Medica
(formerly WellFirst Health)

INJECTABLE MEDICINES

SEARCH TIPS:

Updated: 10/01/2024

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	Q2055	ABECMA	Idecabtagene vicleucel	Yes, through the Plan Pharmacy Services	ABECMA (Idecabtagene vicleucel)	ABECMA (Idecabtagene vicleucel)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9264	ABRAXANE	paclitaxel protein bound	Yes, through the Plan Pharmacy Services	ABRAXANE (paclitaxel protein-bound particles)	ABRAXANE (paclitaxel protein bound)	See National Coverage DeterminatSee National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9296	ACCORD	pemetrexed	Yes, through the Plan Pharmacy Serves	ACCORD (pemetrexed)	ACCORD (pemetrexed)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Pharmacy	J3262	ACTEMRA (SC)	tocilizumab	Yes, through Navitus. Restricted to (in at least consultation with an Rheumatology specialist with authorization.	ACTEMRA SC (tocilizumab)	ACTEMRA SC (tocilizumab)	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	J3262	ACTEMRA (IV)	tocilizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with an Rheumatology specialist with authorization.	ACTEMRA IV (tocilizumab)	ACTEMRA IV (tocilizumab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Pharmacy	J0800	ACTHAR GEL	repository corticotripin injection	PHARMACY BENEFIT ONLY. Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		ACTHAR GEL (repository corticotripin injection)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0791	ADAKVEO	crizanlizumab-tmca	Yes, through the Plan Pharmacy Services. Restricted to an Hematology specialist with authorization.	ADAKVEO (crizanlizumab-tmca)	ADAKVEO (crizanlizumab)	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	J9042	ADCETRIS	brentuximab vedotin	Yes, through the Plan Pharmacy Services	ADCETRIS (brentuximab vedotin)	ADCETRIS (brentuximab vedotin)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9029	ADSTILADRIN	nadogaragene firadenovec-vncg	Yes, through the Plan Pharmacy Services.	ADSTILADRIN (nadogaragene firadenovec-vncg)	ADSTILADRIN (nadogaragene firadenovec-vncg)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0172	ADUHELM	aducanumab	None. Not covered. Please see attached policy for criteria	ADUHELM (aducanumab)		
Medical	J7171	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
Medical	J3590	AHZANTIVE	aflibercept	Yes, through the Plan Pharmacy Services	AHZANTIVE (aflibercept)	AHZANTIVE (aflibercept)	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	J1454	AKYNEZO	fosbetupitant/palonosetron	Yes, through the Plan Pharmacy Services	AKYNEZO (fosbetupitant/palonosetron)	AKYNEZO (fosbetupitant/palonosetron)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1931	ALDURAZYME	laronidase	Yes, through the Plan Pharmacy Services. Restricted to (or in consultation with) medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis with authorization.	ALDURAZYME (laronidase)	ALDURAZYME (laronidase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9305	ALIMTA	pemetrexed	Yes, through the Plan Pharmacy Services	ALIMTA (pemetrexed)	ALIMTA (pemetrexed)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9057	ALIQOPA	copanlisib	Yes, through the Plan Pharmacy Services	ALIQOPA (copanlisib)	ALIQOPA (copanlisib)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J2469	ALOXI	palonosetron	EFFECTIVE 02/01/2023 No Prior Authorization is Required	ALOXI (palonosetron)		See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q5126	ALYMSYS	bevacizumab	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymsys, Mvasi and Vegzelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophtalmological indications.*** **See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.**	ALYMSYS (bevacizumab)	ALYMSYS (bevacizumab)	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	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.
Medical	J9999	AMTAGVI	lifileucel	Yes, through the Plan Pharmacy Services	AMTAGVI (lifileucel)	AMTAGVI (lifileucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0225	AMVUTTRA	vlutisiran	Yes, through the Plan Pharmacy Services	AMVUTTRA (vutrisiran)	AMVUTTRA (vutisiran)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9999	ANKTIVA	nogapendekin alfa inbakicept-pmln	Yes, through the Plan Pharmacy Services	Anktiva (nogapendekin alfa inbakicept-pmln)	Anktiva (nogapendekin alfa inbakicept-pmln)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7175, J7178, J7179, J7180, J7181, J7188, J7189, J7198, J7212	Antihemophilia Factor and Clotting Factors (Coagadex, RiaSTAP, Vonvendi, Corifact, Tretten, Obizur, Novoseven RT, Feiba NF, Sevenfact)	(coagulation factor x (human), fibrinogen concentrate (human), von Willebrand Factor (recombinant), factor XIII concentrate (human), coagulation factor XIII A-subunit (recombinant), antihemophilic factor (porcine), coagulation factor VIIa (recombinant), antiinhibitor coagulant complex, Coagulation factor VIIa (recombinant)-jncw)	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTIHEMOPHILIA FACTOR AND CLOTTING FACTORS	ANTIHEMOPHILIA FACTOR AND CLOTTING FACTORS	
Medical	J7182, J7183, J7185, J7186, J7187, J7190, J7192, J7204, J7205, J7207, J7208, J7209, J7210, J7211, J7214	Antihemophilic Factor VIII (Novoeight, Wilate, Xyntha, Alphanate, Humate-P, Hemofil M, Koate-DVI, Advate, Kogenate FS, Recombinate, Esperoct, Afstyla, Eloctate, Adynovate, Jivi, Nuwiq, Kovaltry, Altuviio)	(antihemophilic factor (recombinant), von Willebrand factor/coagulation factor VIII complex (human), antihemophilic factor (recombinant), antihemophilic factor/von Willebrand factor complex (human), antihemophilic factor/von Willebrand factor complex (human), antihemophilic factor (human), antihemophilic factor (human), antihemophilic factor (recombinant), antihemophilic factor (recombinant), Antihemophilic factor (recombinant) glycol-pegylated, antihemophilic factor (recombinant) single chain, antihemophilic factor (recombinant), antihemophilic factor (recombinant) pegylated, antihemophilic factor (recombinant) pegylated-auc), antihemophilic factor (recombinant) human, antihemophilic factor (recombinant)	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTIHEMOPHILIC FACTOR VIII	ANTIHEMOPHILIC FACTOR VIII	
Medical	J7193, J7194, J7195, J7200, J7201, J7202, J7203	Antihemophilic Factor IX (Alphanine SD, Mononine, Profilnine, Benefix, Ixinity, Rixubis, Alprolix, Idelvion, Rebinyn)	(coagulation Factor IX, coagulation Factor IX, factor IX complex, coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), fc fusion protein, coagulation factor IX (recombinant), human, coagulation factor IX (recombinant), glycopegylated)	Yes, through Dean Health Plan Utilization Management Department. Restricted to Hematology specialist with authorization.	ANTIHEMOPHILIC FACTOR IX	ANTIHEMOPHILIC FACTOR IX	
Medical	J2277	APHEXDA	motixafortide	Yes, through the Plan Pharmacy Services	Aphexda™ (motixafortide)	Aphexda™ (motixafortide)	
Medical	J0256	ARALAST NP	alpha-1-proteinase inhibitor (human)	Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	ARALAST NP (alpha-1-proteinase inhibitor)	ARALAST NP (alpha-1-proteinase inhibitor)	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	J0881	ARANESP	darbepoetin alpha	Yes , through the Plan Pharmacy Services	ARANSEP (darbepoetin alpha)	ARANSEP (darbepoetin alpha)	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	C9072	ASCENIV (IVIG) - non-preferred	immune globulin (Human)	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of all other immune globulin products.	ASCENIV (IVIG)	ASCENIV (IVIG)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9035	AVASTIN	bevacizumab	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymsys, Mvasi and Vegzelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophtalmological indications.*** **See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.**	AVASTIN (bevacizumab)	AVASTIN (bevacizumab)	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	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 (infliximab-axxq)	AVSOLA (infliximab-axxq)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	A9590	AZEDRA	Iobenguane I-131	Yes, through the Plan Pharmacy Services	AZEDRA (iobenguane I-131)	AZEDRA (iobenguane I-131)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9023	BAVENCIO	avelumab	Yes, through the Plan Pharmacy Services	BAVENCIO (avelumab)	BAVENCIO (avelumab)	
Medical	J9032	BELEODAQ	belinostat	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	BELEODAQ (belinostat)	BELEODAQ (belinostat)	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	J9036	BELRAPZO	bendamustine	Yes, through the Plan Pharmacy Services	BELRAPZO (bendamustine)	BELRAPZO (bendamustine)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9034	BENDEKA	bendamustine	Yes, through the Plan Pharmacy Services	BENDEKA (bendamustine)	BENDEKA (bendamustine)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0490	BENLYSTA (IV)	belimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	BENLYSTA IV (belimumab)	BENLYSTA IV (belimumab)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Pharmacy	J0490	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 (belimumab)	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	J0179	BEOVU	brolucizumab-dbll	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	BEOVU (brolucizumab-dbll)	BEOVU (brolucizumab-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, IL, MO
