

# Step Therapy requirements for Medicare outpatient (Part B) medications

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual

(Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs) and Articles may exist and compliance with these policies is required where applicable. Step Therapy will be required for the medications listed in the table below effective 1/1/2021, provided the following are met for the requested drug:

- Meets the definition of a Medicare Part B medication.
- New for the patient, as defined by no use in the last 365 days.
- Proposed use of the requested and alternative drug has been determined to be a medically accepted indication under Medicare rules.
- Dose, frequency and duration of use may not exceed the safety and efficacy data supporting the medically accepted indication.

Non-Preferred Drug	HCPCS Code	Preferred Drug	HCPCS Code
Aloxi	J2469	Kytril/Zofran	J1626/J2405
Avastin <ul style="list-style-type: none"> <li>• Oncology use only</li> </ul>	J9035	Mvasi/Zirabev	Q5107/Q5118
Fusilev	J0641	Leucovorin	J0640
Khapzory	J0642	Leucovorin	J0640
Herceptin	J9355	Ontruzant/Herzuma/Ogivri/Trazimera/Kanjinti	Q5112/Q5113/Q5114/Q5116/Q5117
Herceptin Hylecta	J9356	Ontruzant/Herzuma/Ogivri/Trazimera/Kanjinti	Q5112/Q5113/Q5114/Q5116/Q5117
HP Acthar <ul style="list-style-type: none"> <li>• Exclude for patients with West Syndrome</li> </ul>	J0800	Corticosteroids	multiple
Neulasta	Q5111	Ziextenzo/Fulphila/Udenyca	Q5120/Q5111/Q5108
Neupogen	J1442	Zarxio/Nivestym/Granix	J1447/Q5110/Q5101
Procrit/Epogen (non-ESRD)	J0885	Retacrit (non-ESRD)	Q5106
Eylea	J0178	Avastin - Ophthalmic	C9257

Lucentis	J2778	Avastin - Ophthalmic	C9257
Macugen	J2503	Avastin - Ophthalmic	C9257
Beovu	J0179	Avastin - Ophthalmic	C9257
Rituxan	J9312	Truxima/Ruxience	Q5115/J9999
Rituxan Hyleca	J9311	Truxima/Ruxience	Q5115/J9999
Sustol • Regimens that of moderately emetogenicity or less	J1627	Zofran/Kytril/Aloxi	J2405/J1626/J2469
Treanda	J9033	Belrapzo/Bendeka	J9036/J9034
Prolia/Xgeva • Exclude patients with metastatic breast and metastatic prostate per clinical data	J0897	Zoledronic acid	J3489
Zilretta	J3304	Triamcinolone inj.	J3301
Fereheme	Q0138	Venofer/Infed/Ferrlecit	J1756/J1750/J2916
Injectafer	J1439	Venofer/Infed/Ferrlecit	J1756/J1750/J2916
Infugem	J9199	Gemcitabine	J9201
Marqibo	J9371	Vincristine	J9370
Monoferric	J3490	Venofer/Infed/Ferrlecit	J1756/J1750/J2916

## References

- Centers for Medicare and Medicaid Services, Health Plan Management System (HPMS), MA\_Step\_Therapy\_HPMS\_Memo\_8\_7\_18; available at <http://www.cms.gov> - last checked August 31, 2018 and found under Medicare > Health Plans > Health Plans - General Information > Downloads.
- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sec. 50 (Rev. 241, Feb. 2, 2018); available at <http://www.cms.gov> - last checked August 31, 2018 and found under Medicare > Regulations and Guidance > Manuals > Internet-Only Manuals (IOMs).
- Local Coverage Determination (LCD). Centers for Medicare & Medicare Services. <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>.
- National Coverage Determination (NCD). Centers for Medicare & Medicare Services. <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>.
- U.S. Food & Drug Administration. FDA Approved Drug Products. <https://www.accessdata.fda.gov/scripts/cder/daf/>