



Part B Step Therapy Drug List

The following list of Non-Preferred Part B drugs will be subject to step therapy pursuant to CMS sub-regulatory guidance provided in the HPMS memo dated August 7, 2018. The allowance of step therapy practices for Part B drugs will help achieve the goal of lower drug prices while maintaining access to covered services and drugs for members.

Step therapy requirements will apply to “new starts” only and will not apply to members who are currently and actively receiving therapy with a Non-Preferred product (members with a paid claim within the past 365 days) on the list.

For dates of service on or after January 1st, 2021, we will require step therapy for the following Part B medications that are listed as Non-Preferred products.

Drug Class	Drug Name	HCPCS	Preferred Status
Hyaluronan Injections	Gel-One	J7326	Preferred
	Synvisc/Synvisc-One	J7325	Preferred
	Hyalgan	J7321	Non-preferred
	Hymovis	J7322	Non-preferred
	Monovisc	J7327	Non-preferred
	Orthovisc	J7324	Non-preferred
	Supartz FX	J7321	Non-preferred
	Trivisc	J7329	Non-preferred
	Durolane	J7318	Non-preferred
	Triluron	J7332	Non-preferred
	Synojoynt	J7331	Non-preferred
	Euflexxa	J7323	Non-preferred
	Gelsyn-3	J7328	Non-preferred
	GenVisc 850	J7320	Non-preferred
	Visco 3	J7321	Non-preferred
Colony Stimulating Factors Short-Acting	Granix	J1447	Preferred
	Zarxio	Q5101	Preferred
	Releuko	J3590	Non-Preferred
	Neupogen	J1442	Non-preferred
	Nivestym	Q5110	Non-preferred
Colony Stimulating Factors Long Acting	Neulasta	J2506	Preferred
	Udenyca	Q5111	Preferred
	Nyvepria	Q5122	Non-preferred
	Fylnetra	J3590	Non-preferred
	Fulphila	Q5108	Non-preferred
	Ziextenzo	Q5120	Non-preferred
	Stimufend	Q5127	Non-preferred
	Rolvedon	J1449	Non-preferred
Erythropoietic Agents	Retacrit (non-ESRD)	Q5106	Preferred
	Procrit/Epogen (non-ESRD)	J0885	Non-preferred

Anti-Inflammatory	Remicade	J1745	Preferred
	Unbranded Infliximab	J1745	Preferred
	Inflectra	Q5103	Preferred
	Renflexis	Q5104	Non-preferred
	Avsola	Q5121	Preferred
Drug Class	Drug Name	HCPCS	Preferred Status
Antineoplastic	Trazimera	Q5116	Preferred
	Kanjinti	Q5117	Preferred
	Ogivri	Q5114	Non-Preferred
	Herceptin	J9355	Non-preferred
	Herceptin Hylecta	J9356	Non-preferred
	Herzuma	Q5113	Non-preferred
	Ontruzant	Q5112	Non-preferred
Antineoplastic	Ruxience	Q5119	Preferred
	Truxima	Q5115	Preferred
	Rituxan	J9312	Non-preferred
	Rituxan Hycela	J9311	Non-preferred
	Riabni	Q5123	Non-preferred
Antineoplastic	Mvasi	Q5107	Preferred
	Zirabev	Q5118	Preferred
	Alymsys	J9999	Non-preferred
	Avastin*	J9035	Non-preferred
	Vegzelma	Q5129	Non-preferred

*Preferred products also require prior authorization.

**Oncology indications only