Medical	J9229	BESPONSA	inotuzumab ozogamicin	Yes, through the Plan Pharmacy Services	BESPONSA (inotuzumab ozogamicin)	BESPONSA (inotuzumab ozogamicin)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3590	BEQVEZ	fidanacogene elaparvovec-dzkt	Yes, through the Plan Pharmacy Services	Beqvez (fidanacogene elaparvovec-dzkt)	Beqvez (fidanacogene elaparvovec-dzkt)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J1556	BIVIGAM (IVIG), IMMUNE GLOBULIN	immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	BIVIGAM (IVIG)	BIVIGAM (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3590	BKEMV	eculizumab	Yes, through the Plan Pharmacy Services	BKEMV (eculizumab)	BKEMV (eculizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	BLINCYTO (blinatumomab)	BLINCYTO (blinatumomab)	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	J9322	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	BLUEPOINT (pemetrexed)	BLUEPOINT (pemetrexed)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9044	BORTEZOMIB		Yes, through the Plan Pharmacy Services	BORTEZOMIB	BORTEZOMIB	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	J0585	BOTOX	onabotulinumtoxin	No prior authorization is required.	BOTOX (onabotulinumtoxinA)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q2054	BREYANZI	lisocabtagene maraleucel	Yes, through the Plan Pharmacy Services	BREYANZI (lisocabtagene maraleucel)	BREYANZI (lisocabtagene maraleucel)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J2329	BRIUMVI	ublituximab-xiiy	Yes, through the Plan Pharmacy services.	BRIUMVI (ublituximab-xiiy)	BRIUMVI (ublituximab-xiiy)	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	J0567, C9014	BRINEURA	cerliponase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the Late infantile Ceroid lipofucinosis with authorization.	BRINEURA (cerliponase alfa)	BRINEURA (cerliponase alfa)	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	Q5124	BYOOVIZ	ranibizumab	Yes, through the Plan Pharmacy Services	BYOOVIZ (ranibizumab)	BYOOVIZ (ranibizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9043	CABZITAXEL	Cabazitaxel (Jevtana)	Yes, through the Plan Pharmacy Services	CABAZITAXEL (Jevtana)	CABAZITAXEL (Jevtana)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	C2056	CARVYKTI	ciltacabtagene autoleucel	Yes, through the Plan Pharmacy Services	CARVYKTI (ciltacabtagene autoleucel)	CARVYKTI (ciltacabtagene autoleucel)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3590	CASGEVY	exagamglogene autotemcel	Yes, through the Plan Pharmacy Services	CASGEVY (exagamglogene autotemcel)	CASGEVY (exagamglogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1786	CEREZYME	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)	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	Q5128	CIMERLI	ranibizumab	Yes, through the Plan Pharmacy Services	CIMERLI (ranibizumab)	CIMERLI (ranibizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Pharmacy	J0717	CIMZIA	certolizumab pegol	PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.		CIMZIA (certolizumab pegol)	
Medical	J2786	CINQAIR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	CINQAIR (reslizumab)	CINQAIR (reslizumab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1932	CIPLA	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	CIPLA (lanreotide depot)	CIPLA (lanreotide depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9286	COLUMVI	glofitamab-gxbm	Yes, through the Plan Pharmacy Services	COLUMVI™ (glofitamab-gxbm)	COLUMVI™ (glofitamab-gxbm)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1448	COSELA	trilaciclib	Yes, through the Plan Pharmacy Services	COSELA (trilaciclib)	COSELA (trilaciclib)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J3247	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	COSENTYX IV (secukinumab)	COSENTYX IV (secukinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0584	CRYSVITA	burosumab	Yes, through the Plan Pharmacy Services. Restricted to Endocrinologist, Nephrologist, Medical Geneticist, or Specialist experienced in treatment of Metabolic Bone Disorders with authorization.	CRYSVITA (burosumab)	CRYSVITA (burosumab)	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	J1555	CUVITRU (SCIG), IMMUNE GLOBULIN	immune globulin (cuvitru)	Yes, through the Plan Pharmacy Services	CUVITRU (SCIG)	CUVITRU (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9308	CYRAMZA	ramucirumab	Yes, through the Plan Pharmacy Services	CYRAMZA (ramucirumab)	CYRAMZA (ramucirumab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9348	DANYELZA	naxitamab	Yes, through the Plan Pharmacy Services	DANYELZA (naxitamab)	DANYELZA (naxitamab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9145	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services	DARZALEX (daratumumab)	DARZALEX (daratumumab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9144, C9062	DARZALEX FASPRO	daratumumab/hyaluronidase-fihj	Yes, through the Plan Pharmacy Services	DARZALEX FASPRO (daraumumab/hyaluronidase-fihj)	DARZALEX FASPRO (daratumumab/hyaluronidase-fihj)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0589	DAXXIFY	daxibotulinumtoxinA	None. Please see attached policy for criteria.	DAXXIFY® (daxibotulinumtoxinA)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7318	DUROLANE - non-preferred	sodium hyaluronate	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of DUROLANE requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	DUROLANE (sodium hyaluronate)	DUROLANE (sodium hyaluronate)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0586	DYSPORT	abobotulinumtoxinA	No prior authorization is required.	DYSPORT (abobotulinumtoxinA)		See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9304	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	J9063	ELAHERE	mirvetuximab soravtansine-gynx	Yes, through the Plan Pharmacy Services	ELAHERE (mirvetuximab soravtansine-gynx)	ELAHERE (mirvetuximab soravtansine-gynx)	MAPD 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 (idursulfase)	ELAPRASE (idursulfase)	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	J1413	ELEVIDYS	delandistrogene moxeparvovec-rokl	None. Not Covered	ELEVIDYS (delandistrogene moxeparvovec-rokl)		
Medical	J3060	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 (taliglucerase alfa)	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	J2508	ELFABRIO	pegunigalsidase-alfa-iwxj	Yes, through the Plan Pharmacy Services	ELFABRIO® (pegunigalsidase alfa-iwxj)	ELFABRIO® (pegunigalsidase alfa-iwxj)	MAPD 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	ELREXIFO™ (elranatamab-bcmm)	ELREXIFO™ (elranatamab-bcmm)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9269	ELZONRIS	tagraxofusp-erzs	Yes, through the Plan Pharmacy Services	ELZONRIS (tagraxofusp-erzs)	ELZONRIS (tagraxofusp-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)	EPMLICITI (elotuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9358	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 the Plan Pharmacy Services	ENJAYMO (sutimlimab-jome)	ENJAYMO (sutimlimab-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, J3590	ENSPRYNG	satralizumab-mwge	Yes, Through the Plan Pharmacy Services	ENSPRYNG® (satralizumab-mwge)	ENSPRYNG® (satralizumab-mwge)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3380	ENTYVIO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	ENTYVIO (vedolizumab)	ENTYVIO (vedolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9321	EPKINLY	epcoritamab-bysp	Yes, through the Plan Pharmacy Services	EPKINLY™ (epcoritamab-bysp)	EPKINLY™ (epcoritamab-bysp)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0885	EOPGEN	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)	EPOGEN (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, IL, MO.
Medical	J3590	EPYSQLI	eculizumab	Yes, through the Plan Pharmacy Services	EPYSQLI (eculizumab)	EPYSQLI (eculizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9055	ERBITUX	cetuximab	Yes, through the Plan Pharmacy Services	ERBITUX (cetuximab)	ERBITUX (cetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7323	EUFLEXXA - non-preferred	sodium hyaluronate, 1%	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred product. Coverage of EUFLEXXA requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	EUFLEXXA (sodium hyaluronate, 1%)	EUFLEXXA (sodium hyaluronate, 1%)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	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-aqqg)	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)	EVKEEZA (evinacumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		EVRYSDI	risdiplam	Yes, through Navitus. Restricted to a pediatric neurologist at a Muscular Dystrophy Association care center with authorization.		EVRYSDI (risdiplam)	

