	 	INJ	ECTABLE MEDICINES]	
	(formerly WellFirst Health)	This reference quirte is a nartial listing	g of the most commonly prescribed drugs under the medical benefit	SEARCH TIPS:	(⊗ Medica.	
		are covered, not covered, or not yet review of any drug listed as not cov	eviewed and whether a prior authorization is required. For coverage	This is a large document, but you can search quickly and easily by clicking on the b to type in the name of drug you want to locate. If you do not know the correct spe the name	inocular icon on your toolbar. It will then display a search box for you	••••••	
	Updated: 05/01/2024		Navitus.				
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 vicloucel)	ABECMA (Idecabtagene vicleucel)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	19264	ABRAXANE	paclitaxel protein bound	Yes, through the Plan Pharmacy Services	ABRAXANE (pacitaxel protein-bound particles)	ABRAXANE (pacitaxel 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 WII, II, MO
Medical	19296	ACCORD	pemetrexed	Yes, through the Plan Pharmacy Servces	ACCORD (pemetrexed)	ACCORD (cometreved)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Pharmacy	13262	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 (tociizumab)	ACTEMRA IV (tocilizumab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Pharmacy	10800	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 (NCO), Local Coverage Determinations (LCOs), and Local Coverage Articles (LCAs) for guidance where applicable for Introductions WII, II, 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 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	19042	ADCETRIS	brentuximab vedotin	Yes, through the Plan Pharmacy Services	ADCETRIS (brentusimab vedotin)	ADCETRIS (brenturimab vedotin)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19029	ADSTILADRIN	nadogaragene firadenovec-vncg	Yes, through the Plan Pharmacy Services.	ADSTILADRIN (nadogaragene firadenovec-vnog	ADSTILADRIN (radogaragene firadenovec-vncg)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	J0172	ADUHELM	aducanumab	None. Not covered. Please see attached policy for criteria	ADUHELM (aducanumab)		
Medical	C9167	ADZYNMA	ADAMTS13, recombinant-krhn	Yes, through the Plan Pharmacy Services	ADZYNMA (ADAMTS13, recombinant-lirthn)	ADZYNMA (ADAMTS13, recombinant-krhn)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11454	AKYNEZO	fosbetupitant/palonosetron	Yes, through the Plan Pharmacy Services	AKYNEZO (fosbetupitant/palonsetron)	AKYNEZO (fosbetupitant/palonosetron)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, 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 (Gronidase)	ALDURAZYME (taronidase)	
Medical	19305	ALIMTA	pemetrexed	Yes, through the Plan Pharmacy Services	ALIMTA (pemetrexed)	ALMITA (pemetrexed)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J9057	ALIQOPA	copanlisib	Yes, through the Plan Pharmacy Services	ALIQOPA (copanisib)	ALIQOPA (copanTsib)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	12469	ALOXI	palonosetron	EFFECTIVE 02/01/2023 No Prior Authorization is Required	ALOXX (palonosetron)		See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	Q5126	ALYMSYS	bevocizumab	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alymays, Mixed and Vogedina prior authorization is require through the Film Pharmacy Services. "**Prior authorization for bevacizumab is not required when used for ophatimological indications."** See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	ALVMOVS	ALYMSIS	Medicare coverage for outputient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals
Medical	J1426	AMONDYS	casimersen	None. Not Covered.	AMONDYS (casimersen)		
Medical	19999	AMTAGVI	lifileucel	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services			
Medical	10225	AMVUTTRA	viutisiran	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	J71.75, J71.78, J71.79, J71.80, J71.81, J71.88, J71.89, J71.98, J72.12	Antihemophilia Factor and Clotting Factors (Coagadex, RiaSTAP, Vonvendi, Corifact, Tretten, Obizur, Novoseven RT, Feiba NF, Sevenfact)	(cogulation factor x (human), fibrinogen concentrate (human), von Willebrand Factor (recombinand, factor XIII concentrate (human), cogulation factor XIII A subunit (recombinand), anthemophilic factor (porcine), coagulation factor VIIa (recombinand), antihibitor coagulant complex, Coagulation factor VIIa (recombinand) -jncw)	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTIHEMOPHILIA FACTOR AND CLOTTING FACTORS.	ANTHEMORHILIA FACTOR AND CLOTTING FACTORS	
Medical	17182, 17183, 17185, 17186, 17187, 17180, 17187, 17180, 17180, 1720, 1720, 17211, 17214	Koate-DVI, Advate, Kogenate FS,	(artithemophilic factor (recombinant), von Willetzund factor/ coapulation factor Will complex (human), anthemophilic factor/ Will-complex (human), anthemophilic factor/ Will-complex (human), anthemophilic factor, Willeband factor complex (human), anthemophilic factor (human), district complex (human), anthemophilic factor (human), district complex (human), anthemophilic factor (recombinant), anthemophilic factor (recombinant) gived-pogisted, anthemophilic factor (recombinant) gived-pogisted, anthemophilic factor (recombinant) gived-pogisted, anthemophilic factor (recombinant) period any anthemophilic factor (recombinant) period and anthemophilic factor (recombinant) period has the population, anthemophilic factor (recombinant) human, anthemophilic factor (recombinant) human, anthemophilic factor (recombinant)	Yes, through Dean Health Flas Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTHERMOPHIS FACTOR VII.	ANTHERACOPHIS C FACTOR VIII.	
Medical	17193,17194,17195,17200,17201, 17202,17203	Antihemophilic Factor IX (Alphanine SD, Mononine, Profildine, 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), cliusion protein, coagulation factor IX (recombinant), fusion protein, coagulation factor IX (recombinant), human, coagulation factor IX (recombinant), glycopeg/lated)	Yes, through Dean Health Plan Utilization Management Department. Restricted to Hematology specialist with authorization.	ANTHEMOPHILIC FACTOR IX.	ANTHEMOPHILIC FACTOR IX.	
Medical	12277	APHEXDA	motivafortide	Yes, through the Plan Pharmacy Services	Coming Soon	Coming Stock	
Medical	10256	ARALAST NP	alpha-1-proteinase inhibitor (human)	Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	ARALAST NP (alpha-1-proteinase inhibitor)	ARALAST NP (alpha-1-proteinase inhibitor)	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 (darbegoetin 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)	ASCENIA (IVIG)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDd), and Local Coverage Articles (LCDd) for guidance where applicable for Jurisdictions WI, II, IMO
Medical	J903S	AVASTIN	bevacizumab	Ac of 03/01/2024: Zirabev is the preferred Bevacinumb product and dose not require prior authorization. Austin, Alymps, Mexia and Viggelma prior authorization is require through the Plan Pharmacy Services. ""Prior authorization for beoccinumb is not required when used for ophalmological indications: "See the ALYMSS" (bevacinumb) Policy for a list of applicable ophthalmological diagnoses.	AVASTIN (bevacioumab)	AVASTR (benacioumab)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	Q5121	AVSOLA - non-preferred	inflisimab-assq	Yes, through the Plan Pharmacy Plan after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialists with authorization.	AVSOLA (influinsib-acra)	AVSOLA (infliximate-axeg)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, II, MO

	Medica.	IN	IJECTABLE MEDICINES				
	(formerly WellFirst Health)	This reference guide is a partial list	ting of the most commonly prescribed drugs under the medical benefit	SEARCH TIPS:	(⊗ Medica.	
