabm)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drug

	INJECTA	ABLE MEDICINES			PREVEA360		
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Benefit	Updated: 05/01/2024 J Code	Brand Names		Prior Authorization or Restrictions	D.P.:	Discount of the France	
Medical	J1448	COSELA	Generic names	Yes, through the Plan Pharmacy Services	Policy  COSELA (trilacidib)	Prior Authorization Form  COSELA (trilaciclib)	MAPD  MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	C9166	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	COSENTYX IV (secukinumab)	COSENTYX IV (secukinumah).	
Medical	10584	CRYSVITA	burosumab	Yes, through the Plan Pharmacy Services. Restricted to Endocrinologist, Nephrologist, Medical Geneticist, or Specialist experienced in treatment of Metabolic Bone Disorders with authorization.	CRYSVITA (burosumab)	CRYSVITA (burosumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	J1555	CUVITRU (SCIG), IMMUNE GLOBULIN	immune globulin (cuvitru)	Yes, through the Plan Pharmacy Services	CIMITRUISCIGI	CLWTRU (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	19308	CYRAMZA	ramucirumab	Yes, through the Plan Pharmacy Services	CYRAMZA (ramucirumab)	CYRAMZA (ramucirumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	19348	DANYELZA	naxitamab	Yes, through the Plan Pharmacy Services	DANYEZA (navitamab).	DANYFLZA (navitamab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Polity Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drug
Medical	J9145	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services	DARZALEX (daratmumab)	DARZALEX (daratumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	J9144, C9062	DARZALEX FASPRO	daratumumab/hyaluronidase-fihj	Yes, through the Plan Pharmacy Services	DARZALEX FASPRO (daraumumab/hyaluronidase-fih()	DARZALEX FASPRO (daratumumab/hyaluronidase-fihi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drug
Medical	10589	DAXXIFY	daxibotulinumtoxinA	None. Please see attached policy for criteria.	DAXXIFY* (daxibotulinumtoxinA)	DAXXIFY* (daxibotulinumtoxinA)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drug
Medical	J7318	DUROLANE - non-preferred	sodium hyaluronate	As of OR/OL/2022-HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURDN will be the preferred product. Coverage of DUROLANE requires a falled trail of a preferred product. Prior authorisation is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorisation.	OURDIANE - non-preferred (sodium hysluronate)	QURICKANT (loadium hyalumnate)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ECDs), and Local Coverage Articles (ECAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	10586	DYSPORT	abobotulinumtoxinA	No prior authorization is required.	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, II, MO.
Medical	19304	EAGLE	pemetrexed	Yes, through the Plan Pharmacy Services	EAGLE (pemetrexed)	EAGLE (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19063	ELAHERE	mirvetuximab soravtansine-gynx	EFFECTIVE 04/01/2023. Yes, through the Plan Pharmacy Services	ELAHERE (mirvetuximab soravtansine-gynx)	ELAHERE (mirvetusimab soravtansine-gynx)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1743	ELAPRASE	idursulfase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis II with authorization.	ELAPRASE (idunultsse)	ELAPRASE (Idurulfase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1413	ELEVIDYS	delandistrogene moxeparvovecrokl	None. Not Covered.	ELEVIDYS (delandistrogene mosepanovecroid)		
Medical	13060	ELELYSO	taliglucerase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher 1 DX with authorization.	ELELYSO (taliglucerase alfa)	ELELYSO (taligiucerase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12508	ELFABRIO	pegunigalsidase-alfa-lwxj	Yes, through the Plan Pharmacy Services	ELFARRO* (pegunigalsidase affa-ivori)	ELFABBIO* (pegunigalsidase alfa-iwo()	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1323	ELREXIFO	elranatamab-bcmm	Yes, through the Plan Pharmacy Services	ELRENFO" (elranatamab-bomm)	ELREFIXO" (ekonatamab bemm)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J9269	ELZONRIS	tagraxofusp-erzs	Yes, through the Plan Pharmacy Services	ELZONRIS (tagraxofusp-erzs)	ELZONRIS (tagraxofuso-erzs)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9176	EMPLICITI	elotuzumab	Yes, through the Plan Pharmacy Services	EMPLICITI (elotuzumab)	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	19358	ENHERTU	fam-trastuzumab deruxtecan-nxki	Yes, through the Plan Pharmacy Services	ENHERTU (fam-trastuzumab deruxtecan-nxki)	ENHERTU (fam-trastuzumab deruxtecan-nxki)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1302	ENJAYMO	sutimlimab	Yes, through Plan Pharmacy Services	ENJAYMO (sutimlimab-jome)	ENJAYMO (sutimilmab-jome)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C9399, 13590	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, 550 Drugs and Biologicals for drugs
Medical	13380	ENTYVIO	vedoltzumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	ENTYVIO (vedolizumab)	ENTYVIO (vedolizumzb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19321	EPKINLY	epcoritamab-bysp	Yes, through the Plan Pharmacy Services.	EPKINLY*** (epcoritamals-byso)	EPKINLY*** (encoritamah-busp)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10885	EPOGEN	epoetin alfa, (for non-esrd use)	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epogen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	EPOGEN (epoetin-alfa)	EFOGEN (epoetin alpha)	AMFO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Aurisdictions Will, MO.
Medical	19055	ERBITUX	cetusimab	Yes, through the Plan Pharmacy Services	ERBITUX (cetuximab)	ERBITUX (cetux/mab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17323	EUFLEXXA - non-preferred	sodium hyaluronate, 1%	As of OR/OL/2022 HYALGAN, SYNVISC, SYNVISC, ONE, HYMOVIS, and TRILLIRON will be the preferred product. Coverage of EURLEDA. requires a falled trial of a preferred product. Prior authorisation is required through the Plan Pharmacy Services and is restricted to a Recurstoolage, Orthoppedic, Sports Medicine, or Pain Medicine specialist with authorization.	SUFLEDIA (ordism hysturpnate, 1%)	EUFLEXXA (sodium hysteronate, 310)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MD
Medical	J3111	EVENITY	romosozumab-aqqg	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Endocrinology or Rheumatology specialists with authorization.	EVENITY (romosozumab-aqog)	EVENITY (romosozumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1305	EVKEEZA	evinacumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Cardiologist, Lipidologist, or Endocrinologist specialist with authorization.	EVKEEZA (evinacumab)	EVICEEZA (evinacumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-12), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		EVRYSDI	risdiplam	Yes, through Navitus. Restricted to a pediatric neurologist at a Muscular Dystrophy Association care center with authorization.	EVRYSDI (risdiplam)	EVRYSDI (risdiplam)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	J1428	EXONDYS 51	eteplirsen	None. Not Covered.	EXONDYS 51 (eteplirsen)		

	INIECTA	ABLE MEDICINES			PREVEA360		
	1102011		listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	continued around you		
	Updated: 05/01/2024	benefit are covered, not covered, or not yet reviewed and whether a prior authorisation 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 modical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.		type in the name of drug you want to locate. If you do not know the correct	n the binocular icon on your toolbar. It will then display a search box for you to spelling, you can start your search by entering just the first few letters of the ame		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J0178	EYLEA	aflibercept	None. Please see attached policy for criteria.	EYLEA (aflibercept)		MAPO 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.