Medica
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INJECTABLE MEDICINES

SEARCH TIPS:

Updated: 10/01/2024

This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name

Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1428	EXONDYS 51	eteplirsen	None. Not Covered.	EXONDYS 51 (eteplirsen)		
Medical	J0178	EYLEA	aflibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	EYLEA (aflibercept)	EYLEA (aflibercept)	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	J0177	EYLEA HD	aflibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	EYLEA HD (aflibercept)	EYLEA HD (aflibercept)	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	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.	FABRYZYME (agalsidase)	FABRYZYME (agalsidase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0517	FASENRA	benralizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	FASENRA (benralizumab)	FASENRA (benralizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q0138, Q0139	FERAHEME - preferred	ferumoxytol	As od 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERAHEME (ferumoxytol)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J2916	FERRLECIT - preferred	sodium ferric gluconate complex	As of 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERRLECIT (sodium ferric gluconate complex)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	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/FLEBOGAMMA 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, IL, MO
Medical	Q5108	FULPHILA	pegfilgrastim-jmbd	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	FULPHILA (pegfilgrastim-jmbd)	FULPHILA (pegfilgrastim-jmbd)	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	J0641	FUSILEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	FUSILEV (levoleucovorin)	FUSILEV (levoleucovorin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9331	FYARRO	sirolimus albumin-bound	Yes, through the Plan Pharmacy Services	FYARRO (sirolimus albumin-bound)	FYARRO (sirolimus 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 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	FYLNETRA (pegfilgrastim-pbbk)	FYLNETRA (pegfilgrastim-pbbk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9210	GAMIFANT	emapalumab-lzsg	Yes, through the Plan Pharmacy Services	GAMIFANT® (emapalumab-lzsg)	GAMIFANT® (emapalumab-lzsg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 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, §50 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, IL, MO
Medical	J1561	GAMUNEX-C/GAMMAKED (SCIG), IMMUNE GLOBULIN	gamunex injection	Yes, through the Plan Pharmacy Services	GAMUNEX-C/GAMMAKED (SCIG)	GAMUNEX-C/GAMMAKED (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9301	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
Medical	J7326	GEL-ONE - non-preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GEL-ONE (hyaluronate sodium)	GEL-ONE (hyaluronate sodium)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J7328	GELSYN-3 - non-preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GELSYN-3 (hyaluronate sodium)	GELSYN-3 (hyaluronate sodium)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J7320	GENVISC 850 - non-preferred	hyaluronan or derivitive	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GENVISC 850 (hyaluronan derivitive)	GENVISC 850 (hyaluronate or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0223	GIVLAARI	givosiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematologist or specialist with expertise in diagnosis and management of AHP with authorization.	GIVLAARI (givosiran)	GIVLAARI (givosiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	GLASSIA (alpha-1-proteinase inhibitor)	GLASSIA (alpha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1447	GRANIX	tbo-filgrastim	Yes, through the Plan Pharmacy Services	GRANIX (tbo-filgrastim)	GRANIX (tbo-filgrastim)	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 dezaparvovec-drlb	Yes through the Plan Pharmacy Services	HEMGENIX (etranacogene dezaparvovec-drlb)	HEMGENIX (etranacogene dezaparvovec-drlb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J7170	HEMLIBRA	emicizumab	Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		HEMLIBRA (emicizumab)	