		are covered, not covered, or not ye review of any drug listed as not co WellFirst Health website for med	It reviewed and whether a prior authorization is required. For coverage overed, please complete the Exception to Coverage form found on the ical 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 to type in the name of drug you want to locate. If you do not know the correct sp the name	binocular icon on your toolbar. It will then display a search box for you elling, you can start your search by entering just the first few letters of	(formerly WellFirst Health)	
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	A9590	AZEDRA	iobenguane I-131	Yes, through the Plan Pharmacy Services	AZEDRA (ichenguane-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, II, MO
Medical	19023	BAVENCIO	avelumab	Yes, through the Plan Pharmacy Services	<u>BAVENCIO (avelumab)</u>	BAVENCIO (avelumab)	
Medical	19032	BELEODAQ	belinostat	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	BELFODAQ (belinostat)	BELEODAQ (belinostat)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	19036	BELRAPZO	bendamustine	Yes, through the Plan Pharmacy Services	BELRAPZO (bendamustine)	BELBAPZO (bendamuttine)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, E, MO
Medical	19034	BENDEKA	bendamustine	Yes, through the Plan Pharmacy Services	BENDEKA (bendamustine)	BENDEXA (bendamustine)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	10490	BENLYSTA (IV)	belimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	SENLYSTA IV (belimumab)	BENLYSTA IV (belimumzb)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Pharmacy	10490	BENLYSTA (SC)	belimumab	Yes, through Navitus. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	BENLYSTA SC (belimumab)	BENLYSTA SC (belimumab)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	J0179	BEOVU	brolucizumab-dbll	None. Please see attached policy for criteria.	SECVU (brolucisumab-dbll)		See National Coverage Determination (NCD), Local Coverage Determinations (LCDq), and Local Coverage Articles (LCAs) for guidance where applicable for hurisdictions WI, II, IMO
Medical	J0179	BEOVU	brolucizumab-dbll	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	19229	BESPONSA	inotuzumab ozogamicin	Yes, through the Plan Pharmacy Services	BESPONSA (inotuzumab ozogamicin)	BESPONSA (inctuzumab ozogamicin)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1556	BIVIGAM (IVIG), IMMUNE GLOBULIN	immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	BIVIGAM (IVIG)	BIVIGAM (IVIG)	
Medical	19039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	SLINCYTO (blinstumomab)	BUNCYTO (blinatumomab)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	19322	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	BLUE POINT (permetrowed).	BLUEPOINT (pernetroxed)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19044	BORTEZOMIB		Yes, through the Plan Pharmacy Services	<u>BORTEZOMIB</u>	BORTEZOM/B	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	10585	вотох	onabotulinumtoxin	No prior authorization is required.	BOTOX (on abotulinumtoxinA)		
Medical	Q2054	BREYANZI	lisocabtagene maraleucel	Yes, through the Plan Pharmacy Services	BREYANZI (Isocabtagene 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, MD
Medical	12329	BRIUMVI	ublituximab-xily	Yes, through the Plan Pharmacy services.	SRUMVI (ublitusimab-siiy)	BRILIMIVI (ublitusimab-siiyl	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 (certiponase atta)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	Q5124	BYOOVIZ	ranibizumab	No. No prior authorization required	SYOOVIZ** (ranibizumab)	BYGGVIZ** (canibitumab)	MMO Prior Authorization based on National Coverage Determination (PCCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Institutions WII, E. MO
	Q5124	BYDOVIZ	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	19043	CABZITAXEL	Cabazitaxel (Jevtana)	Yes, through the Plan Pharmacy Services	CASAZITAXEL (inctana)	CARZITAXEL (Motanal	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for trisdictions WI, II, MD
Medical	C2056	CARVYKTI	clitacabtagene autoleucel	Yes, through the Plan Pharmacy Services	CARVYICTI (citacabtagene autoleucel)	CARVYKTI (citacabtagene 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	13590	CASGEVY	exagamglogene autotemcel	Yes, through the Plan Pharmacy Services	CASGEVY (exagamplogene autotemcel)	CASGEVY (exagamgiogene autotemcel)	
Medical	J1786	CEREZYME	imiglucerase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX with authorization.	CEREZYME (miglucerase) (Intravenous)	CEREZYME (imiglucerase) (invtravenous)	Medicare coverage for outgatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	Q5128	CIMERLI	ranibizumab	No. No prior authorization required	GMERLI (ranipizumab)		MAPD Fror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCbs) for guidance where applicable for Authorization WI, E, MO
	Q5128	CIMERU	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Pharmacy	10717	CIMZIA	certolizumab pegol	PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.			
Medical	12786	CINQAIR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	ONGAIR (restinament)	CINOAUR (restitumab)	See National Coverage Determination (NCS), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictors WI, R, 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 (Janreotide depot)	CIPLA (lanrectide depot)	
Medical	19286	COLUMVI	glofita mab-gxbm	Yes, through the Plan Pharmacy Services	COLUMVI** (glofizamab-gobm)	COLUMNI** (glofitamab-grbm)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCRs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	11448	COSELA	trilaciciib	Yes, through the Plan Pharmacy Services	COSFLA (trilacicib)	COSELA (trilacidib)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	C9166	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	COSENTIX IV (secukinumab)	COSENTYX IV (secukinumab)	

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	Updated: 05/01/2024				1		
Benefit		Brand Names	Generic names	Prior Authorization or Restrictions Yes, through the Plan Pharmacy Services. Restricted to Endocrinologist,	Policy	Prior Authorization Form	MAPD
Medical	10584	CRYSVITA	burosumab	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 (Pab. 100-2), Chapter 15, §50 Drugs and Biologicals
Medical	11555	CUVITRU (SCIG), IMMUNE GLOBULIN	immune globulin (cuvitru)	Yes, through the Plan Pharmacy Services	CUVITRU (SCIG)	CUVITRU (SCIG)	
Medical	19308	CYRAMZA	ramucirumab	Yes, through the Plan Pharmacy Services	CYRAMZA (ramucirumab)	CRYRAMZA (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	19348	DANYELZA	naxitamab	Yes, through the Plan Pharmacy Services	DANYELZA (navitamab)	DANYEZA (navitamab)	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19145	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services	DARZALEX (daratmumab)	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-fihi)	<u>DARZALEX FASPRO (daratumumab/hyaluronidase-fihi)</u>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	10589	DAXXIFY	daxibotulinumtoxinA	None. Please see attached policy for criteria.	DAXXIFY* (daxibotulinumtoxinA)		MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17318	DUROLANE - non-preferred	sodium hyaluronate	Ac of 08/01/2022: HYALGAN, SYNVDC, SYNVDC ONE, HYMDVIS, and TRILLIRON will be the preferred product. Coverage of DUROLANE requires a falled fixed of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rehematology. Orthopodic, Sports Medicine, or Pain Medicine specialist with authorization.	QUROLANE (sodium hyeluronate)	QUIROLANE (sodium hyaluronate)	See National Coverage Determination (NCS), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Artifactions VM, E, MO
Medical	10586	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 WII, IL, MO
Medical	19304	EAGLE	pemetrexed	Yes, through the Plan Pharmacy Services	SAGLE (comptrexed)	<u>EAGLE (permetrayard)</u>	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19063	ELAHERE	mirvetuximab soravtansine-gyrox	Yes, through the Plan Pharmacy Services	ELAHERE (mirvetuoimab soravtansine-gynx)	ELAHERE (mirvetusimab soravtansino-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 Mucopolyaccharidosis II with authorization.	ELAPRASE (idumsiffase)	ELAPRASE (idursulface)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals
Medical	11413	ELEVIDYS	delandistrogene moxeparvovec-rold	None. Not Covered	ELEVIDYS (delandistrogene moxepanyovec-rokl)		
Medical	13060	ELELYSO	taliglucerase alfa (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher 1 DX with authorization.	ELELYSO (taliglucerace alfa)	ELELYSO (traligibucerase aifa)	Medicare coverage for outpatient (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 35, 550 Drugs and Biologicals
Medical	12508	ELFABRIO	pegunigalsidase-alfa-ixwj	Yes, through the Plan Pharmacy Services	ELFARRIO* (pegunigalridase alfa lwei)	Elfabrio* (pegunigalsidase alfa-bouj)	MMFO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11323	ELREXIFO	eiranatamab-bcmm	Yes, through the Plan Pharmacy Services	ELREOFO** (elranatamab-bennn)	ELREXIFO** (elran atamab-b-cmm)	MMPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19269	ELZONRIS	tagraxofusp-erzs	Yes, through the Plan Pharmacy Services	ELZONRIS (tagraxofusp-erzs)	ELZONRIS (tagraxofusp-erzs)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19176	EMPLICITI	elotuzumab	Yes, through the Plan Pharmacy Services	EMPLICITI (elotuzumab)	EPMLICITI (elotuzumab)	MAPD Prior Authorization needed outlined in the Medicare Senefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19358	ENHERTU	fam-trastuzumab deruxtecan-nxki	Yes, through the Plan Pharmacy Services	ENHERTU (fam-trastuzumab deruxteran-ricki)	ENHERTU (fam-trastuzumab deruxtecan-nukl)	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)	ENSAYIMO (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* (catralizumab-mwge)	ENSPRYING* (satralitumal-mwge)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13380	ENTYVIO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	ENTYVIO (vedolizumab)	ENTY/IO (vedolizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19321	EPKINLY	epcoritamab-bysp	Yes, through the Plan Pharmacy Services	EPKINLY** (epcoritamab-byso)	EPKINIY*** (epcoritamab-byse)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10885	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 Pharmary 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, E, MO.