	J0178	EYLEA	afilbercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0177	EYLEA HD	aflibercept	None. Please see attached policy for criteria.	Eylea* HD (Affibercept)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
	J0177	EYLEA HD	aflibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0180	FABRYZYME	agalsidase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical geneticist or other prescriber specialized in the treatment of Fabry DX with authorization.	FABRAZYME (agalsidase)	FABRAZYME (agalsidase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J0517	FASENRA	benralizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	FASENRA (benralizumab)	FASENRA (benralizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 Z), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q0138, Q0139	FERAHEME - preferred	ferumoxytol	As of 08/01/2022 VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INIECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNUL are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	EERAHEME (fanumouytol)		
Medical	J2916	FERRLECIT - preferred	sodium ferric gluconate complex	As of 08/01/2022 VENOFER, INVED, FERRLECIT, and FERAHEME are the preferred parenteral from products and do not require prior authorization. INJECTAFER, MONDERRIC, TRIFERIC, and TRIFERIC AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERRIECIT (codium ferric gluconate complex)		
Medical	J1744	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	J1572	FLEBOGAMMA/FLEBOGAMMA DIF (IVIG), IMMUNE GLOBULIN	flebogamma	Yes, through the Plan Pharmacy Services	FLEBOGAMMA/FLEBOGAMMA DIF (IVIG).	FLEBOGAMMA/FLEBOGAMME DIF (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, II, MD
Medical	Q5108	FULPHILA	pegfilgrastim-jmbd	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegilliparatim products and do not require pior authorization. Must have a failed rist of ZEXTENZO AND FULPHILA Before coverage of Neulasta. UDENCYA, NYVEPRIA, PINNETRA, and STIMUFEND require a pior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	FLAPHIA (poptigrasim-imbd)	FLAPHILA (pagdiffsatim-inbd)	MAPD Prior Authorization based on National Coverage Determination (PICD), Local Coverage Determinations (ECDs), and Local Coverage Articles (LCAs) for guidance where applicable for Avriadictions WI, II, MD
Medical	10641	FUSILEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	FUSILEV (levoleucovorin)	FUSILEV (levolescovorin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCA) for guidance where applicable for Articletons VII, II, MD
Medical	J9331	FYARRO	sirolimus albumin-bound	Yes, through the Plan Pharmacy Services	FYARRO (sirolimus albumin-bound)	FYARRO (sirolmus albumin-bound)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5130	FYLNETRA - non-preferred	pegfilgrastim-pbbk	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Peglilipastim products and do not require prior authorization. Must have a failed trail of ZEXTENDA ONE FULPHILA Peter coverage of Neulasta. UDENCYA, NYVEPRIA, PILNETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	PYMETRA (poglisy action globb)	FENETRA (posffigrantim obbid)	MATC Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 500 Drugs and Biologicals for drugs.
Medical	J9210	GAMIFANT	emapalumab-lzsg	Yes, through the Plan Pharmacy Services	GAMIFANT® (emapalumab-lzsg)	GAMIFANT* (emapalumab-lzg)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1569	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, 950 Drugs and Biologicals for drugs
Medical	J1557	GAMMAPLEX (IVIG), IMMUNE GLOBULIN	immune globulin (gammaplex liquid)	Yes, through the Plan Pharmacy Services	GAMMAPLEX (IVIG)	GAMMAPLEX (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1561	GAMUNEX-C/GAMMAKED (SCIG)	gamunex injection	Yes, through the Plan Pharmacy Services	GAMUNEX-C/GAMMAXED (SCIG)	GAMUNEX-C/GAMMAKED (SCIG)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19301	IMMUNE GLOBULIN GAZYVA	obinutuzumab	Yes, through the Plan Pharmacy Services	GAZYVA (obinutuzumab)	GAZYVA (obinutuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Wedical	3301	GAZIVA	Complexion	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and	SACT VA (OBITOCOMINA)	GRZTVA (domictozumad)	march rian Autoritation receive declines in the medicale senion rollicy wallian (run: 100-2), chapter 1.5, 390 things also designate for intigs
Medical	J7326	GEL-ONE - non-preferred	hyaluronate sodium	INCLUDED AND ADDRESS OF THE ADDRESS	GEL-CNE (hyaluronata sodium)	GELONE (hysturonate sodium)	MAND Prior Authorization based on National Coverage Determination (NCO), Local Coverage Determinations (SCDs), and Local Coverage Articles (SCAs) for guidance where applicable for Jurisdictions Wi, II, MD
Medical	17328	GELSYN-3 - non-preferred	hyaluronate sodium	As of 08/01/2022 - IYALGAM, SNNNSC, SNNNSC ONE, HYMOVIS, and RIBLIRDON will be the preferred hashcanic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Eufleox, Geloyn-3, Vacco-3, sodium hyalurosates, TriVisc, Orthoxies, Supartz KV, and Gerel/McSSO are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Polely for criteria.	GELSTN-3 fhyalurosate sodium).	GESSN-3 (hyalumnate sodium).	MATO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Acticles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	17320	GENVISC 850 - non-preferred		As of 08/01/2022- HYALGAN, SYNYSC, SYNYSC ONE, HYMOVS, and TRUING will be the preferred hyalurenic acid products and on not require prior authorisation. Monovice, Durollane, Gel-One, Editiona, Gellyn 3, Yiko-3, sodium hyaluronate, TriNic, Orthonic, Sapart PA, and GenVickSSD and the non-preferred hyaluronic acid products and prior authorisation is required through the Plan Pharmacy Services. Please see Medical Policy for or Items 1.	<u>SIANOSC BIO (hyalusutan or denniather)</u>	GENVISC 850 (hyaluranian or derivative)	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	10223	GIVLAARI	givosiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematologist or specialist with expertise in diagnosis and management of AHP with authorization.	SIVLAARI (givosiran)	GIVEARN (glvosiran)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	10257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonolog specialist with authorization.	GLASSIA (alpha-1-proteinase inhibitor)	GLASSIA (alpha-1proteinase ihibitor)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11447	GRANIX	tbo-filgrastim	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Please see Medical Policy for criteria.	GRANIX (tho-filgrastim)	GRANIX- tbo-filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	J7170	HEMLIBRA	emicizumab	Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		HEMLIBRA (emicizumab)	
Medical	J7170	HEMLIBRA	emicizumab	Yes, through the Plan Pharmacy Services	HEMLIBRA (emicizumab)	HEMLIBRA (emicizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19355	HERCEPTIN	trastuzumab injection	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	MERCEPTIN (tracturumab injection).	HERCEPTRI (tradusumab injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs

	INIECT	ABLE MEDICINES			PREVEA360		
			listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	contained around year		
	Updated: 05/01/2024	benefit are covered, not covered, or coverage review of any drug liste	issing of the most commonly prescribed artigs under the medical rend yet reviewed and whether a prior authorization is required. For d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by dicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9356	HERCEPTIN HYLECTA	trastuzumab and hyaluronidase-oysk	Yes, through the Plan Pharmacy Services	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1411	HEMGENIX	etranacogene dezapanvovec-drlb	Yes, through the Plan Pharmacy Services	HEMGENIX (etranacogene dezaparvovec-drbl)	HEMGENIX (etranacogene dezaparvovec-drbl)	MAPD Prior Authorisation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5113	HERZUMA	trastuzumab-pkrb	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HERZUMA (trastuzumab-pkrb)	HERZUMA (trastuzumab-pirrb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1559	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	19294	HOSPIRA	pemetrexed	Yes, through the Plan Pharmacy Services	HOSPIRA (pemetrexed)	HOSPIRA (pemetrexed)	MAPO 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, HYMOVS, and TRILLINON will be the preferred hyaluronic acid products and do not require prior arbitration. Momoves, Duralise, Gel-One, Gulfons,	1004 GAN (hyalumonte or denovativa)		MAPO Fror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Autodictions WI, II, MO.