Medica
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INJECTABLE MEDICINES

Updated: 10/01/2024

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SEARCH TIPS:

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9248	HEPZATO	melphalan hydrochloride	EFFECTIVE 10/01/2024. Yes, through the Plan Pharmacy Services	Hepzato (melphalan hydrochloride)	Hepzato™ (melphalan hydrochloride)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9355	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.	HERCEPTIN (trastuzumab injection)	HERCEPTIN (trastuzumab injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
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	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-pkrb	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	J9294	HOSPIRA	pemetrexed	Yes, through the Plan Pharmacy Services	HOSPIRA (pemetrexed)	HOSPIRA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7321	HYALGAN - preferred	hyaluronate or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenViscS50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	HYALGAN (hyaluronate or derivative)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, 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)	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	J7322	HYMOVIS - preferred	hyaluronan	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenViscS50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	HYMOVIS (hyaluronan)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
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	ILUMYA™ (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-actl	Yes, through the Plan Pharmacy Services	IMJUDO (tremelimumab-actl)	IMJUDO (tremelimumab-actl)	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	talimogene laherparepvec	Yes, through the Plan Pharmacy Services	IMLYGIC (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	J9999	IMDELLTRA	tarlatamab-dlle	Yes, through the Plan Pharmacy Services	Imdelltra™ (tarlatamab-dlle)	Imdelltra™ (tarlatamab-dlle)	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	J1750	INFED - preferred	iron dextran	As of 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	INFED (iron dextran)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5103	INFLECTRA - non-preferred	infliximab-dyyb	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	INFLECTRA (infliximab-dyyb)	INFLECTRA (infliximab-dyyb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9198	INFUGEM	premixed gemcitabine in sodium chloride solution	Yes, through the Plan Pharmacy Services	INFUGEM (premixed gemcitabine in sodium chloride solution)	INFUGEM (premixed gemcitabine 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	J1439	INJECTAFER - non-preferred	ferric caroxymaltose	As of 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	INJECTAFER (ferric caroxymaltose)	INJECTAFER (ferric caroxymaltose)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	INSULIN PUMPS	INSULIN PUMPS	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NF)	immune globulin, powder	Yes, through the Plan Pharmacy Services	SCIG (Immune Globulin)	SCIG (Immune Globulin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services	IVIG (Immune Globulin)	IVIG (Immune Globulin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q5109	IXIFI	Infliximab-gbtx	Yes, through the Plan Pharmacy Services after failed trial of AVSOLA. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	IXIFI (infliximab-gbtx)	IXIFI (infliximab-gbtx)	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	J2782	IZERVAY	avacincaptad pegol	Yes, through the Plan Pharmacy Services	IZERVAY™ (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)	MAPD 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-gxly)	JEMPERLI (dostarlimab)	MAPD 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)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	JUBBONTI	denosumab	Yes, through the Plan Pharmacy Services	JUBBONTI (denosumab)	JUBBONTI (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services	KADCYLA (ado-trastuzumab emtansine)	KADCYLA (ado-trastuzumab emtansine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

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INJECTABLE MEDICINES

Updated: 10/01/2024

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SEARCH TIPS:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name

Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J1290	KALBITOR	Kalbitor (ecallantide)	Yes, through the Plan Pharmacy Services	KALBITOR (ecallantide)	KALBITOR (ecallantide)	MAPD 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	Yes, through the Plan Pharmacy Services	KANJINTI (trastuzumab-anns)	KANJINTI (trastuzumab-anns)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	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	J3490	KETAMINE for Chronic Pain and Mental Health and Substance Related Disorders		None. Not Covered	KETAMINE FOR CHRONIC PAIN		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	KEYTRUDA (pembrolizumab)	KEYTRUDA (pembrolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0175	KISUNLA	donanemab-azbt	EFFECTIVE 11/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9274	KIMMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	KIMMTRAK (tebentafusp-tebn)	KIMMTRAK (tebentafusp-tebn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	KRYSTEXXA (pegloticase)	KRYSTEXXA (pegloticase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q2042	KYMRIAH	tisagenlecleucel	Yes, through the Plan Pharmacy Services	KYMRIAH (tisagenlecleucel)	KYMRIAH (tisagenlecleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9047	KYPROLIS	carfilzomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	KYPROLIS (carfilzomib)	KYPROLIS (carfilzomib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0217	LAMZEDE	velmanase alfa-tycv	Yes, through the Plan Pharmacy Services	LAMZEDE™ (velmanase alfa-tycv)	LAMZEDE™ (velmanase alfa-tycv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	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	J3590	LANTIDRA	donislecel-jujn	Yes, through the Plan Pharmacy Services	LANTIDRA™ (donislecel-jujn)	LANTIDRA™ (donislecel-jujn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0202	LEMTRADA	alemtuzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialist with authorization. Infusions must be administered at a facility certified for LEMTRADA infusions.	LEMTRADA (alemtuzumab)	LEMTRADA (alemtuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	LENMELDY	atidarsagene autotemcel	Yes, through the Plan Pharmacy Services	LENMELDY (atidarsagene autotemcel)	LENMELDY (atidarsagene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0174	LEQEMBI	lecanemab-irmb	Yes, through the Plan Pharmacy Services	LEQEMBI™ (lecanemab-irmb)	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.	LEQVIO (inclisiran)		
Medical	J0641, J0642	LEVOLEUCOVORIN	fusilev khapzory	Yes, through the Plan Pharmacy Services	LEVOLEUCOVORIN	LEVOLEUCOVORIN	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0650	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INJECTION (INTRAVENOUS)	LEVOTHYROXINE INJECTION (INTRAVENOUS)	
Medical	J9119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	LIBTAYO (cemiplimab-rwlc)	LIBTAYO (cemiplimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2001		LIDOCAINE for Chronic Pain	None. Not Covered	LIDOCAINE FOR CHRONIC PAIN		
Medical	J3263	LOQTORZI	toripalimab-tpzi	Yes, through the Plan Pharmacy Services	LOQTORZI (toripalimab-tpzi)	LOQTORZI (toripalimab-tpzi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2778	LUCENTIS	ranibizumab	Yes, through the Plan Pharmacy Services	LUCENTIS (ranibizumab)	LUCENTIS (ranibizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0221	LUMIZYME	alglucosidase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX with authorization.	LUMIZYME (alglucosidase alfa)	LUMIZYME (alglucosidase alfa) (Intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9313	LUMOXITI	moxetumomab pasudotox	Yes, through the Plan Pharmacy Services	LUMOXITI (moxetumomab pasudotox-tdfk)	LUMOXITI (moxetumomab pasudotox)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9350	LUNSUMIO	mosunetuzumab-axgb	Yes, through the Plan Pharmacy Services	LUNSUMIO (mosunetuzumab-axgb)	LUNSUMIO (mosunetuzumab-axgb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	A9513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services	LUTATHERA (lutetium Lu 177)	LUTATHERA (lutetium Lu 177 dotatate)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3398	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-rzyl)	LUXTURNA (voretigene neparvovec-rzyl)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3394	LYFGENIA	lovotibeglogene autoemcel	Yes, through the Plan Pharmacy Services	LYFGENIA (lovotibeglogene autoemcel)	LYFGENIA (lovotibeglogene autoemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9353	MARGENZA	margetuximab	Yes, through the Plan Pharmacy Services	MARGENZA (margetuximab)	MARGENZA (margetuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3397	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-vjbk) (Intravenous)	MEPSEVII (vestronidase alfa-vjbk) (Intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9349	MONJUVI	tafasitamab-cxix	Yes, through the Plan Pharmacy Services	MONJUVI (tafasitamab-cxix)	MONJUVI (tafasitamab-cxix)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1437	MONOFERRIC - non-preferred	ferric derisomaltose	As of 08/01/2022: VENOFER, INFED, FERRLECIT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	MONOFERRIC (ferric derisomaltose)	MONOFERRIC (ferric derisomaltose)	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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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J7327	MONOVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	MONOVISC (hyaluronan or derivative)	MONOVISC (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	Q5107	MVASI	bevacizumab-awwb	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymsys, Mvasi and Vegzelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophtalmological indications.*** **See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.**	MVASI (bevacizumab-awwb)	MVASI (bevacizumab-awwb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J9203	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	MYLOTARG (gemtuzumab ozogamicin)	MYLOTARG (gemtuzumab ozogamicin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J0587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	MYOBLOC (rimabotulinumtoxinB)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J3490	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INTRAVENOUS	LEVOTHYROXINE INTRAVENOUS	
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.	NAGLAYME (galsulfase)	NAGLAYME (galsulfase)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J2506	NEULASTA	pegfilgrastim	Yes, Through Navitus	NEULASTA (pegfilgrastim)	NEULASTA (pegfilgrastim)	
Medical	J2506	NEULASTA	pegfilgrastim	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	NEULASTA (pegfilgrastim)	NEULASTA (pegfilgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1442	NEUPOGEN	filgrastim	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEUPOGEN (filgrastim)	NEUPOGEN (filgrastim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW	New to Market Medical Pharmacy Products currently under clinical review	New policy regarding Medical Pharmacy products under current clinical review	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW		
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS	New to Market Medical Pharmacy Products	New policy regarding New to Market Medical Products	NEW TO MARKET MEDICAL PHARMACY PRODUCTS		
Medical	J0219	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.	NEXVIAZYME (avalglucosidase alfa)	NEXVIAZYME (avalglucosidase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	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 (filgrastim-aafi)	NIVESTYM (filgrastim-aafi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2796	NPLATE	romipostim	Yes, through the Plan Pharmacy Services	NPLATE (romipostim)	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 asthma: Restricted to Pulmonology, Allergy, and Immunology specialists with authorization. Eosinophilic granulomatosis with polyangitis (EGPA): Restricted to a Pulmonology, Immunology, Allergy or Rheumatology specialist with authorization.	NUCALA (mepolizumab)	NUCALA (mepolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3490, C9399	NULIBRY	fosdenopterin	Yes, through the Plan Pharmacy Services. Restricted to a neurologist, medical geneticist, or a provider who specializes in management of inborn errors of metabolism with authorization.	NULIBRY (fosdenopterin)	NULIBRY (fosdenopterin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	NYPOZI	filgrastim-txid	Yes, through the Plan Pharmacy Services	NYPOZI (filgrastim-txid)	NYPOZI (filgrastim-txid)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5122	NYVEPRIA	pegfilgrastim-apgf	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, NYVEPRIA, FYLNETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	NYVEPRIA (pegfilgrastim-apgf)	NYVEPRIA (pegfilgrastim-apgf)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2350	OCREVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	OCREVUS (ocrelizumab)	OCREVUS (ocrelizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1568	OCTAGAM (IVIG), IMMUNE GLOBULIN	immune globulin (octagam liquid)	Yes, through the Plan Pharmacy Services	OCTAGAM (IVIG)	OCTAGAM (IVIG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q5114	OGIVRI	trastuzumab-dkst	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.	OGIVRI (trastuzumab-dkst)	OGIVRI (trastuzumab-dkst)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	OMSIGRE	omidubicel-onlv	Yes, through the Plan Pharmacy Services	OMISIRGE* (omidubicel-onlv)	OMISIRGE* (omidubicel-onlv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2267	OMVOH	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	J9205	ONIVYDE	irinotecan liposome injection	Yes, through the Plan Pharmacy Services	ONIVYDE (irinotecan liposome injection)	ONIVYDE (irinotecan liposome injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0222	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.	ONTRUZANT (trastuzumab-dttb)	ONTRUZANT (trastuzumab-dttb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9299	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