Medical	19055	ERBITUX	cetuximab	Yes, through the Plan Pharmacy Services	ERBITUX (cotusimab)	ERBITLIX (cetus/mab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	17323	EUFLEXXA - non-preferred	sodium hyaluronate, 1%	As of OB/OJ/2022-HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TBILLIRON will be the preferred product. Coverage of EUFEDXA requires a Saled trial of a perierred product. For subtorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopeoic, Sports Medicine, or Plan Medicine specialist with authorization.	EUFLEXXA (addium hydroriate, 110)	EUFLEXXA (codium hydluronate, 15)	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for survicinion W. E., 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-aqqq)	EVENITY (romosozumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 590 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 (ovinacumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 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.		EVRYSOI (risdiplam)	
Medical	J1428	EXONDYS 51	eteplirsen	None. Not Covered.	EXONDYS 51 (etaplirsen)		
Medical	J0178	EYLEA	aflibercept	None. Please see attached policy for criteria.	EYLEA (affibercept)		MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (NCD), Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, II, MO.
	10178	EYLEA	afilbercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	

	⊗ Medica.	IN	JJECTABLE MEDICINES				
	(formerly WellFirst Health)	are covered, not covered, or not ye review of any druz listed as not co	ting of the most commonly prescribed drugs under the medical benefit et reviewed and whether a prisor authoritation is required. For coverage were complete the Exception to Coverage form found on the leaf submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	SEARCH TIPS: This is a large document, but you can search quickly and easily by cisking on the to type in the name of drug you want to locate. If you do not know the correct specific harmonic description in the name.	hinocular icon on your toolbar. It will then display a search how for your	Medica. (formerly WellFirst Health)	
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J0177	EYLEA HD	afibercept	None. Please see attached policy for criteria.	EYLEA* HD (Affibercept)	Prior Authorization Form	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.
	J0177	EYLEA HD	afilbercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0180	FABRYZYME	agalsidase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical geneticist or other prescriber specialized in the treatment of Fabry DX with authorization.	FABRYZYME (agalsidase)	FABRYZYME (agalisidase)	MMPD 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 (benralbumab)	EASENRA (benralizumab)	MAYD Prior Authoritation needed positived in the Medicare Benefit Policy Manual (Pub. 100-2), Chepter 15, 550 Drugs and Biologicals for drugs
Medical	Q0138, Q0139	FERAHEME - preferred	ferumosytal	As od 08/01/2022: VENOTER, INVED, FERRILECT, and FERRHEME are the preferred parenteed it ron products and do not require prior authorization. NULCTARE, MONDFERRIC, TREERIC, and TREERIC, ANNU are the non- referred parenteed into products and prior authorization is required through the Plan Pharmacy Services with authorization.	EERAHEME (Terumonytod)		
Medical	12916	FERRLECIT - preferred	sodium ferric gluconate complex	As of 08/01/2022-VENOFER, INFED, FERRILECTT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. NECTATEM, MONOFERRIC, TREFIEC, and TREFERC, ANNU are the non- preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	ETRIN SCIT (sodium ferric glucinate complex)		
Medical	J1744	FIRAZYR	icatibant	Yes, through the Plan Pharmacy Services	FIRAZYR* (icatibant)	FIRAZYR® (icatbane)	MMFO 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 D (IVIG), IMMUNE GLOBULIN	IF Bebogamma	Yes, through the Plan Pharmacy Services	FLEBOGAMMA/FLEBOGAMMA DIF (WIG)	FLEBOGAMMA/FLEBOGAMMA DIF (WIG)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Auridictions VII, II, MO
Medical	Q5108	FULPHILA	pegfigrastim-jmbd	EFFC.TVR 0.1/01/2023. FULHHLA and ZIEXTRXIO are the preferred Pegfligrastim products and do not require prior authorization. Must have a failed trial of ZIEXTRXIO AND FULPHILA before coverage of Neulata. UDENCYA, NYVEPRIA, PYLNETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	EULPHILA (pogfligrastim-jmbd)	FULPHILA (pogfigractim-imbd)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for suredictions WI, E, MD
Medical	J0641	FUSILEV	levolaucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	FUSILEV (levolescovorin)	FUSIL EV (Bevoleucovorin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9331	FYARRO	sirolimus albumin-bound	Yes, through the Plan Pharmacy Services	EYARRO Isirolimus albumin-boundi	EYARRO (sirelimus albumin-bound)	MAPO 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	pegfágrastim-pbbk	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegiliparatim products and do not require prior authorization. Must have a falled triol of ZIEXTENZO MON EUPHILA Debrie coverage of Neulasta, UDENCVA, NYVERRIA, PLYNETRA, and STIMMJENO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	SLVNETRA (seepflagraction publish)	EXYNETRA (cogfligraction abbits)	MANO Prior Authorisation needed outlined in the Medicare benefit Policy Manual (Pub. 100-2), Chepter 15, 550 Drugs and Biologicals for drugs
Medical	J9210	GAMIFANT	emapalumab-lzsg	Yes, through the Plan Pharmacy Services	SAMIFANT* (emapalumab-lasg)	GAMIFANT* (emapalumab-lzsg)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs.
Medical	J1569	GAMMAGARD (SCIG), IMMUNE GLOBULIN	immune globulin, (gammagard liquid)	Yes, through the Plan Pharmacy Services	GAMMAGARD (SOG)	GAMMAGARD (SCIG)	MANO Prior Authorization needed dustined in the Medicare Benefit Policy Manual (Pub. 150-2), Chapter 15, 550 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)	MAPO Prior Authorization based on National Coverage Determination (NCO), Local Coverage Determinations (LCO), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1561	GAMUNEX-C/GAMMAKED (SCIG) IMMUNE GLOBULIN	gamunex injection	Yes, through the Plan Pharmacy Services	GAMUNEX-C/GAMMAKED (SOG)	GAMUNEX-C/GAMMAXED (SCIG)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J9301	GAZYVA	obinutuzumab	Yes, through the Plan Pharmacy Services	GAZYVA (obinutuzumab)	GAZYVA (obinutuzumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17326	GEL-ONE - non-preferred	hyaluronate sodium	Ac of 08/01/2022: HYBLGAN, STRVISC, STRVISC ONE, HYBDVIS, and TBILLIRON will be the perferent hyblurinic acid products and do not require prior authorization. Monoxic, burdane, Gel-Ho, Euflexxx, Gelsyn-3, Visco-3, sodium hyblurosate, Trivisc, Orthoxic, Sypatra DX, Gelsyn-3, Visco-3, sodium hyblurosate, Trivisc, Orthoxic, Sypatra DX, Gellyniscosate of products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	GEL ONE (hyphronate collum)	GEL-CRE Evalumente sodumi	MAYO Prior Authorization based on National Coverage Determination (HCO), Local Coverage Determinations (LCO), and Local Coverage Articles (LCA) for goldence where applicable for abridictions WL 8, MO
Medical	17328	GELSYN-3 - non-preferred	hyaluronate sodium	As of OB/OJ/2022: HYALGAN, STNYISC, STNYISC ONE, HYMOVIS, and TRILLIGNOW will be the preferred hybranic acid products and do not require prior authorization. Monoxic, Durate, Geld-One, Euders, Queller, Quidens, Agents, Carlon, State 18, Agents, Gelders, Agents, Visco 3, sodium hybrid protein, Critico, Chritovico, Superte RA, and envirold to the more preferred hybranic acid products and prior authorization is required through the Rian Pharmacy Services. Please see Model Prior for Commission of Services and Commission of Services	SELSYN-3 (hydurovate sodium)	GESTN-3 (hyalurocate sodium)	MAPD Prior Authorization based on National Coverage Determination (PCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Introductions WI, II, MO
Medical	17320	GENVISC 850 - non-preferred	hyaluronan or derivitive	As of OB/OI/2022 HYALGAN, SYNYISC, SYNYISC ONE, HYMIOVIS, and TRILLIGION will be the preferred hyblinoric acid products and do not require prior subtributation. Microsic, Duration, 604-6the, Eufersa, acid Carlyn, 3, Visc. 3, sodium hybrid product, Triviac, Christowa, Lippur Dr. and acid products of the confidence of the confidence of the confidence authorization is reprinced through the Plan Pharmacy Services. Please see Medical Policy for criteria	GENVISC 850 Byekuronan derivibied	GENYISE 850 (hyulumonate or derivative)	MAMO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for availations Wil, R, MO
Medical	10223	GIVLAARI	givosiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematologist or specialist with expertise in diagnosis and management of AHP with authorization.	GIVLAARI (glyppiran)	GINLAARI (ghookran)	MAPO 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.	SLASSIA (algha-1-proteinase inhibitor)	GLASSIA (algha-1-proteinase inhibitor)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11447	GRANIX	tbo-filgrastim	Yes, through the Plan Pharmacy Services	GRANIX (the filgrastim)	GBANIX (the-figractim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy	17170	HEMLIBRA	emicizumab	Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		HEMLIBRA (emiciaumab)	
Medical	J7170	HEMLIBRA	emicizumab	Yes, through the Plan Pharmacy Services	HEMLIBRA (emicizumab)	HEMLIBRA (emicizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

	Medica.	IN.	JECTABLE MEDICINES				
	(formerly WellFirst Health)	This reference guide is a partial listi are covered, not covered, or not vet	ing of the most commonly prescribed drugs under the medical benefit t reviewed and whether a prior authorization is required. For coverage	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 yo	Medica.	