Medical	J9351	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, SYRVISC, SYRVISC ONE, HYMOVS, and TRILLINGN will be the preferred hyalumoric acid products and do not require prior arbitration. Monovesc, Duralesce, Gel-One, Gulfoxas, Gelyn-3, Visco-3, sodium hyalumonate, TriVisc, Drimonsc, Saparta TX, and Geril-ViscOSD are the none preferred hyalumoric acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	ADRIGOS (hydiuman)		MAYD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ILCD), and Local Coverage Articles (ILCa) for guidance where applicable for Jurisdictions WI, IL, MD.
Medical	J1575	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	J3245	ILUMYA	tildrakizumab-asmn	Yes, through the Plan Pharmacy Services	BUMYA* (tildrakizumab-asmn)	ILUMYA* (tildrakizumab-asmn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9173	IMFINZI	durvalumab	Yes, through the Plan Pharmacy Services	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	J9347	IMJUDO	tremelimumab-acti	Yes, through the Plan Pharmacy Services	MJUDO (tremelimumab-acti)	IMJUDO (tremelimumab-acti)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9325	IMLYGIC	tallmogene laherparepvec	Yes, through the Plan Pharmacy Services	BMLYGIC (talimogene laherparepvec)	IMLYGIC (talimogene laherparepvec)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1750	INFED - preferred	iron dextran	As of 08/01/2022 VENOFER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior suntherization. INSECTAFER, MONDERSECT, TRIFERC, and TRIFERC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	BIFED (ron deutran)		
Medical	Q5103	INFLECTRA - non-preferred	infikimab-dyyb	Yes, through the Plan Pharmacy Services after falled trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	INFLECTRA (infliximab-dyyb)	INFLECTRA (Infliximab-dyyb)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Aurisdictions WI, II, MO
Medical	J9198	INFUGEM	premixed gemcitabline in sodium chloride solution	Yes, through the Plan Pharmacy Services	INFUGEM (premixed gemcitabine in sodium chloride solution)	INFUGEM (premixed gemcitabline in sodium chloride solution)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11439	INJECTAFER - non-preferred	ferric caroxymaltose	As of 08/01/2022 VENDFER, INFED, FERRIECTT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INSECTAFER, MONDRESHIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	BMECTAFER Herric curronmalticush	DUECTAFER (fortic carcosymalloss).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	INSULIN PUMPS	INSULIN PUMPS	
Medical	J1566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NE)	immune globulin, powder	Yes, through the Plan Pharmacy Services	SCIG (Immune Globulin)	SCIG (Immune Globulin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services	N/G (Immune Globulin)	IVIS (Immune Globulin)	MAYD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Authorizations WI, III, MO
Medical	J2782	IZERVAY	avacincaptad pegol	Yes, through the Plan Pharmacy Services	@ERVAY*** (avacincaptad pegol)	IZERVAY™ (avacincaptad pegol)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9281	JELMYTO	mitomycin	Yes, through the Plan Pharmacy Services	JELMYTO (mitomycin)	JELMYTO (mitomycin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9272	JEMPERLI	dostarlimab	Yes, through the Plan Pharmacy Services	JEMPERLI (dostarlimab-gyly)	JEMPERLI (dostarlimab-gdy)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9043	JEVTANA	cabazitaxel	Yes, through the Plan Pharmacy Services	JEVTANA (cabazitaxel)	JEVTANA (cabazitaxel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	JUBBONTI	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	IJBBONTI (denosumab)	JUBBONTI (denosumab)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services	KADCYIA (ado-trastuzumab emtansine)	KADCYIA (ado-trastuzumab-emtansine)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1290	KALBITOR	Kalbitor (ecallantide)	Yes, through the Plan Pharmacy Services	KALBITOR (ecallantide)	KALBITOR (ecaliantide)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5117	KANJINTI	trastuzumab-anns	Herauma and Trazimera are the preferred Trastusumab 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.	(ONJINT) (trasturumab-anns)	EANINTI (trastuturnab-anns)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2840	KANUMA IV	sebelipase alfa	Yes, through the Plan Pharmacy Services	KANUMA IV (sebelipase alfa)	KANUMA IV (sebelipase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13490	KETAMINE For Chronic Pain and Mental Health and Substance Related Disorder	ketamine	None. Not Covered.	KETAMINE FOR CHRONIC PAIN		
Medical	J9271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	KEYTRUDA (pembrolizumab)	KEYTRUDA (pembrolizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19274	KIMMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	KIMMTRAK (tebentafusp-tebn)	KIMMTRAK (tebentafusp-tebn)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

	INJECTA	ABLE MEDICINES			PREVEA360		
		This reference guide is a partial li	sting of the most commonly prescribed drugs under the medical	SEARCH TIPS:	centared around you		
		benefit are covered, not covered, or coverage review of any drug listed found on the Prevea 360 website for	and the transfer of the transfer and t	This is a large document, but you can search quickly and easily by dicking on type in the name of drug you want to locate. If you do not know the correct nai	spelling, you can start your search by entering just the first few letters of the		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	KYRSTEXXA (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 (tisagenledeucel)	KYMRIAH (tisangenledeucel)	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.	KYPROUS (carfilzomib)	KYPROUS (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	J3490, 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	13590	LANTIDRA	donislecel-jujn	Yes, through the Plan Pharmacy Services	<u>LANTRIDA™ (donislecel-jujo)</u>	<u>LANTIDRA™ (donislecel-jujn)</u>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10202	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 (Puls. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0174	LEQEMBI	lecanemab-irmb	Yes, through the Plan Pharmacy Services	<u>LEQEMBI™ (lecanemab-irmb)</u>	LEQEMBI™ (lecanemab-irmb)	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	inclisiran	None. Not covered.	LEQVID (inclisiran)		
Meducal	J0641, J0642	LEVOLEUCOVORIN	fusilev khapzory	Yes, through the Plan Pharmacy Services	LEVOLEUCOVORIN	LEVOLEUCOVORIN (fusilev khapzory)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10650	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INJECTION (INTRAVENOUS)	LEVOTHYROXINE INJECTION (INTRAVENOUS)	
Medical	J9119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	USTAYO (cemiplimab-rwlc)	LISTAYO (comiplimab)	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.	UDOCAINE FOR CHRONIC PAIN		
Medical	19999	LOQTORZI	toripalimab-tpzi	Yes, through the Plan Pharmacy Services	LOQTORZI (toripalimab-tpsi)	LOQTORZI (toripalimab-tpzi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12778	LUCENTIS	ranibizumab	No. No prior authorization required	LUCENTIS (ranibizumab)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
	J2778	LUCENTIS	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0221	LUMIZYME	alglucosidase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX with authorization.	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	J9313	LUMOXITI	moxetumomab pasudotox	Yes, through the Plan Pharmacy Services	LUMOXITI (moxetumomab pasudotox-tdfk)	LUMOXITI (moxetumomab pasudotox)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	J9350	LUNSUMIO	mosunetuzumab-axgb	Yes, through the Plan Pharmacu Services	LUNSUMIO (mosunetuzumab-axgb)	LUNSUMIO (mosunetuzumab-axgb)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals.