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9298	OPDUALAG	nivolumab/relatlimab-rmbw	Yes, through the Plan Pharmacy Services	OPDUALAG (nivolumab/relatlimab-rmbw)	OPDUALAG (nivolumab/relatlimab-rmbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0129	ORENCIA (IV)	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	ORENCIA IV (abatacept)	ORENCIA IV (abatacept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J0129	ORENCIA (SC)	abatacept	Yes, through Navitus. Restricted to an Rheumatology specialist with authorization.	ORENCIA SC (abatacept)	ORENCIA SC (abatacept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7324	ORTHOVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	ORTHOVISC (hyaluronan or derivative)	ORTHOVISC (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0224	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	OXLUMO (lumasiran)	OXLUMO (lumasiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9529	PACLITAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services	PACLITAXEL PROTEIN-BOUND PARTICLES	PACLITAXEL PROTEIN-BOUND PARTICLES	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9177	PADCEV	enfortumab vedotin-ejfv	Yes, through the Plan Pharmacy Services	PADCEV (enfortumab vedotin-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	J9304	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	J9247	PEPAXTO	melphalan flufenamide	Yes, through the Plan Pharmacy Services	PEPAXTO® (melphalan flufenamide)	PEPAXTO® (melphalan flufenamide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9306	PERJETA	pertuzumab	Yes, through the Plan Pharmacy Services	PERJETA (pertuzumab)	PERJETA (pertuzumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	PIASKY	crovalimab-akkz	EFFECTIVE 11/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	PHESGO (pertuzumab)	PHESGO (pertuzumab, trastuzumab, hyaluronidase)	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 tetraxetan)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9309	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)	MAPD 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	J9204	POTELIGEO	mogamulizumab-kpkc)	Yes, through the Plan Pharmacy Services	POTELIGEO (mogamulizumab-kpkc)	POTELIGEO (mogamulizumab-kpkc)	MAPD 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)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Pharmacy	J0885	PROCRIT - non-preferred	epoetin alfa, (for non-esrd use)	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	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, IL, 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.	PROCRIT (epoetin alfa, (for non-esrd use)	PROCRIT epoetin alfa, (for non-esrd use)	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	J9015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services	PROLEUKIN (aldesleukin)	PORLEUKIN (aldesleukin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0897	PROLIA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	PROLIA (denosumab)	PROLIA (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q2043	PROVENGE	sipuleucel-T	Yes, through the Plan Pharmacy Services	PROVENGE (sipuleucel-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, MO
Medical	J1304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	QALSODY™ (tofersen)	QALSODY™ (tofersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	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, §50 Drugs and Biologicals for drugs
Medical	J0896	REBLOZYL	lusptercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	REBLOZYL (luspatercept-aamt)	REBLOZYL (luspatercept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5125	RELEUKO	filgrastim-ayow	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.	RELEUKO (filgrastim-ayow)	RELEUKO (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)	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	J3285	REMODULIN IV	treprostinil	Generic Treprostinil will be covered with prior Authorization through the Plan Pharmacy Services. Brand REMODULIN will not be covered. Restricted to (in at least consultation with) a Cardiology or Pulmonology specialists with authorization.	REMODULIN IV (treprostinil)	REMODULIN IV (treprostinil)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5104	RENFLEXIS - preferred infliximab product	infliximab-abda	As of 10/01/2019: Prior authorization for the preferred infliximab product will only require provider attestation to an appropriate indication through the Plan Pharmacy Services. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	RENFLEXIS (infliximab)	RENFLEXIS (infliximab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Pharmacy	Q5105	RETACRIT - preferred	epoetin alfa-epbx	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	RETACRIT (epoetin alfa-epbx)	RETACRIT (epoetin alfa-epbx)	
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-epbx)	RETACRIT (epoetin alfa-epbx)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J7311	RETISERT	fluocinolone acetonide intravitreal implant	None. Not Covered.	RETISERT (fluocinolone acetonide intravitreal implant)		
Medical	J3590	RETHYMIC	allogeneic processed thymus tissue-agdc)	Yes, through the Plan Pharmacy Services	RETHYMIC (allogenic processed thymus tissue-agdc)	RETHYMIC (Allogenic processed thymus tissue-agdc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	J3590, C9399	REVCOVI	elapegademase-lvlr	Yes, through the Plan Pharmacy Services	REVCOVI® (elapegademase-lvlr)	REVCOVI® (elapegademase-lvlr)	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.	RHOPRESSA (netarsudil)	RHOPRESSA (netarsudil)	
Medical	Q5123	RIABNI	rituximab-arrx	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	RIABNI (rituximab-arrx)	RIABNI (rituximab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3490	RIVFLOZA	nedosiran	Yes, through the Plan Pharmacy Services	RIVFLOZA (nedosiran)	RIVFLOZA (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	rituximab	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	RITUXAN (rituximab)	RITUXAN (rituximab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	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, IL, MO
Medical	J9312	RITUXIMAB IV	rituxan, truxima, ruxiencem riabni	Yes, through the Plan Pharmacy Services	RITUXIMAB IV (rituxan, truxima, ruxience, riabni)	RITUXIMAB IV (rituxan, truxima, ruxiencem riabni)	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	J1412	ROCTAVIAN	valoctocogene roxaparvovec-rvox	Yes, through the Plan Pharmacy Services	ROCTAVIAN® (valoctocogene roxaparvovec-rvox)	ROCTAVIAN® (valoctocogene roxaparvovec-rvox)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1449	ROLVEDON	eflapegrastim-xnst	Yes, through the Plan Pharmacy Services	ROLVEDON™ (eflapegrastim-xnst)	ROLVEDON™ (eflapegrastim-xnst)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5119	RUXIENCE	rituximab-pvvr	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	RUXIENCE (rituximab-pvvr)	RUXIENCE (rituximab-pvvr)	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	J9061	RYBREVANT	amivantamab-vmjw	Yes, through the Plan Pharmacy Services	RYBREVANT (amivantamb-vmjw)	RYBREVANT (amivantamab-vmjw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2998	RYPLAZIM	plasminogen, human-tvmh	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical Hematologist or MD specializing in plasminogen deficiency (PLGD) with authorization.	RYPLAZIM (plasminogen, human-tvmh)	RYPLAZIM (plasminogen, human tvmh)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9333	RYSTIGGO	rozanolixizumab-noli	Yes, through the Plan Pharmacy Services	RYSTIGGO® (rozanolixizumab-noli)	RYSTIGGO® (rozanolixizumab-noli)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9999	RYTELO	imetelstat	EFFECTIVE 10/01/2024. Yes, through the Plan Pharmacy Services	Rytelo (imetelstat)	Rytelo (imetelstat)	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	J9361	RYZNEUTA	efbemalenograstim alfa-vuxw	Yes, through the Plan Pharmacy Services	RYZNEUTA (efbemalenograstim alfa-vuxw)	RYZNEUTA (efbemalenograstim alfa-vuxw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		SANDOSTATIN	octreotide	Yes, through Navitus. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or Gastroenterologist specialist with authorization.	SANDOSTATIN (octreotide acetate)		
Medical	J2353	SANDOSTATIN LAR	octreotide suspension	Yes, through the Plan Pharmacy Services	SANDOSTATIN LAR (octreotide suspension)	SANDOSTATIN LAR (octreotide suspension)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2354	SANDOSTATIN	octreotide suspension (non-depot form)	Yes, through the Plan Pharmacy Services	SANDOSTATIN octreotide suspension (non-depot form)	SANDOSTATIN octreotide suspension (non-depot form)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Services	SANDOZ (pemetrexed)	SANDOZ (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0491	SAPHNELO	anifrolumab-fnia	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	SAPHNELO (anifrolumab-fnia)	SAPHNELO (anifrolumab-fnia)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9227	SARCLISA	isatuximab-irfc	Yes, through the Plan Pharmacy Services	SARCLISA (isatuximab-irfc)	SARCLISA (isatuximab-irfc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7352	SCENESSE	afamelanotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Dermatologist, Medical Geneticist, or a Physician specializing in the treatment of cutaneous porphyrias with authorization.	SCENESSE (afamelanotide)	SCENESSE (afamelanotide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		SELF-ADMINISTERED DRUGS		PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.	SELF-ADMINISTERED DRUGS		
Medical	J2502	SIGNIFOR LAR	pasireotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist specialist with authorization.	SIGNIFOR LAR (pasireotide)	SIGNIFOR LAR (pasireotide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1602	SIMPONI ARIA	golimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (golimumab)	SIMPONI ARIA (golimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		SIMPONI ARIA	golimumab	Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (golimumab)	SIMPONI ARIA (golimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical		SITE OF SERVICE		Yes, through the Plan Pharmacy Services. Requests for select specialty drugs as listed in the list in section 'Drugs in Scope' to be administered in a hospital outpatient setting may be directed to a preferred alternative site of care, such as home infusion provider or a physician office.	SITE OF SERVICE		
Medical	J2327	SKYRIZI IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterolgy.	SKYRIZI IV (risankizumab)	SKYRIZZI IV (risankizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	SKYSONA	elivaldogene autotemcel	Yes, through the Plan Pharmacy Services	SKYSONA* (elivaldogene autotemcel)	SKYSONA* (elivaldogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1300	SOLIRIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Nuero-Opthalmongist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	SOLIRIS (eculizumab)	SOLIRIS (eculizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1930	SOMATULINE	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	SOMATULINE (lanreotide depot)	SOMATULINE (lanreotide depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1747	SPEVIGO	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	S0013	SPRAVATO	esketamine	Yes, through the Plan Pharmacy Services	SPRAVATO (esketamine)	SPRAVATO (esketamine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2326	SPINRAZA	nusinersen	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurology specialist with expertise in SMA treatment with authorization.	SPINRAZA (nusinersen)	SPINRAZA (nusinersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3358	STELARA (IV)	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	STELARA IV (ustekinumab)	STELARA IV (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	J3358	STELARA (SC)	ustekinumab	Yes, through Navitus. Restricted to an Gastroenterology specialist with authorization.	STELARA SC (ustekinumab)	STELARA SC (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	STIMUFEND	pegfilgrastim-pbbk	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	STIMUFEND (pegfilgrastim-pbbk)	STIMUFEND (pegfilgrastim-pbbk)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		Sublingual Immunotherapy (SLIT) for ALLERGY products	GRASTEK (Timothy grass pollen allergen extract), RAGWITEK (Short ragweed pollen allergen extract), ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens allergen extract), ODACTRA (House Dust Mite allergen extractt)	Yes, through Navitus. Must be prescribed by an allergist, immunologist, or physician with active and ongoing experience in the diagnosis and treatment of allergic disease and use of immunotherapy products with authorization	SLIT for Allergy Products	SLIT for Allergy Products	
Medical	J7321	SUPARTZ FX - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	SUPARTZ FX (hyaluronan or derivative)	SUPARTZ FX (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1627	SUSTOL	granisetron extended-release	Yes, through the Plan Pharmacy Services	SUSTOL (granisetron extended-release)	SUSTOL (granisetron extended-release)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2781	SYFOVRE	pegcetacoplan	No. Please see medical policy for criteria.	SYFOVRE (pegcetacoplan)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2860	SYLVANT	siltuximab	Yes, through the Plan Pharmacy Services	SYLVANT (siltuximab)	SYLVANT (siltuximab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	90378	SYNAGIS	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)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	J7325	SYNVISC - preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	SYNVISC (hyaluronan or derivative)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J7325	SYNVISC ONE - preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	SYNVISC ONE (hyaluronan or derivative)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3055	TALVEY	talquetamab-tgvs	Yes, through the Plan Pharmacy Serices	TALVEY™ (talquetamab-tgvs)	TALVEY™ (talquetamab-tgvs)	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 (atezolizumab)	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