	Updated: 05/01/2024	review of any drug listed as not co WellFirst Health website for medic	reviewed and whether a prior authorization is required. For coverage evend, please complete the Exception to Coverage form found on the cal 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 cEcking on the to type in the name of drug you want to locate. If you do not know the corrects the name	selling, you can start your search by entering just the first few letters o	f (formerly WellFirst Health)	
Benefit		Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9355	HERCEPTIN	trastuzumab injection	Herzum 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 (tractuzumab injection)	HERCEPTIN (tractuzumab injection)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19356	HERCEPTIN HYLECTA	trastuzumab and hyaluronidase-oysk	Yes, through the Plan Pharmacy Services	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)	HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1411	HEMGENIX	etranacogene dezaparvovec-drib	Yes, through the Plan Pharmacy Services Herzuma and Trazimera are the preferred Trastuzumab products and do	HEMGENIX (etranacogene dezaparvovec-drib)	HEMGENIX (etranacogone dezaparvovec-drib)	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	ner crimin and inaziment and one prevented in accounting products, and do not require prior authorization. Herceptin, Oglyri, Kanjinti and Ontruzani, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	* HERZUMA (tractuzumab-pkrb)	HERZUMA (trastozumab-akrb	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11559	HIZENTRA (SCIG), IMMUNE GLOBULIN	immune globulin (hizentra)	Yes, through the Plan Pharmacy Services	HIZENTRA (SCHS)	HZENTRA (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19294	HOSPIRA	pemetrexed	Yes, through the Plan Pharmacy Services	HOSPIRA (pemetrexed)	HOSPIRA (pemetrexed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17321	HYALGAN - preferred	hyaluronate or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMDVIS, and TBILLIOND will be the preferred hybritonic and products and do not require price arbitrosiston. Microsistic, Darlana, Gel-One, Eufleway, Gelsyns-3, Visco-3, sodium hybrid counter, TriVisc, Chrishovis, Spatra FR, AnderwickSia are the one preferred hybridance and product and price authorization is required through the Plan Pharmacy Services. Please see Michical Policy for calls	1976 GAN (hydronate or derhalbed)		MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Artisticions WI, II, MO.
Medical	J9351	HYCAMTIN	topotecan	IV dosage form does not require PA Oral dosage form requires PA - Restricted to Oncologists with authorization through the Plan Pharmacy Services.		HYCAMTIN (topotocan)	
Medical	17322	HYMOVIS - preferred	hyaluronan	As of GM/01/2022: HYALGAN, SYNVISC, SYNVISC DNE, HYMNOVS, and TRILLIKON will be the preferred hydronic acid products and do not require prior subtraction. Monovinc, Drudne, Gel-One, Eufleway, Gelsyn-3, Yaco-3, sodium hydriconate, TriVisc, Chriswosc, Supert FX, and Gelsyn-3, Yaco-3, sodium hydriconate, TriVisc, Chriswosc, Supert FX, and Gerin-ViscSS are the non-preferred hydronica od products and event control of the contro	PRACOS (halocoas)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for goldance where applicable for Intellictions WI, E, MO.
Medical	J1575	HYQVIA (SCIG), IMMUNE GLOBULIN	immune globulin (hyqvia)	Yes, through the Plan Pharmacy Services	HYOWIA ISCIS)	HYDVIA (SCIG)	MAPO Prior Authorization needed autlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13245	ILUMYA	tildrakizumab-asmn	Yes, through the Plan Pharmacy Services	ILUMYA* (tildrakizumab-asmn)	ILUMYA* (tildrakizumab-asmn)	MAPO 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)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19347	IMJUDO	tremelimumab-acti	Yes, through the Plan Pharmacy Services	IMUDO (tremelimumab-acti)	IMRIDO fremelimumab-acti	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19325	IMLYGIC	talimogene laherparepvec	Yes, through the Plan Pharmacy Services	IMIYGIC (talimogene lahernaregvect)	IMLYGIC (talimogene laherparesvec)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11750	INFED - preferred	von dextran	As of OR/OI/2022-VENDER, INFID, FERRIECIT, and FERRHIME are the preferred parenter if non products and do not require prior authorization NIECTAPER, MONOFERRIC, THEFRIC, and TRIFERIC AVMUJare the non- preferred parenter if iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	NFTD (ron destran)		
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 [infiximab-dyyb)	MAPO hird Authorization based on National Coverage Determination (NCS), Local Coverage Determinations (LCS), and Local Coverage Articles (LCAs) for guidance where applicable for Artistrictions Will, II, MO
Medical	19198	INFUGEM	premixed gemcitabine in sodium chloride solution	Yes, through the Plan Pharmacy Services	INFUGEM (premixed gemcitabline in sodium chloride solution)	INFUGEM [premixed genicitabline in sodium chloride solution]	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11439	INJECTAFER - non-preferred	ferric caroxymaltose	As of OB/OI/2022: VENORER, INSED, FERRIECIT, and FERAHEME are the preferred parenter all ron products and do not require prior authorization NINECTAPER, MONOFERRIC, TRIEFRIC, and TRIEFRIC AVMUJ are those preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.		NUECTAFR (forric caronymattoss)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	INSULIN PUMPS	INSULIN PUMPS	
Medical	J1566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NF)	immune globulin, powder	Yes, through the Plan Pharmacy Services	SCIG (Immune Globulin)	SOG (Immune Globulin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (NCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	11599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services	IVIG (Immune Globulin)	IVIG Emmune Globulin)	MAPO Frior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for surfactions WI, II, MO
Medical	12782	IZERVAY	avacincaptad pegol	Yes, through the Plan Pharmacy Services	IZERVAY™ (avacincaptad pegol)	(ZERVAY™ (avacincaptad pegol)	MAPO 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)	IELMYTO (mitomycin)	MATO 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-goly)	JEMPERLI (dostarlimab)	MAPO Prior Authorization needed outlined in the Medicare Berefit Policy Manual (Pub. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19043	JEVTANA	cabazitaxel	Yes, through the Plan Pharmacy Services	JEVTANA (cabasitaxel)	JEVTANA (cabasitaxel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	JUBBONTI	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	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, E, MO
Medical	19354	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, 590 Drugs and Biologicals for drugs
Medical	J1290	KALBITOR	Kalbitor (ecallantide)	Yes, through the Plan Pharmacy Services	KALBITOR (ecaliantide)	KALBITOR (ocaliantide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 590 Drugs and Biologicals for drugs
Medical	Q5117	KANJINTI	trastuzumab-anns	Yes, through the Plan Pharmacy Services	KANENTI (trastuzumab-anns)	KANJINTI (trastus-mah arns)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

	Medica.	INJ	ECTABLE MEDICINES				
	(formerly WellFirst Health)			SEARCH TIPS:		⊗ Medica.	