Medical	A9513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services	LUTATHERA (Jutetium Lu 177)	LUTATHERA (lutetium Lu 177)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals.
Medical	13398	LUXTURNA	voretigene neparvovec-rzyl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the retinal dystrophy with authorization.	LUXTURNA (voretigene neparvovec-ravil	LUXTURNA (voretigene neparvovec-rzvil)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	LYFGENIA	lovotibeglogene autoemcel	Yes, through the Plan Pharmacy Services	LYFGENIA (lovotibeglogene autoemcel)	LYFGENIA (lovotibeglogene autoemcel)	
Medical	J9353	MARGENZA	margetuximab	Yes, through the Plan Pharmacy Services	MARGENZA (margetoximab).	MARGENZA (margetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13397	MEPSEVII	vestronidase alfa-vjbk (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VII with authorization.	MEPSEVII (vestronidase alfa vibbi (intravenous)	MEPSEVII (vestronidase aifa sõbki (Intravenous).	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 500 Drugs and Biologicals for drugs
Medical	19349	MONJUVI	tafasitamab-cxix	Yes, through the Plan Pharmacy Services	MONIUVI (tafasitamab-coix)	MONIUVI (tafasitamab-coix)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11437	MONOFERRIC - non-preferred	ferric derisomaltose	As of OR/OL/2022-VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INIECTAFER, MONOFERMIC, THEFRIC, and TRIFERIC AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	MONOFERN: (ferric derisonal tose)	MONOFERIC (ferric derisomaltose)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17327	MONOVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVYS, and TRILLURON will be the preferred hyalmonic acid products and do not require prior authorisation. Momovisc, proteines, Gel-One, Eufleoxo, Geldyn-3, Visco-3, sodium hyalmoniate, Trivisc, Christovisc, Suparta FA, and Genivisci50 are the non-preferred hyalmonic acid production, and prior authorization is required through the Plan Pharmacy Services. Please see Medical Plosi for criteria.	MCNOVSC (thephyronian or derivative).	MONOVSC (hyskurpnan or derivative)	MAPD Prior Authorization based on National Coverage Determination (PCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisd closs WI, II, MD.
Medical	Q5107	MVASI	bevacizumab-awwb	As of 63/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Awatin, Alympy, Mwasi and Vegetima prior authorization is required through the Plan Pilamary Services. ***Prior authorization for bevacizumab is not required when used for ophstamological indications. ***See the ALYMSO (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	MVASI (bevocitarnalo arevib)	MVASI (bevactuumab-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, II, MO.
Medical	J9203	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	MYLOTARG (gentuzumab 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.	MYOBLAC (rimabotulinumtoxinB)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J1458	NAGLAZYME	galsulfase (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VI with authorization.	NAGLAZYME (galculfuse) (Intravenous)	NAGLAZYME (galculfase) (Intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2323	NATALIZUMAB	tysabri	Yes, through the Plan Pharmacy Services	NATALIZUMAB: (Tysabri: Tyruko)	NATALIZUMAB: (Tysabri; Tyruko)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 500 Drugs and Biologicals for drugs

	INJECTA	ABLE MEDICINES			PREVEA360		
		This reference quide is a nartial	listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	centered around you		
	Undated: 05/01/2024	benefit are covered, not covered, o	r not yet reviewed and whether a prior authorization is required. For d as not covered, please complete the Exception to Coverage form for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct no	t the binocular icon on your toolbar. It will then display a search box for you to spelling, you can start your search by entering just the first few letters of the ame		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12506	NEULASTA	pegfligrastim	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Peglilgrazim products and do not require prior authorization. Must have a falled trial of ZEXTENZO AND FULPHILA Before coverage of Neulasta. UDENCYA, NYVEPRIA, PYLNETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	NEULASTA (positiligration)	NEULASTA (pogfilgrastim)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	J2506	NEULASTA	pegfilgrastim	Yes, through Navitus	NEULASTA (posfiliprastim)		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	filgraxtim	EFFECTIVE 01/01/2023: Nivestym and Zanxio are the preferred Filgrastim products and do not require prior authorization. Neupogen Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	* <u>NEUPOGEN (filuroatim)</u>	NEUPOGEN (filpractim)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 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	NEXVIAZYME	avalglucosiidase 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.	NEXVIATYME (avaiglucosidase affa)	NEXVIATME (avaiglucoside se affa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5110	NIVESTYM	filgrastim-aafi	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NIVESTYM (Bigrastim-aafi)	NIVESTYM (filgrastim-aafi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2796	NPLATE	romipostim	Yes, through the Plan Pharmacy Services	NPLATE (romi postim)	NPLATE (romipostim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2182	NUCALA	mepolizumab	Yes, through the Plan Pharmacy Services. Eosinophilic authma: Restricted to Pulmonology, Allergy, and Immunology specialists with authorization. Eosinophilic granulomatosis with polyangitis (EGPA): Restricted to a Pulmonology, Immunology, Allergy or Rheumatology specialist with authorization.	NUCALA (mepolizumab)	NUCALA (mepolitumab)	MATO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13490, C9399	NULIBRY	fosdenopterin	Yes, through the Plan Pharmacy Services. Restricted to a neurologist, medical geneticist, or a provider who specializes in management of inborn errors of metabolism with authorization.	N.R. SEV (fordenopterin).	NULIBRY (fosdenopterin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5122	NYVEPRIA	pegfiligrastim-apgf	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegilipazatin products and do not require prior authorization. Must have a falled trial of ZEXTENZO AND FULPHILA Enforce occurage of Neulasta. UDENCVA, NYVEPRIA, PULNETRA, and STIMULFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NYVEPSA (one-fligrantism-angit).	NYVEPBA (negfligranten augfli	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 900 Drugs and Biologicals for drugs
Medical	12350	OCREVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	OCREVUS (ocretizumab)	QCREVUS (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 (NIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	Q5114	OGIVRI	trastuzumab-dist	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjintl and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	OGIVRI (tractuzumab-dkst)	OGIVRI (trastuzumab-dist)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13590	OMISIRGE	omidubicel-only	Yes, through the Plan Pharmacy Services	OMISIRGE* (omidubicel-only)	OMISIRGE* (amidubicel-only)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	C9168	омуон	mirikizumab-mrkz	Yes, through the Plan Pharmacy Services	OMVOH (mirikizumab-mrkz)	OMVOH (mirikizumab-mrkz)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs, and Biologicals for drugs
Medical	19205	ONIVYDE	irinotecan liposome injection	Yes, through the Plan Pharmacy Services	ONIVYDE (Irinotecan liposome injection)	ONIVYDE (irinotecan liposome injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0222	ONPATTRO	patisiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Hematology or Neurology specialist with authorization.	ONPATTRO (patisiran)	ONPATTRO (patisiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5112	ONTRUZANT	trastuzumab-dttb	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	CNTRUZANT (trastusumab-dttb)	QNTESCANT (trasturumak-dttb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19299	OPDIVO	nivolumab	Yes, through the Plan Pharmacy Services	OPDIVO (nivolumab)	OPDIVO (nivolumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19298	OPDUALAG	nivolumab/relatlimab-rmbw	Yes, through the Plan Pharmacy Services	OPDUALAG (nivolumab/relatlimab-rmbw)	OPDUALAG (nivolumab/relatimab-rmbw)	MAPO 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)	abstacept	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 Senell? 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, 550 Drugs and Biologicals for drugs