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INJECTABLE MEDICINES

Updated: 10/01/2024

This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9314	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	TEVA (pemetrexed)	TEVA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9999, C9399	TEVIMBRA	tislelizumab-jsgr	Yes, through the Plan Pharmacy Services	TEVIMBRA (tislelizumab-jsgr)	TEVIMBRA (tislelizumab-jsgr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2356	TEZSPIRE	tezepelumab	Yes, through the Plan Pharmacy Services	TEZSPIRE (tezepelumab)	TEZSPIRE (tezepelumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9273	TIVDAK	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 (tocilizumab-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-qyyp)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services	TREANDA (bendamustine)	TREANDA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7332	TRILURON - preferred	sodium hyaluronate	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred products. No Prior Authorization needed for preferred product	TRILURON (sodium hyaluronate)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J7329	TRIVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	TRIVISC (hyaluronan or derivative)	TRIVISC (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9317	TRODELVY	sacituzumab govitecan-hziy	Yes, through the Plan Pharmacy Services	TRODELVY (sacituzumab govitecan-hziy)	TRODELVY (sacituzumab govitecan-hziy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1746	TROGARZO	ibalizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Infectious Disease specialist with authorization.	TROGARZO (ibalizumab)	TROGARZO (ibalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5115	TRUXIMA	rituximab-abbs	As of 01/01/2023: 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	TRUXIMA (rituximab-abbs)	TRUXIMA (rituximab-abbs)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	Q5134	TYRUKO	natalizumab	Yes, though the Plan Pharmacy Services	TYRUKO (natalizumab)	TYRUKO (natalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2323	TYSABRI	natalizumab injection	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	TYSABRI (natalizumab)	TYSABRI (natalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C9149	TZIELD	teplizumab-mzwv	Yes, through the Plan Pharmacy Services	TZIELD (teplizumab-mzwv)	TZIELD (teplizumab-mzwv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5111	UDENYCA	pegfilgrastim-cbqv	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	UDENCYA (pegfilgrastim-cbqv)	UDENCYA (pegfilgrastim-cbqv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1303	ULTOMIRIS	ravulizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematology, Oncology, or Immunology specialist with authorization.	ULTOMIRIS (ravulizumab)	ULTOMIRIS (ravulizumab)	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	J8499	UPTRAVI-IV	selexipag	Yes, though the Plan Pharmacy Services. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI-IV (selexipag)	UPTRAVI-IV (selexipag)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		UPTRAVI	selexipag	Yes, though Navitus. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI (selexipag)	UPTRAVI (selexipag)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2777	VABYSMO	faricimab-svoa	Yes, through the Plan Pharmacy Services	VABYSMO (faricimab-svoa)	VABYSMO (faricimab-svoa)	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	J9303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	VECTIBIX (panitumumab)	VECTIBIX (panitumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	VELCADE (bortezomib - preferred)	VELCADE (bortezomib - preferred)	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	Q5129	VEGZELMA	bevacizumab-adcd	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymsys, Mvasi and Vegzelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophtalmological indications.*** **See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.**	VEGZELMA (bevacizumab-adcd)	VEGZELMA (bevacizumab-adcd)	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	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, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	VENOFER (iron sucrose)		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9376	VEOPOZ	pozelimab-bbfg	Yes, through the Plan Pharmacy Services	VEOPOZ* (pozelimab-bbfg)	VEOPOZ* (pozelimab-bbfg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1427	VILTEPSO	viltolarsen	None. Not Covered.	VILTEPSO (viltolarsen)		