		are covered, not covered, or not yet review of any drug listed as not cov	g of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage ered, please complete the Exception to Coverage form found on the all submit to the Plan Pharmacy Services and for pharmacy submit to	This is a large document, but you can search quickly and easily by clicking on the b to type in the name of drug you want to locate. If you do not know the correct spe the name	inocular icon on your toolbar. It will then display a search box for you fling, you can start your search by entering just the first few letters of	(formerly WellFirst Health)	
	Updated: 05/01/2024	WEITER TREATMENT OF THE OLD	Navitus.	L/100 10001100			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12840	KANUMA IV KETAMINE for Chronic Pain and	sebeli pase alfa	Yes, through the Plan Pharmacy Services	KANUMA IV (sebeligase alfa)	KANUMA IV (sobelipase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13490	KETAMINE for Chronic Pain and Mental Health and Substance Related Disorders		None. Not Covered	KETAMINE FOR CHRONIC PAIN		
Medical	19271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	KEYTRUDA (pembrolizumab)	KEYTRUDA (pembrolizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9274	KIMMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	XIMMTRAK (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	12507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	KYRSTEXXA (pegleticase)	KRYSTECKA (pogloticase)	MAPTO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q2042	KYMRIAH	tisagenlecieucel	Yes, through the Plan Pharmacy Services	KYMRIAH (tisagenlecleucel)	CYMRIAH (tisagenlecleusel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19047	KYPROLIS	carfilzomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	(CYPROLIS (carfiltomib)	EYPROLIS (carfizomib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	J0217	LAMZEDE	velmanase alfa-tycv	Yes, through the Plan Pharmacy Services	LAMZEDE* (volmanase alfa-tycy)	LAMZEDE* (volmanaso alfa-tycvi).	MAPO 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	LANKEOTIDE (somatuline depot)	LANREOTIDE (somatuline depot)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	LANTIDRA	donislecel-jujn	Yes, through the Plan Pharmacy Services	LANTIDRA™ (donislecel-jujn)	LANTIDRA™ (donislecel-jujn)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10202	LEMTRADA	alemtuzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialist with authorization. Influsions must be administered at a facility certified for LEMTRADA influsions.	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	30174	LEQEMBI	lecanemab-irmb	Yes, through the Plan Pharmacy Services	SEGEMBI** (lecanomab-limb)	LEGEMBI** Becanemub-irmb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11306	LEQVIO	inclisiran	None. Not covered.	LEQVIO (inclisiran)		
Meducal	J0641, J0642	LEVOLEUCOVORIN	fusilev khapzory	Yes, through the Plan Pharmacy Services	LEVOLEUCOVORIN	LEVOLEUCOVORIN	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10650	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INJECTION (INTRAVENOUS)	LEVOTHYROXINE INJECTION (INTRAVENOUS)	
Medical	19119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	LISTAYO (comiplimab-rwk)	LIBTAYO (complimab)	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	19999	LOQTORZI	toripalimab-tpzi	Yes, through the Plan Pharmacy Services	LOQTORZI (toripalimab-tpsi)	LOQTORZI (toripalimab-tpzi)	MAPO 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	No. No prior authorization required	LUCENTIS (ranibizumab)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	J2778	LUCENTIS	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	J0221	LUMIZYME	alglucosidase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX with authorization.	LUMIZYME (alglucosidase alfa)	LUMIZYME (alglucosidase alfa) (Intravenous)	MAPD Prior Authorization needled outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	19313	LUMOXITI	maxetumomab pasudotox	Yes, through the Plan Pharmacy Services	EUMOXITI (moxetumomab pasudotox-tdfl.)	LUMOXITI (moxetumomab pasudotox)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19350	LUNSUMIO	mosunetuzumab-axgb	Yes, through the Plan Pharmacy Services	<u>LUNSUMIO (mosuneturumab-avgb)</u>	LUNSUMIO (mosun etuzumab-axgb)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), 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	13398	LUXTURNA	voretigene neparvovec-rzyl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the retinal dystrophy with authorization.	LUXTURNA (voretigene neparvovec-rzyl)	LUXTURNA (voretigene neparvovec-rzyt)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590	LYFGENIA	lovotibegiogene autoemcel	Yes, through the Plan Pharmacy Services	LYFGENIA (lovotibeglogene autoemcel)	LYFGENIA (lovotibeglogene autoemcel)	
Medical	19353	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	13397	MEPSEVII	vestronidase alfa-vjok (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-vijtki) Entravenous)	MEDSEVII (vestronidase alfa-sjöb) (intravenous)	MAPD Prior Authorization needed dudined in the Medicare Benefit Policy Manual (Puls. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19349	MONJUVI	tafasitamab-cxix	Yes, through the Plan Pharmacy Services	MONJUVI (tafasitamab-cxix)	MONJUVI (tafasitamab-cxix)	MAPO 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 OR/OJ/2022: VENOTER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. NUCCTAFE, MONOTERIC, TRIFFIC, and TRIFFIC, ANNU are the non- preferred parenter all non products and prior authorization is required through the Plan Pharmacy Services with authorization.	MONOFERRIC (ferric derisions/fores)	MONOFERRO (ferro dericonsilipse)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls 100-2), Chapter 15, \$00 Drugs and Biologicals for drugs
Medical	17327	MONOVISC - non-preferred	hyaluronan or derivative	As of 08/01/202: HYALGAN, SYNVISC, SYNVISC ONG, HYMDVIS, and TRILLINGN will be the preferred hyalumoic and products and on not require prior arbitrations. Microsisc, Condin., 664 One, fielding, 664 One,	MONOVSC (hyphronan or definative)	MONOVISC (hyaluronan or derkathel)	MAPO Prior Authorisation based on National Coverage Determination (NCO), Local Coverage Determinations (LCO), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions Wil, II, MO.
Medical	Q5107	MVASI	bevacizumab-awwb	As of 03/01/2024: Zirabev is the preferred Bevacitumab product and does not require prior authorization. Ausstin, Alymoys, Minasi and Vigeriema prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacitumab is not required when used for ophtalmological indications.*** See the ALYMOYS Devacitumab Policy for a list of applicable ophthalmological diagnoses.	MVASI (bevacaumab-awwb)	MVASI (Devaic (outholo-ovenb)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for sursdictions WI, E, MO.

		IN	JECTABLE MEDICINES				
	(formerly WellFirst Health)	This reference guide is a partial list are covered, not covered, or not ye review of any drug listed as not co Wellfirst Health website for medi	ing of the most commonly prescribed drugs under the medical benefit treviewed and whether a prior authorisation is required. For coverage wered, please complete the Exception to Coverage form found on the cal submit to the Plan Pharmacy Services and for pharmacy submit to	SEARCH TIPS: This is a large document, but you can search quickly and easily by clicking on the to type in the name of drug you want to locate. If you do not know the correct speak	inocular icon on your toolbar. It will then display a search box for you	Medica. (formerly WellFirst Health)	
	Updated: 05/01/2024	Weilrist Heath Website for medi	Navitus.	one name			
Benefit		Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19203	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	MYLOTARG (gentuzumab ozogamicin)	MYLOTARG (gemtuzumab ozogamicin)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Medical	10587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	MYOBLOC (rimabotulinumtoxinB)		MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	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 (galouttoo)	NAGLAYME (gaisuffase)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs.