Medical	17324	ORTHOVISC - non-preferred	hyaluronan or derivative	As of OR/DI/2022 HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURON will be the preferred hyalaronic acid products and on not require prior authorisation. Monovisc, Christope, Gel-Ore, Cildiexo, Gellyn S, Visco S, sociam hyalaroniette, TriVisc, Christope, Supert XV, proportional acid of the product of the proportion of the proportion of the proportion of the proportion of the plan Pharmacy Services. Please see: Medical Policy for criteria.	GET TENTRATES. Desalvacement on decembrations	CATEGORIC (Insulances or deniative).	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	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	19259	PACITAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services	PACITAXEL PROTEIN-BOUND PARTICLES	PACITAXEL PROTEIN-BOUND PARTICLES	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictors WI, II, MD
Medical	19177	PADCEV	enfortumab vedotin-ejfv	Yes, through the Plan Pharmacy Services	PADCEV (enfortumab vendotin-ejfv)	PADCEV (enfortumab-vedotin-ejfv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0208	PEDMARK	sodium thiosulfate	Yes, through the Plan Pharmacy Services.	PEDMARK (sodium thiosulfate)	PEDMARK (sodium thiosulfate)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19304	PEMFEXY	pemetrexed	Yes, through the Plan Pharmacy Services	PEMFEXY (pemetrexed)	PEMFEXY (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19247	PEPAXTO	(molphalan flufenamide	Yes, through the Plan Pharmacy Services	PEPAXTO® (molphalan flufenamide)	PEPAXTO* (melphalan flufenamide)	MMID Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, \$50 Drugs and Biologicals for drugs

	INIECTA	ABLE MEDICINES			PREVEA360		
			sting of the most commonly prescribed drugs under the medical	SEARCH TIPS:	continued around you		
	Hadward 05/01/2024	benefit are covered, not covered, or	sang or me most commonly prestructed range under the measure not yet reviewed and whether a prior authorization is required. For I as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by dicking on type in the name of drug you want to locate. If you do not know the correct na	the binocular icon on your toolbar. It will then display a search box for you to spelling, you can start your search by entering just the first few letters of the me		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19306	PERIETA	pertuzumab	Yes, through the Plan Pharmacy Services	PERIETA (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	19316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	PHESGO (perturumab)	PHESGO (perturumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	A9699	PLUVICTO	lutetium Lu 177 vipivotide tetraxetan	Yes, through the Plan Pharmacy Services	PLUVICTO (lutetium Lu 177 vipivotide tetraxetan)	PLUVICTO (lutetium LU 177 vipivotide tetraxtan)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19309	POLIVY	polatuzumab vedotin-piiq	Yes, through the Plan Pharmacy Services	POLIVY (polatuzumab vedotin-piiq)	POLIVY (polatuzumab vedotin-piiq)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1203	POMBILITI	cipaglucosidase alfa-atga	Yes, through the Plan Pharmacy Services	POMBILITI (cipaglucosidase alfa-atga)	POMBILITI (cipaglucosidase alfa-atga)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9295	PORTRAZZA	necitumumab	Yes, through the Plan Pharmacy Services	PORTRAZZA (necitumumab)	PORTRAZZA (necitumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19204	POTELIGEO	mogamulizumab-kpkc)	Yes, through the Plan Pharmacy Services	POTELIGEO (mogamulizumab-kpkc)	POTELIGEO (mogamulizumab-kpkc)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1459	PRIVIGEN (IVIG), IMMUNE GLOBULIN	privigen	Yes, through the Plan Pharmacy Services	PRIVIGEN (IVIG)	PRIVIGEN (IVIG)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Pharmacy	10885	PROCRIT - non-preferred	epoetin alfa, (for non-esrd use)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	PROCRIT (epoetin alpha)	PROCRIT (epoetin alpha)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J0885, Q4082	PROCRIT	epoetin alfa, (for non-esrd use)	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epogen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	PROCTRIT (epoetin alfo, (for non-erod use)	EROCRIT (epoetin alpha)	MAPD Prior Authorisation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions VII, II, MIO.
Medical	J9015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services	PROLEUKIN (aldesleukin)	PROLEUKIN (aldesleukin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10897	PROLIA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	PROLIA (denosumab)	PROLIA (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for burisdictions VM, IL, MD
Medical	Q2043	PROVENGE	sipuleucel-T	Yes, through the Plan Pharmacy Services	PROVENGE (siguleucel-T)	PROVENGE (sipuleucel-T)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD
Medical	J1304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	QALSODY** (tolersen)	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	J1301	RADICAVA	edaravone	Yes, through the Plan Pharmacy Services. Restricted to an Neurology specialist with authorization.	RADICAVA (edaravone)	RADICAVA (edaravone)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 590 Dugs and Biologicals for drugs
Medical	10896	REBLÖZYL	lusptercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<u>REBLOZYL (luspatercept-aamt)</u>	REBLOZYL (luspatercept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5125	RELEUKO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Fligrastim products and do not require prior authorization. Neupogen, Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RELEUKO (filgrattim-ayow)	RELEUIO (filgrastim-ayow)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1745	REMICADE - non-preferred	infliximab	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	REMICADE (Infliximab)	REMICADE (Infliximab)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, IMD.
Medical	13285	REMODULIN IV	treprostinil	Generic Treprostinii 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.	SEMODULIN IV (treprostinii)	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	Q5104	RENFLEXIS - preferred infliximab product	inflikimab-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.	BENFLEXIS (infliximals-abda)	BENFLEXIS (infliximab-abda)	MAPD Prior Authorization based on National Goverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.
Pharmacy	Q5105	RETACRIT - preferred	epoetin alfa-epbx	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	RETACRIT (epoetin alfa-ephx)	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, II, MO.
Medical	Q5106	RETACRIT	epoetin alfa-epbx	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epogen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RETACRIT (epoetin alfa-epbs)	RETACRIT (epoetin alfa-epbs)	MAPD Prior Authorisation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J7311	RETISERT	fluocinolone acetonide intravitreal implant	None. Not Covered.	RETISERT (fluocinolone acetonide intravitreal implant)		
Medical	13590	RETHYMIC	allogeneic processed thymus tissue-agdc)	Yes, through the Plan Pharmacy Services	RETHYMIC (Allogenic processed thymus tissue-agdc)	RETHYMIC (Allogenic processed thymus tissue-agdc)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	13950, C9399	REVCOVI	elapegademase-ivir	Yes, through the Plan Pharmacy Services.	<u>REVCOVI* (elapegademase-lvir)</u>	REVCOVI* (elapegademase-lvfr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitus.	BHOPRESSA (netarsudii)	RHOPRESSA (netarsudil)	
Medical	Q5123	RIABNI	rituximab-arrx	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria	SIABNI (ritusimab-arrx)	RIABNI (ritusimab-arrx)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	13490	RIVFLOZA	nedosiran	Yes, through the Plan Pharmacy Services	SIVELOZA (nedoskan).	BIVELOZA (nedosiran).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9312	RITUXAN	ritusimab	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Rusience or Truxima. Please see Medical Policy for criteria	RITUXAN (ritusimab)	RITUXAN (ritusimab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J9311	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, II, MO
Medical	J9312	RITUXIMAB IV	rituxan, truxima, ruxiencem riabni	Yes, through the Plan Pharmacy Services	SITUXIMAB IV (rituxan, truxima, ruxience, riabni)	RITUXIMAB IV (rituxan, truxima, ruxiencem riabni)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals.