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Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
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)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7321	VISCO-3 - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflexxa, Gelsyn-3, Visco-3, sodium hyaluronate, TriVisc, Orthovisc, Supartz FX, and GenVisc850 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	VISCO-3 (hyaluronan or derivative)	VISCO-3 (hyaluronan or derivative)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9999	VIVIMUSTA	bendamustine	Yes, through the Plan Pharmacy Services	VIVIMUSTA (bendamustine)	VIVIMUSTA (bendamustine)	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	J3385	VPRIV	velaglucerase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX with authorization.	VPRIV (velaglucerase alfa)	VPRIV (velaglucerase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3032	VYEPTI	eptinezumab-jjmr	Yes, through the Plan Pharmacy Services	VYEPTI (eptinezumab-jjmr)	VYEPTI (eptinezumab-jjmr)	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	VYJUVEK™ (beremagene geperpavec-svdt)	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	J9332	VYVGART	efgartigimod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	VYVGART (efgartigimod)	VYVGART (efgartigimod)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9334	VYVGART-HYTRULO	efgartigimod alfa-fcab and hyaluronidase-qvfc	Yes, through the Plan Pharmacy Services	VYVGART* Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc)	VYVGART* Hytrulo (efgartigimod 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 (daunorubicin and cytarabine – liposome)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5138	WEZLANA	ustekinumab	Yes, through the Plan Pharmacy Services.	WEZLANA (ustekinumab)	WEZLANA (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	WYOST	denosumab	Yes, through the Plan Pharmacy Services	WYOST (denosumab)	WYOST (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J1558	XEMBIFY (SCIG)	immune globulin	Yes, through the Plan Pharmacy Services	XEMBIFY (SCIG)	XEMBIFY (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)	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	J0588	XEOMIN	incobotulinumtoxinA	No prior authorization is required.	XEOMIN (incobotulinumtoxinA)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J0897	XGEVA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	XGEVA (denosumab)	XGEVA (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J3299	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)	XIPERE (triamcinolone acetonide injectable suspension)	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	J2357	XOLAIR	omalizumab, 5mg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	XOLAIR (omalizumab)	XOLAIR (omalizumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J9228	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services	YERVOY (ipilimumab)	YERVOY (ipilimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q2041	YESCARTA	axicabtagene ciloleucel	Yes, through the Plan Pharmacy Services	YESCARTA (axicabtagene ciloleucel)	YESCARTA (axicabtagene ciloleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9352	YONDELIS	trabectedin	Yes, through the Plan Pharmacy Services	YONDELIS (trabectedin)	YONDELIS (trabectedin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5101	ZARXIO	filgrastim-ayow	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.	ZARXIO (filgrastim-ayow)	ZARXIO (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	J0256	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	J9223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	ZEPZELCA (lurbinectedin)	ZEPZELCA (lurbinectedin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5120	ZIEXTENZO - preferred	pegfilgrastim-bmez	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	ZIEXTENZO (pegfilgrastim-bmez)	ZIEXTENZO (pegfilgrastim-bmez)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5118	ZIRABEV - preferred	bevacizumab-bvzr	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymsys, Mvasi and Vegzelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophtalmological indications.*** **See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.**	ZIRABEV (bevacizumab-bvzr)	ZIRABEV (bevacizumab-bvzr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
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 (onasemnogene abeparvovec-xioi)	ZOLGENSMA (onasemnogene abeparvovec)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9359	ZYNLONTA	loncastuximab tesirine	Yes, through the Plan Pharmacy Services	ZYNLONTA (loncastuximab)	ZYNLONTA (loncastuximab tesirine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

Medica
(formerly WellFirst Health)

INJECTABLE MEDICINES

SEARCH TIPS:

Updated: 10/01/2024

This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name

Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J3393	ZYNTEGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	ZYNTEGLO® (betibeglogene autotemcel)	ZYNTEGLO® (betibeglogene autotemcel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9345	ZYNYZ	retifanlimab-dlwr	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
	Notes:						
			These drugs are all medical injectable drugs, and are not listed on the WellFirst Health 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, WellFirst Health has payment restrictions consistent with WellFirst Health Medical or Drug Policies.		The Health Plan will not cover U.S. Food and Drug Administration (FDA) approved drugs that are new to the market until the Pharmacy and Therapeutics (P&T) Committee formally reviews and grants approval, within a maximum timeframe of 1 year from FDA approval. If a provider believes that use of a new drug is medically necessary prior to P&T Committee approval, they may submit an exception to coverage form request.	
			J3590 and J3490 are miscellaneous codes used for drugs that do not have a 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 WellFirst Health.	It is recommended that any use of the miscellaneous codes be pre-approved ahead of time through WellFirst Health Utilization Management, especially for off-label uses from FDA indications.	Pharmacy Drug Exception to Coverage Form - IL Pharmacy Drug Exception to Coverage Form - MO	Medical Injectable Drug Exception to Coverage Form - IL Medical Injectable Drug Exception to Coverage Form - MO