Pharmacy	12506	NEULASTA	pegfilgrastim	Yes, Through Navitus	NEULASTA (pegfilgrastim)	NEULASTA (pogfigrastim)	
Medical	12506	NEULASTA	pogffigraxtim	EFFECTIVE 01/01/2023: FLILPHILA and ZIEXTINIZO are the perferred Pegiligraziani products and do not require prior authorization. Mank have a falled that of ZIEXTIZOA DOM PULVHILA before coverage of Noulasta. UDENCYA, PRYCEPIA, PYLIKITRA, and STIMUFENO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEURASTA (Insufficiación)	NEGRASTA (postfigraction)	MANO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), 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 Granks, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEUPOGEN (figractim)	NEUPOGEN (filgractin)	MAPO Prior Authorization needed authined in the Medicare Benefit Policy Manual (Pub. 100 1), 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 CUNICAL 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 (avalighucosidase alfa)	NEXVIAZYME (avaightosidase 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, Refeuiko and Grankir, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NIVESTYM (fligrastim-aafi)	NIVESTYM (figractim-aafi)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12796	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 (megolisumab)	NUCALA (mapolizumab)	MAVO Pror Authorization needed patiend in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13490, C9399	NULIBRY	fosdenopterin	Yes, through the Plan Pharmacy Services. Restricted to a neurologist, medical geneticist, or a provider who specializes in management of inborn errors of metabolism with authorization.	NULIBRY (fosdenoptarin)	NUUSRY (foudenopterin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5122	NYVEPRIA	pegfigratim-apgf	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pagiligrazim products and do not require prior authorization. Must have a falled with of ZIEXTEZO DN DILPHIRA before coverage of Neulasta, UDENCYA, NYVEPRIA, PYMETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	NOVEPRIA (pagetiar action agen)	NYVEPRA (popular action appl)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12350	OCREVUS	ocrekzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	OCREVUS (ocretizumab)	OCREVUS (ocretitumab)	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-disst	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 (trasturumab-dist)	OGIVRI (trastuzumab-dist)	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	amidubicel-only	Yes, through the Plan Pharmacy Services	OMISIRGE® (omidubicel-only)	OMISIRGE® (omidubicel-only)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C9168	омуон	mirikizumab-mrkz	Yes, through the Plan Pharmacy Services	OMVOH (mirikbumab-mrkz)	OMVOH (miriktrumab-mrks)	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	QNIVYDE firinatecan liposome injection)	ONIV/DE (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 concultation with) a Oncology, Hematology or Neurology specialist with authorization.	ONPATTRO (patisiran)	ONPATTRO (patisiran)	MAYO Prior Authorization needed politined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 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, Oglvri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	QNTRUZANT (trasturumah-dtth)	CNTRUZANT (trastuzumak-sttb)	MMPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19299	OPDIVO	nivolumab	Yes, through the Plan Pharmacy Services	CPDVQ (nhohmab)	OPOIVO (nivolumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19298	OPDUALAG	nivolumab/relatlimab-rmbw	Yes, through the Plan Pharmacy Services	OPDUALAG (nivolumab/relatlimab-rmbw)	OPDUALAG (nivolumab/relatlimab-rmbw)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0129	ORENCIA (IV)	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	ORENCIA IV (abatacopt)	ORENCIA IV (abatacept)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
				Yes, through Navitus. Restricted to an Rheumatology specialist with	ORFNOA SC (abstacent)		
Pharmacy	J0129	ORENCIA (SC)	abatacept	authorization.	(MENCIA SC (Abstracept)	ORENCIA SC (abataceot)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 950 Drugs and Biologicals for drugs
Medical	17324	ORTHOVISC - non-preferred	hyaluronan or derivative	As of 80(07/2022 - HYALGAN, STNVEX, SYNVEX ONE, HYMONYS, and TRULIRON will be the preferred hydrocric acid products and do not require prior authorization. Monosics, Durolane, Gel-One, Euflexa, Gellyes 3, Vacc-3, sidemly hydrocrate, ITVISC, Orthoxec, Suparta TX, and GenVicSSD are the non-preferred hydrocrate acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for orthera	CATHOUSE (hyahuranan or derivative)	OSTHOVISC (bysiumonae or dentrative)	MAYO Prior Authorization based on National Coverage Determination (NCS), Local Coverage Determinations (LCSs), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions VM, R, MO

		INJ	ECTABLE MEDICINES				
	(formerly WellFirst Health)	are covered, not covered, or not yet in review of any drug listed as not covered.	g of the most commonly prescribed drugs under the medical benefit without and whether a prior authorization is required. For coverage ered, please complete the Euception to Coverage form Bound on the Is submit to the Pfan Pharmacy Services and for pharmacy submit to Navirus.	SEARCH TIPS: This is a larger document, but you can search quickly and easily by clicking on the let to type in the name of drug you want to locate. If you do not know the correct specific manner of the property of the name of the correct specific manner of the name of the correct specific manner of the name of the	inneular icon on your toolbar. It will then display a search how for you	Medica. (formerly WellFirst Health)	
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
	10224	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	QXLUMO (lumasiran)	OXLUMO (lumasiran)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19529	PACLITAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services	PACLITAXEL PROTEIN-BOUND PARTICLES.	PACLITAXEL PROTEIN-BOUND PARTICLES	MAPO Prior Authorization based on National Coverage Determination (MCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICDs) for guidance where applicable for Jurisdictions WI, R, MO
Medical	19177	PADCEV	enfortumab vedotin-ejfv	Yes, through the Plan Pharmacy Services	PADCEV (enfortumab vendotin-ejőv)	PADCEV (enfortumals vedetin-ejfy)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 590 Drugs and Biologicals for drugs
Medical	J0208	PEDMARK	soodium thiosulfate	Yes, through the Plan Pharmacy Services	PEDMARK* (sodium thiosulfate)	PEDMARK* (sodium thiosulfate)_	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19304	PEMFEXY	pemetrexed	Yes, through the Plan Pharmacy Services	PEMFEXY (pemetrexed)	PEMFEXY (pemetrexed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §10 Drugs and Biologicals for drugs
Medical	19247	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, 550 Drugs and Biologicals for drugs
Medical	19306	PERJETA	pertuzumab	Yes, through the Plan Pharmacy Services	PERIETA (pertuzumab)	PERJETA (pertuzumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	PHESGO (perticumab)	PHESGO (pertuzumab, trastuzumab, hyaluronidase)	MAPO 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)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19309	POLNY	polatuzumab vedotin-piiq	Yes, through the Plan Pharmacy Services	POLIVY (polatuzumab vedotin-piiq)	POLNY (polatuzumab vedotin-piio)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1203	POMBILITI	cipaglucosidase alfa-atga	Yes, through the Plan Pharmacy Services	POMBILITI (cipaglucosidase alfa-atga)	POMBILITI (cipaglucosidase alfa-atga)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19295	PORTRAZZA	necitumumab	Yes, through the Plan Pharmacy Services	PORTRAZZA (neckumumab)	PORTRAZZA (necitumumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-7), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19204	POTELIGEO	mogamulizumab-kpkc)	Yes, through the Plan Pharmacy Services	POTELIGEO (mogamulizumab-kokc)	POTELIGEO (mogamulizumab-kpkx)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11459	PRIVIGEN (IVIG), IMMUNE GLOBULIN	privigen	Yes, through the Plan Pharmacy Services	PRIVIGEN (IVIG)	PRIVIGEN (IVIG)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCDs) for guidance where applicable for Jurisdictions Wil, IL, MD.
Pharmacy	10885	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 aleha).	PROCRIT (epoetin aleha).	
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-ersd use)	PROCRIT epoetin alfa, (for non-eard use)	NAMO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for burisdictions W, E, MO.
Medical	19015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services	PROLEUKIN (aldesleukin)	PORLEUKIN (aldesleukin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10897	PROLIA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	PROLIA (denosumab)	PROUA (denosumab)	MAVD fror Authorization based on National Coverage Determination (NCS), local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Artifactions WI, II, MO
Medical	Q2043	PROVENGE	sipuleucel+T	Yes, through the Plan Pharmacy Services	PROVENGE (sipuloucel-T)	PROVENGE (signiture)-T)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	QALSODY** (tofersen)	OALSODY™ (tofersen)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Rub. 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)	MAVO Prior Authorization needed outlined in the Medicare Benefit Rolley Manual (Pub. 100-3), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	10896	REBLOZYL	lusptercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	SEBLOZYL (luspatercept-aamt)	REBLOZYL (luspatercept)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 550 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 Granks, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<u>RELEUKO (figrastim-ayow)</u>	RELEUKO (filgrastim-ayow)	MAYO 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.	SEMICADE (infliximab)	SEMICADE Finflishnabb	MMO Fror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	13285	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.	SEMODULIN IV (trepresticil)	SEMODULIN IV (trapprostinil)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-7), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5104	RENFLEXIS - preferred infliximab product	infiltulmab-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.	<u>MENTLEXS (officienab)</u>	RENFLDUS [inflatinub]	MAYO Pror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, IMO.
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.	SETACSIT (epostin alfa-ephx)	SETACRIT (epoetin alfa-ephs)	
Medical	Q5106	RETACRIT	epoetin alfa-epbx	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authoritation. Epogen and Procrit prior authoritation is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RETACRIT (epoetin alfa epbx)	RETACRET (epoetin alfa-ophu)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for harbdictions WI, IL, MO
Medical	J7311	RETISERT	fluocinolone acetonide intravitreal implant	None. Not Covered.	RETISERT (fluocinolone acetonide intravitreal implant)		
Medical	13590	RETHYMIC	allogeneic processed thymus tissue-agdc)	Yes, through the Plan Pharmacy Services	SETHYMIC (allogenic processed thumus tissue agds)	RETHYMIC (Alloganic processed thymus tissue-agdc)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals
Medical	J3590, C9399	REVCOVI	elapegademase-lvir	Yes, through the Plan Pharmacy Services	REVCOVI* (elapegademase-lvir)	REVCOVI* (elapogademase-lvlr)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitus.	<u>8HOPRESSA (netarsudil)</u>	RHOPRESSA (netarsudi)	

	 	10	VIECTABLE MEDICINES]	
	(formerly WellFirst Health)	This reference cuids is a partial Es	tion of the most commonly exceeded down under the modical baselit	SEARCH TIPS:	(⊘ Medica.	