Medical	J1412	ROCTAVIAN	valoctocogene roxaparvovec-rvox	Yes, through the Plan Pharmacy Services	ROCTAVIAN* (valoctocogene roxaparvovec-rvox)	ROCTAVIAN* (valoctocogene roxapanyovec-rvox)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals.
Medical	J1449	ROLVEDON	eflapegrastim-xnst	Yes, through the Plan Pharmacy Services.	BOLVEDON™ (eflapegrastim-xnst)	ROLVEDON™ (eflapegrastim-xnst)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	Q5119	RUXIENCE	rituximab-pvvr	As of 01/01/2023: Rusience and Trusima are the preferred Ritusimab products and does not require prior authorization. Riabni and Ritusan prior authorization is required. Please see medical policy for criteria	SUBSENCE (citualmab-poor)	RUNDENCE (citualinals-gover)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J9061	RYBREVANT	amivantamab-vmjw	Yes, through the Plan Pharmacy Services	RYBREVANT (amivantamb-vm/w)	RYBREVANT (amivantamab-vmjw)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

	INJECTA	ABLE MEDICINES			PREVEA360		
		This reference guide is a partial I	isting of the most commonly prescribed drugs under the medical	SEARCH TIPS:	centarred arround you		
		benefit are covered, not covered, or coverage review of any drug lister found on the Prevea360 website for	not yet reviewed and whether a prior authorization is required. For I as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by clicking on t type in the name of drug you want to locate. If you do not know the correct nat	spelling, you can start your search by entering just the first few letters of the		
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J2998	RYPLAZIM	plasminogen, human-tvmh	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical Hematologist or MD specializing in	Policy	Prior Authorization Form	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drups
Medical	12536	KIPLAZIM	pasimogen, noman-centri	plasminogen deficiency (PLGD) with authorization.	ATT AZZYI (Dazzininger), Hulhari Ayrim	CITOZINI (DESTINOSTI, HURSII-AVIRI)	мент и по инионации переди очинен и не песнов е еспет и по уманов (том 2004), сторие 15, 550 году ана володово от отду-
Medical	19333	RYSTIGGO	rozanolixizumab-noli	Yes, through the Plan Pharmacy Services	RYSTIGGO* (rozanolixizumab-noli)	RYSTIGGO* (rozanolixizumab-noli)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	RYZNEUTA	efbemalenograstim alfa-vuxw	Yes, through the Plan Pharmacy Services	RYZNEUTA (efbemalenograstim aifa-vunw)	RYZNEUTA (efbernalenograstim alfa-vuxw)	
Pharmacy		SANDOSTATIN	octreotide	Yes, through Navitus. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or Gastroenterologist specialist with authorization.	SANDOSTATIN (octreodide)		
Medical	12353	SANDOSTATIN LAR	octreotide suspension	Yes, through the Plan Pharmacy Services	SANDOSTATIN (actreotide suspension)	SANDOSTATIN LAR (octreotide suspension)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12354	SANDOSTATIN	octreotide suspension (non-depot form)	Yes, through the Plan Pharmacy Services	SANDOSTATIN (actreotide suspension (non depot form).	SANDOSTATIN (ortractide suspension (non depot form)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Servcies	SANDOZ (pemetrexed)	SANDOZ (pemetrexed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J0491	SAPHNELO	anifrolumab-fnia	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	SAPHNELO (anifrolumab finia)	SAPHNELO (anifrolumab fnia)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19227	SARCLISA	isatuximab-irfc	Yes, through the Plan Pharmacy Services	SARCLISA (isatuximab-irfc)	SARCLISA (isatunimab-irfc)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17352	SCENESSE	afamelanotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Dermatologist, Medical Geneticist, or a Physician specializing in the treatment of cutaneous porphyrias with authorization.	SCENESSE (afamelanotide)	SCENESSE (afamelanotide)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drups and Biologicals for drups
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.	SIGNFOR LAR (pasireortide)	SIGNIFOR LAR (pasireortide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 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)	MARTO Prior Authorization needed outlined in the Medicare Briefit Policy Manual (Pub. 100-3), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	11602	SIMPONI ARIA	golimumab	speciasis with authorization.  Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONE ARIA (golimumah)	SIMPONI ARIA (golimumab.)	
Medical		SITE OF SERVICE		automization.  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	12327	SKYRIZI IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterologiy specialist with authorization.	SKYRIZI IV (risankizumab IV)	SKYRIZI IV (risankizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	SKYSONA	elivaldogene autotemcel	Yes, through the Plan Pharmacy Services.	SKYSONA* (elivaldogene autotemcel)	SKYSONA* (elivaldogene autotemcel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1300	SOLIRIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Nuero-Opthalmonogist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	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 W, II, MD
Medical	11930	SOMATULINE	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	SOMATUUNE (unreotide depot).	SOMATULINE (Jarreotide depot)	MARD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1747	SPEVIGO	spesolimab	Yes, through the Plan Pharmacy Services	SPEVIGO* (spesolimab)	SPEVIGO* (spesolimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	12326	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, 550 Drugs and Biologicals for drugs
Medical	13490	SPRAVATO	esketamine	Yes, through Plan Pharmacy Services	SPRAVATO (esketamine)	SPRAVATO (esketamine)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13358	STELARA (IV)	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	STELARA IV (estekinumab)	STELARA IV (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs.
Pharmacy	13358	STELARA (SC)	ustekinumab	Yes, through Navitus. Restricted to an Gastroenterology specialist with authorization.	STELARA SC (ustekinumab)	STELARA SC (ustekinumab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy		Sublingual Immunotherapy (SLIT) for ALLERGY products		Yes, through Navitus. Must be prescribed by an allergist, immunologist, or physician with active and ongoing experience in the	SUT for Allergy Products		
Medical	J7321	SUPARTZ FX - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVS, and TRILLIDRON will be the preferred hyalarmoic acid products and on not require prior activatorization. Memories, Duraless, Geldons, E., Gulless, Geldons, S., Wisco 3, sodium hyaluronate, TriVinc, Christones, Suparta XV, and GenvilvaCide are the own preferred hyalarmoic acid products and and GenvilvaCide are the own preferred hyalarmoic acid products and and GenvilvaCide are the own preferred hyalarmoic acid products and products and the control of the preferred hyalarmoic acid products and the control of the preferred hyalarmoic acid products and the preferred hyalarmoic acid products and the products and the preferred hyalarmoic acid products and the p	53-PARTX FX (hyphyronan or derivative)	51/9ART PX (hyahironan or derhative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	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	pegcetacopian	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 (sitummab)	SYLVANT (siturimab)	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	palivizumab	Yes, through the Plan Pharmacy Services. Restricted to NICU Physician, Neonatologist, or Pediatric specialist (including family practice, general pediatrics, pediatric pulmonology, and pediatric cardiology) with authorization.	SYNAGIS (palivizumab)	SYNAGIS (palivizumab)	

	INJECTA	ABLE MEDICINES			PREVEA360		
			isting of the most commonly prescribed drugs under the medical	SEARCH TIPS:	contarned arround year		
		benefit are covered, not covered, or coverage review of any drug lister	not yet reviewed and whether a prior authorization is required. For d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy	This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the		
	Updated: 05/01/2024		submit to Navitus.				
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and	Policy	Prior Authorization Form	MAPD
Medical	17325	SYNVISC - preferred	hyaluronan or derivative	as to log/uz/2022 revisions, 31VEVS., 31VEVS. ONE, PHROUSS, and TITULIBRON will be the preferred hybotronic adopt products and do not require prior authorization. Monovisc, Durolane, Gel-One, Eufleno, Gellyn-3, Visco 3, odulm hyaluronate, TriVisc, Orthowisc, Suparte 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	5270/SC (Itraliuman or dentiative)		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	17325	SYNVISC ONE - preferred	hyaluronan or derivative	As of OR/DI/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLURGN will be the preferred hyaluronic acid products and do not require prior authoration. Momovisc, Carolinae, Geld-One, Gulfoxox, Geldyn-3, Visco-3, sodium hyaluronate, Trivisc, Orthoxoc, Supartar N, and GenViscSSD and the non-preferred hyaluronic acid products and prior authoritation is required through the Plain Pharmacy Services. Please see Medical Placy for criteria	SYNVES, CME Dysilurenan or derivative)		MAPO Prior Authorization based on National Coverage Determination (NCS), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	13055	TALVEY	talquetamab-tgvs	Yes, through the Plan Pharmacy Services	TALVEY** Balquetamab tystl	TALVEY** (talquetamab-tpvl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q2053	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	TECVAYLI	teclistamab-cqyv	Yes, through the Plan Pharmacy Services	TECVAYLI (teclistamab-cqyv)	TECVAYLI (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	19314	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	TEVEA (pemetrexed)	TEVA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologiculs 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	tisotumab vedotin-tftv)	Yes, through the Plan Pharmacy Services	TIVDAK (tisotumab vedotin-tftv)	TIVDAK (tisotumab vedotin-tftv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5133	TOFIDENCE	tocilizumab-bavi	Yes, through the Plan Pharmacy Services	TOFIDENCE (todilzumab-bavi)	TOFIDENCE (tocilizumab-bavi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5116	TRAZIMERA	trastuzumab-qyyp	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	TRAZIMERA (trastuzumab-qyyp)	TRAZIMERA (trastuzumab vedotin-tfty)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services	TREANDA (bendamustine)	TREANDA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17332	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, II, MO
Medical	17329	TRIVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVS, and TRILLION Will be the preferred hyalumoric acid products and do not require prior subtraction. Monoves, Curolome, Gel-One, Gulfono, Geldono, Sudoma hyalumorate, Tofrico, Orthonox, Suparta PX, and GenVisicSSD and the mon-preferred hyalumoric acid products and prior authorization is required through the Plain Pharmacy Services. Please see Middle and Policy for criteria.	198005 (hydroson or dehather)	TBIOSS (Incluronan or defruitter)	MAPO Prior Authorization based on National Coverage Determination (NCS), Local Coverage Determinations (ECD), and Local Coverage Articles (ECAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J9317	TRODELVY	sacituzumab govitecan-hziy	Yes, through the Plan Pharmacy Services	TRODELVY (sacituzumab govitecan-hziy)	TRODELVY (sacituzumab govitecan-hziy)	MAPO 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 (ibalizumanages)	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: Ruxience 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	TRU00MA (ritusimab-abbs)	TRUXIMA (ritusimab-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, II, MIO.
Medical	Q5134	TYRUKO	natalizumab	Yes, though the Plan Pharmacy Services	TYRUKO (natalizumab)	TYRUKO (natalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 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-mzwv	Yes, through the Plan Pharmacy Services.	TZIELD (teplizumab-mzwv)	TZIELD (teplizumab-mzav)	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	pegfligrastim-cbqv	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegiligastim products and do not require prior authorization. Must have a failed triol of ZEXTENZO AND FULPHILA Defore coverage of Neulasta. UDENCYA, NVYEPRIA, FYLNETRA, and STIMUEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	SDENCYA (popflips a stim chop)	UDENCYA (pogifisy astim chav).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1303	ULTOMIRIS	ravultzumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematology, Oncology, or immunology specialist with authorization.	LILTOMARIS (ravulizumab).	LILTOMARIS (ravolizumah).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1823	UPLIZNA	inebilizumab-cdon	Yes, through the Plan Pharmacy Services	UPLIZNA* (inebilizumab-cdon)	UPLIZNA* (inebilizumab-cdon)	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, though the Plan Pharmacy Services. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI-IV (selesipag)	UPTRAVI-IV (selevipag)	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, though Navitus. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI (selexipag)	UPTRAVI (setexipag)	
Medical	12777	VABYSMO	faricimab-svoa	No. No prior authorization required.	VABYSMO** (faricimab-svea)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions Wi, II, MO
Medical	12777	VABYSMO	faricimab-svoa	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for surisdictions WI, IL, MO
Medical	19303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	VECTIBIX (panitumumab)	VECTIBIX (ganitumumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	VELCADE (bortezomib)	VELCADE (bortezomib)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for Jurisdictions WI, II, MD

	INJECT	TABLE MEDICINES			PREVEA360		
		This reference guide is a partial I	listing of the most commonly prescribed drugs under the medical	SEARCH TIPS:	centured around yets		
	Updated: 05/01/2024	benefit are covered, not covered, or coverage review of any drug liste found on the Prevea360 website for	r not yet reviewed and whether a prior authorization is required. For d as not covered, please complete the Exception to Coverage form or medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	This is a large document, but you can search quickly and easily by clicking on type in the name of drug you want to locate. If you do not know the correct na	spelling, you can start your search by entering just the first few letters of the		
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions As of 03/01/2024: Zirabev is the preferred Bevacizumab product and	Policy	Prior Authorization Form	MAPD
Medical	Q5129	VEGZELMA	bevacizumab-adcd	As or US/US/AUX- Intakes is the preserved sevacuraman product and does not require prior authorization. Avastin, Alymany, Marsal and Vegaciena prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacularmab is not required when used for ophtalmological indications.*** See the ALYMSYS (bewacirumab) Policy for a list of applicable ophthalmological disamoses.	VEGZELMA (beva dzwnab adrd)	VEGZELMA (bevadaumab-adrd)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions VII, II, MD
Medical	J1756	VENOFER - preferred	iron sucrose	As of 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONDERRIC, TRIFERIC, and TRIFERIC AVMU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	VENOFER (Iron sucrose)		
Medical	19376	VEOPOZ	pozelimab-bbfg	Yes, through the Plan Pharmacy Services	VEOPOZ* (pozelimab-bd/g)	WEOPO2* (pessimab bbfg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1427	VILTEPSO	viltolarsen	None. Not Covered.	<u>VILTEPSO (viltolarsen)</u>		
Medical	J1323	VIMIZIM	elosulfase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis IVA with authorization.	VIMIZIM (elosulfase)	VIMIZIM (elosulfase)	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	17321	VISCO-3 - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, STRVISC, SYRVISC ONE, HYMOVS, and TRILLIORN will be the preferred hyalumoric acid products and do not require prior authoration. Monovice, prolivene, Gel-One, Eufloax, Geldyn-3, Visco-3, scellum hyalumorate, Trivisc, Orthorox, Suparta PX, and GenViscSSD are the non-preferred hyalumoric acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Pilotify for criteria.	VSCO-3 (hyakuronan or derivative)	195CO 1 (hyakuronan 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, II, MD.