		are covered, not covered, or not ye review of any drug listed as not co WellFirst Health website for med	et revisived and whether a prior authorization is required. For coverage overed, please complete the Exception to Coverage form found on the lical 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 to type in the name of drug you want to locate. If you do not know the correct sp the name	binocular icon on your toolbar. It will then display a search box for you elling, you can start your search by entering just the first few letters of		
	Updated: 05/01/2024						1400
Benefit Medical	J Code 05123	Brand Names	Generic names	Prior Authorization or Restrictions Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for	Policy RIABNI (ritucimals-arrx)	Prior Authorization Form	MAPD MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
medica:	(511)	N. P. C.	TAMES WITH	criteria		THE OWNER OF THE OWNER	нае от 100 моничного выего да цанови, подава в техничного (каст) тога съдава на техничного (каст) подава на технич
Medical	J3490	RIVFLOZA	nedosiran	Yes, through the Plan Pharmacy Services	RIVFLOZA (nedosiran)	RNFLOZA (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	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria	RTUXAN (riturimab)	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 Auridictions WI, E, MD
Medical	J9311	RITUXAN HYCELA	rituximab and hyaluronidase human	Yes, through the Plan Pharmacy Services	RTUXAN HYCELA (ritusimab and hyaluronidase human)	RITUXAN HYCELA (ritusimab and hyaluronidase human)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J9312	RITUXIMAB IV	rituxan, truxima, ruxiencem riabni	Yes, through the Plan Pharmacy Services	RTUXIMAB IV (rituxan, truxima, ruxience, riabni)	RITUXIMAB IV (rituxan, truxima, ruxiencem riabni)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for surviscitions WI, II, MO
Medical	J1412	ROCTAVIAN	valoctocogene roxaparvovec-rvox	Yes, through the Plan Pharmacy Services	ROCTAVIAN® (valoctocogene roxaparvovec-rvox)	ROCTAVIAN® (valoctocogene roxaparvovec-rvox)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 3), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1449	ROLVEDON	eflapegrastim-xnst	Yes, through the Plan Pharmacy Services	ROLVEDON™ (efflapegrastim-xmst)	ROLVEDON™ (eflapograstim-xnst)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5119	RUXIENCE	ritusimab-pwr	As of 01/01/2023: Ruxience and Truxima are the preferred Rituximab products and does not require prior authorization. Riabni and Rituxian prior authorization is required. Please see medical policy for criteria	SUMENCE (ritusimals-poor)	BLIXENCE (riturimals-povr)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	J9061	RYBREVANT	amivantamab-vmjw	Yes, through the Plan Pharmacy Services	RYBREVANT (amivantamb-vmjw)	RYBREVANT (amivantamab-vm/w)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12998	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.	SYPLAZMI (plasminogen, human humb)	EYPLAZIM (plaimingen, human hemh)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19333	RYSTIGGO	rozanolixizumab-noli	Yes, through the Plan Pharmacy Services	RYSTIGGO* (rezanolivizumab-noli)	RYSTIGGO* (rozanotxizumab-noti)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J3590	RYZNEUTA	efbemalenograstim alfa-vuxw	Yes, through the Plan Pharmacy Services	NYZNEUTA (efbomalenograstim alfa-vanw)	SYZNEUTA(efbernalen ogractim alfa-vuxw)	
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	12353	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	12354	SANDOSTATIN	octreotide suspension (non-depot form)	Yes, through the Plan Pharmacy Services	SANDOSTATIN octreotide suspension (non-depot form)	SANDOSTATIN actreatide 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	19064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Services	SANDOZ (pemetrexed)	SANOOZ (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-fnla	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	SAPHNELO (anifrolumab-fnia)	SABHNELO (anifrolumab-fria)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19227	SARCLISA	isatuximab-irfc	Yes, through the Plan Pharmacy Services	SARCLISA (isatuvimab-irfc).	SARCUSA (icatusimab-irlc)	MAPD Prior Authorization needed cutlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	17352	SCENESSE	afamelanotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Dermatologist, Medical Geneticit, 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 (paireortide)	SIGNIFOR LAR (pasireortide)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11602	SIMPONI ARIA	golimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least concultation with) an Rheumatology (Rheumatold Arthritis, Peripheral Ankylozing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (golimumab)	SIMPONI ABA (golimumah)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy		SIMPONI ARIA	golimumab	Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatold Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ASIA (polimumab)	SIMPONI ABIA (golimumab)	
Medical		SITE OF SERVICE		Yes, through the Plan Pharmacy Services. Requests for select specially 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 influsion provider or a physician office.	SITE OF SERVICE		
Medical	12327	SKYRIZI IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterolgy.	SKY8/Zi IV (risankizumab)	SKYRIZZI IV (risankizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13590	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 Biologiculs for drugs
Medical	J1300	SOLIRIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Nuero-Opthalmonogist, Nephrology, Hematology, Oncology, or Transplan specialist with authorization.	t SOLIRIS (eculizumab)	SOLBIS (eculizumab)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictors WI, II, MO
Medical	11930	SOMATULINE	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	SOMATULINE (lunreotide depot)	SOMATULINE (larrectide deport)	MAYO Prior Authorisation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11747	SPEVIGO	spesolimab	Yes, through the Plan Pharmacy Services	SPEVIGO* (spesolimab)	SPEVIGO* (spssolmab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs

	 	IN	IJECTABLE MEDICINES				
	(formerly WellFirst Health) Updated: 05/01/2024	This reference guide is a partial list are covered, not covered, or not ye review of any drug listed as not co WellFirst Health website for medi	ing of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage evened, plases complete the Exception to Coverage form bound on the call submit to the FRA Prainmacy Services and for pharmacy submit to Navitus.	SEARCH TIPS: This is a large document, but you can search quickly and each by cricking on the I to type in the name of drug you want to locate. If you do not know the correct spotting the name of the name.	olonocular icon on your toolbar. It will then display a search box for you silling, you can start your search by entering just the first few letters of	Medica. (formerly WellFirst Health)	
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	13490	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	12326	SPINRAZA	nusinersen	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurology specialist with expertise in SMA treatment with authorization.	SPINRAZA (nusinersen)	SPINRAZA (nusinersen)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13358	STELARA (IV)	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	STELARA IV (ustokinumab)	STELARA IV (ustekinumab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	J3358	STELARA (SC)	ustekinumab	Yes, through Navitus. Restricted to an Gastroenterology specialist with authorization.	STELARA SC (u stekinumab)	STELARA SC (ustekinumab)	MM/O Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 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 extract)	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	SAIT for Allergy Products	
Medical	J7321	SUPARTZ FX - non-preferred	bysluronan or derivative	As of 08/01/2022 HYALGAN, SYNVISC, SYNVISC ONE, HYMDVIS, and TRULUKION will be the preferred hyblutonic acid products and do not closely and the preferred hyblutonic acid products and do not closely a-1 Viceo. A colour hyblutonic RIVEO, Orthonics, Synylate RIV, and GenivicaSD are the non-preferred hyblutonic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	SUPARTZ FX (hyalluronan or derivative)	SUPARTZ FX (hyaluronan or derivative)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1627	SUSTOL	granisetron extended-release	Yes, through the Plan Pharmacy Services	SUSTOL (granisatron extended-release)	SUSTOL (granisetron-extended-release)	MAPO 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)		MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2860	SYLVANT	slitusimab	Yes, through the Plan Pharmacy Services	SYLVANT (citusimab)	SYLVANT (situsimab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	90378	SYNAGIS	pallvizumab	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 (palivirumab)	
Medical	17325	SYNVISC - preferred	hyaluronan or derivative	As of DR(DIZD22: HYALGAN, SYNYDC, SYNYDC ONE, HYMCVDC, and TRULDIGN will be the preferred hybriumic acid products and do not require prior adhoritation. Microvidc, Druthan, Gel-One, Euflewa, Gellyn 3, Visco 3, sodium hybrium ratte, Trivinc, Christovic, Suparta TX, Gellyn 3, Visco 3, sodium hybrium ratte, Trivinc, Christovic, Suparta TX, Gellyn 3, Visco 3, sodium hybrium ratte, Trivinc, Christovic, Suparta TX, Gellyn St. Visco 3, sodium hybrium ratte, Trivinc, Christovic, Suparta TX, Gellyn St. Visco 3, sodium hybrium ratte, Christovic, Suparta TX, Gellyn St. Visco 3, sodium ratte, Christovic, Suparta St. Visco 4, St. Visco 3, St. Visco 3, St	S2000SC (hydluranae or deniathed)		MAYO Prior Authorization based on National Coverage Determination (NCO), Local Coverage Determinations (LCOs), and Local Coverage Articles (LCAs) for guidance where applicable for sursidictions Wil. II, MO