Medical	19999	VIVIMUSTA	bendamustine	EFFECTIVE 05/01/2023. Yes, through the Plan Pharmay Services	VIVIMUSTA (bendamustine)	VIVIMUSTA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13385	VPRIV	velagiucerase aifa (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 lvelaglucerase alfal.	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3032	VYEPTI	eptinezumab-jjmr	Yes, through the Plan Pharmacy Services	VYEPTI (optinezumab)	VYEPTI (eptinezumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3401	VYJUVEK	beremagene geperpavec-svdt	Yes, through the Plan Pharmacy Services	VYILIVEK™ (beremagene geperpavec-ovdt)	VYJUVEK™ [beremagene geperpavec-svdt]	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1429	VYONDYS 53	golodirsen	None. Not Covered.	VYONDYS 53 (golodirsen)		
Medical	19332	VYVGART	efgartigimod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	VYVGART (efgartigmoid)	VYVGART (efgartigimod alfa-fcab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19334	VYVGART-HYTRULO	efgartigimod alfa-fcab and hyaluronidase-qvfc	Yes, through the Plan Pharmacy Services.	VYVGART* Hytrulo (efgartig/mod alfa-fcab and hyaluronidase-qvfc)	VYVGART* Hytrulo (efgartig/mod alfa-fcab and hyaluronidase-qvfc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9153	VYXEOS	daunorubicin and cytarabine – liposome	Yes, through the Plan Pharmacy Services	VYXEOS (daunorubicin and cytarabine – liposome)	VYXEOS (danucrubicin and cytarabine-liposome)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		VYZULTA	latanoprostene bunod	PHARMACY BENEFIT ONLY. Yes, through Navitus.	VYZULTA (latanoprostene bunod)	VYZULTA (latanoprostene bunod)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J3590	WYOST	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	WYOST (denosumab)	WYOST (denosumab)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wil, II, MO
Medical	J1558	XEMBIFY (SCIG)	immune globulin	Yes, through the Plan Pharmacy Services	XEMBIPY (SCIG)	XEMBITY (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0218	XENPOZYME	olipudase alfa	Yes, through the Plan Pharmacy Services.	XENPOZYME** (olipudase alfa)	XENPOZYME™ (olipudase alfa)	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	10588	XEOMIN	incobotulinumtoxinA	No prior authorization is required.	XEOMIN (incobotulinumtoxinA)		MAVD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
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 (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	13299	XIPERE	triamcinolone acetonide injectable suspension	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an opthamalogist specialist with authorization.	XIPERE (triamcinolone acetonide injectable suspension)	XVPERE (triamcinolone acetonide injectable suspension)	MAYD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDd), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
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)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions VII, II, MO
Medical	J9228	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services	YERVOY ((plimumab)	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	Q2041	YESCARTA	axicabtagene ciloleucel	Yes, through the Plan Pharmacy Services	YESCARTA (axicabtagene ciloleucel)	YESCARTA (axicabtagene ciloleucel)	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19352	YONDELIS	trabectedin	Yes, through the Plan Pharmacy Services	YONDEUS (trabectedin)	YONDELIS (trabectedin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5101	ZARXIO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Refeuko and Grank, require prior authorization through the Plan pharmacy Services. Please see Medical Policy for criteria.	ZASOO Hilgrastim-ayood	ZARXIO (filigrastim-ayoso)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10256	ZEMAIRA/PROLASTIN-C	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)	ZEMAIRA/PROLASTIN C (alpha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	ZEPZELCA (lurbinectedin).	ZEPZELCA (lurbinectedin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5120	ZIEXTENZO	pegfligrastim-brnez	EFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pogligazatim products and do not require prior authorization. Must have failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENTERA, and STIMULEN require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	ZEXTENZO (popfigrantim-homes)	2UXTENZO (oog/lag-action-lumes)	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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	INJECT	ABLE MEDICINES		SEARCH TIPS:	PREVEA360		
	This reference golde is a partial listing of the most commonly prescribed drugs under the medical baseful are correct, and covered, on the yet reviewed and whether a price authorization is required to the property of the p		For 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				
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	мард
Medical	Q5118	ZIRABEV	bevacizumab-bvzr	As of 03/01/2004: Zirabev is the preferred Bevaciumab product and does not require prior authorization. Awastin, Alymps, Maxis and Yegzelma prior authorization is required through the Plan Pharmacy Services. "*Prior authorization for bevaciumab is not required when used for ophthalmological indications."* See the ALYMSYS (Bevaciumab) Policy for a list of applicable ophthalmological disamoses.	28AREV (bevicioumab-boar)	ZWAREV (bevidzumab byer)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Autodictions WI, II, MD
Medical	C9399, J3590	ZOLGENSMA	onasemnogene abeparvovic-xioi	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Neurologist with expertise in the diagnosis of Spinal Muscular Atrophy (SMA) with authorization.	ZOLGENSMA (onasemnogne abepanovic viol)	ZOLGENSMA (onasemnogene abepanovic)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19359	ZYNLONTA	loncastuximab tesirine	Yes, through the Plan Pharmacy Services	ZYNLONTA (loncastuximab)	ZYNLONTA (loncastusimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 Z), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13590,C9399	ZYNTEGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	ZYNTEGLO* (betibeglogene autotemcel)	ZYNTEGLO* (betibeglogene autotemcel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19345	ZYNZ	retifanlimab-dlwr	EFFECTIVE 08/01/2023. Yes, through the Plan Pharmacy Services	ZYNYZ (retifanlimab-dlwr)	ZYNYZ (retifanlimab-dlwr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
			These drugs are all medical injectable drugs, and are not listed on the Prevea360 Health Plan drug formulary. The on-line formulary only lists drugs covered by the pharmacy benefit.	There are claim specific edits for many of these drugs. The edits limit the uses of these drugs to approved indications and dosages. In addition, Proves ISO Nealth Plan has payment restrictions consistent with Preves ISO Nealth Plan Medical or Drug Policies.		The Mexish Plan will not cover U.S. Food and Drug Administration (PSA) approved drug that are new to the mortest until the Phannacy and Threepastics (PSR Tomentee formally reviews and grants approved, within a maximum timeframe of 1 year from PSA approval. If a provider believes that use of a new drug in Intel® 10 year from PSA approval. If a provider believes that use of a new drug in Intel® 10 year (PSA PSA) on MT Committee approval, they may submit an exception to coverage from request.	
			13590 and 13490 are miscellaneous codes used for drugs that do not have a J code assigned by the FDA. New drugs may take between 12-18 months to get a J code assigned	Any drug submitted under either J3590 or J3490 with a cost of \$750 or greater will be reviewed post-claim by Prevea360 Health Plan.	It is recommended that any use of the miscellaneous codes be pre- approved ahead of time through Prevea360 Health Plan Utilization Management, especially for off-label uses from FDA indications.	Pharmacy Drug Exception to Coverage Request Form  Medical Injectable Drug Exception to Coverage Request Form	