Medical	17325	SYNVISC ONE - preferred	hydluronan or derivative	As of OB/OJ/2022: HYALGAN, SYNYISC, SYNYISC ONE, HYMOVIS, and TRELURON will be the preferred hybluronic acid products and on not require prior subriscation. Monoxisc, Durada, Gel-One, Euflewa, Geldyna, Visco-3, sodium hybluroniste, Irviviac, Christoviac, Suparta FX, and Gellyna, Visco-3, sodium hybluroniste, Irviviac, Christoviac, Suparta FX, and Gerlyna Sylvaco-3, sodium hybluroniste, Irviviac, Christoviac, Suparta FX, and Gerlyna Gerlyna and prior for the control of products and prior for the control of products and prior for the control of the control of the files of	SMMISCONE (hyaharonan or derivative)		MAYO Prior Authorization based on National Coverage Determination (NCO), Local Coverage Determinations (LCOs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wil. 1, MO
Medical	13055	TALVEY	talquetamab-tgvs	Yes, through the Plan Pharmacy Serices	TALVEY** (talquatamab tavs)	TALVEY" (talquetamab (pos)	MAPO 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 (aterolizumab)	MAPO 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-cgyv)	TECVAYLI (teclistamab-cqw)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3241	TEPEZZA	teprotumumab-trbw	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Ophthalmologist and Endocrinologist specialist with authorization.	TEPEZZA (teprotumumab-trbw)	TEPEZZA (teprotumumab-trbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	19314	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	TEVA (pemetrexed)	TEVA (pemetrexed)	MAPO Fror Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12356	TEZSPIRE	tezepelumab	Yes, through the Plan Pharmacy Services	TEZSPIRE (tezepslumabl	TEZSPIRE (tezegekimzb)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19273	TIVDAK	tisotumab vedotin-tftv)	Yes, through the Plan Pharmacy Services	TIVDAK (tisotumab vedotin-tftv)	TIVDAK (tisotumab vedotin-třivl)	MAPO 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 (tocifizumab-bavi)	MAPO 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, Xanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	TRAZIMERA (trastuzumab-gwo)	TBAZIMERA (trastuzumāb-gwp)	MMPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	19033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services	TREANDA (bendamustine)	TREANDA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17332	TRILURON - preferred	sodium hyaluronate	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred products. No Prior Authorization needed for preferred product	TRILURON (sodium hyaluronate)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WII, II, MO
Medical	17329	TRIVISC - non-preferred	bysluronan or derhotive	As of OR/OJ/2022: HYALGAN, SYNYISC, SYNYISC ONE, HYMOVYS, and TRILLIGNOW will be the preferred hyalumoric acid products and do not require prior authorization. Monovinic, Charlan, Gel-Orie, Euflewa, Gelleys-J., Visco-J., sodium hyalumorite, Trivinc, Cottowice, Suparta TX, and authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	TBNSSC Dyslamown or derisative)	TRVSC (hydroman or derhathe)	MAYO Pror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCn); for guidance where applicable for Institutions W. E., MO

		IN	ECTABLE MEDICINES				
	(formerly WellFirst Health)	This reference guide is a partial listin	ng of the most commonly prescribed drugs under the medical benefi	SEARCH TIPS:	(⊗ Medica.	
		are covered, not covered, or not yet review of any drug listed as not cov WellFirst Health website for medic	reviewed and whether a prior authorization is required. For coverage ered, please complete the Exception to Coverage form found on the al 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 bito type in the name of drug you want to locate. If you do not know the correct spetthe name	inocular icon on your toolbar. It will then display a search box for you lling, you can start your search by entering just the first few letters of	(formerly WellFirst Health)	
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19317	TRODELVY	sacituzumab govitecan-hziy	Yes, through the Plan Pharmacy Services	TRODELVY (cacituzumab govitecan-hziy)	TRODELVY (sacituzumab govitecan-hziy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11746	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)	MAPO 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	TRLDOIMA (ritusimab-abbs)	TRUXIMA (ritusimab-abbs)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCDs) for guidance where applicable for Jurisdictions WI, R, MO.
Medical	Q5134	TYRUKO	natalizumab	Yes, though the Plan Pharmacy Services	TYRUKO (natalaumab)	TYRUKO (natalizumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12323	TYSABRI	natalizumab injection	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	TYSAB8I (natalizumab)	TYSABRI (natalizumab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	C9149	TZIELD	teplizumab-mzwv	Yes, through the Plan Pharmacy Services	Tari D (tophromab-mass).	IZiFs 0 (teplizumah-mzend	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5111	UDENYCA	pegfilgrastim-cbqv	EFECTIVE 0.1/01.2023: FILIPHIA and ZIEXTENCO are the preferred regilipscarin products and dis not require prior authorization. Must have a failed trial of ZIEXTEXO DN UTUPHIA before coverage of Neulasta, UDENCYA, PRYEPRIA, PRINETRA, and STIMUFEND require a prior authorization brough the Plan Pharmacy Services. Please see Medical Policy for criteria	UDDNCTA (confligration-shoul	UDENCYA Longifigrantim-chood	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11303	ULTOMIRIS	ravultzumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematology, Oncology, or immunology specialist with authorization.	ULTOMIRIS (rendiremeb)	LILTOM/SS (randramab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1823	UPLIZNA	inebilizumab-cdon	Yes, through the Plan Pharmacy Services	UPLIZNA (inebilizumab-cdon)	UPLIZNA (ineblizumab-cdon)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	18499	UPTRAVI-IV	selexipag	Yes, though the Plan Pharmacy Services. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	UPTRAVI-IV (selecipag)	LIPTRAVI-V (selevipar)	MAND Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 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 (selloripas)	
Medical	12777	VABYSMO	faricimab-svoa	No. No prior authorization is required	VABYSMO** [faricimab-svoa]		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCDs) for guidance where applicable for burisdictions WI, E, MO
Medical	12777	VABYSMO	faricimab-svoa	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, E, MO
Medical	19303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	VECTIBIX (panitumumab)	VECTIBOX (panitumumab.)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	VELCADE (bortezomib - preferred)	VELCADE (bortezomib - preferred)	MAPD Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for furfactions Wi, II, MO
Medical	Q5129	VEGZELMA	bevacizumab-adcd	As of 03/07/2024: Zirabev is the preferred Bevacinumab product and does not require prior authorization. Austin, Alymps, Missia and Vegerina prior authorization is require through the Filan Pharmacy Services. ***Prior authorization for bevacinumab is not required when used for ophathamilogical indications** "See the ALMNS"s bevacinumab) Policy for a list of applicable ophthalmological diagnoses.	VEGZEIMA (beskisumab adsd)	VEGTEMA (bevidsamab adod)	MAPIO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Authorization WI, E, MO
Medical	11756	VENOFER - preferred	iron sucrose	As of 08/01/2022: VENOTER, INFED, FERRILETT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. NUECTAPER, MONDFERRIC, TRIERIC, and TRIERICA ANNU are the non- preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	VENOFFR [reo sucrose]		
Medical	19376	VEOPOZ	pozelimab-bbfg	Yes, through the Plan Pharmacy Services	VEOPOZ* (pozelimab-bbfg)	VEOPGZ* (porelimab-bbfg)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drups and Biologicals for drugs
Medical	11427	VILTEPSO	viltolarsen	None. Not Covered.	VILTEPSO (vitolarsen)		
Medical	11323	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.	YEMITAA Edoculfasek	VINITAN (shoulfase)	MAYD Prior Authorization needed cullined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drups and Biologicals for drups
Medical	17321	VISCO-3 - non-preferred	hyaluronan or derivative	As of Bil(DI/D222 HYALGAN, SYNYIGC, SYNYIGC ONE, HYMOVIS, and TRILLIGHOW will be the perfectly epiluronic acid products and do not require prior substructation. Microsist, Continuing, Gild Chee, Enforce, General Continuing, Continu	VSCC-3 (Ingalurectae or derivative)	105CO-3 (hyaliuronan or derivathed	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19999	VIVIMUSTA	bendamustine	Yes, through the Plan Pharmacy Services	WVBMUSTA (bendamustine)	VIVIMUSTA (bendamustine)	MAPD Prior Authorization based on National Coverage Determination (MCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	13385	VPRIV	velaglucerase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX with authorization.	VPRV (velaglucerase alfa)	VPRIV (velaglucerase alfa)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 590 Drugs and Biologicals for drugs
Medical	J3032	VYEPTI	epinezumab-jjmr	Yes, through the Plan Pharmacy Services	YYEPTI (epinezumab-jimr)	VYEPTI (epinezumab-ijimr)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13401	VYJUVEK	beremagene geperpavec-svdt	Yes, through the Plan Pharmacy Services	VY/JUVEK*** (beremagene geperpavec-ovdt)	VYJUVEK** (beremagene goperpavec-svdt)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11429	VYONDYS 53	golodirsen	None. Not Covered.	VYONDYS 53 (golodirsen)		

	Medica. (formerly WellFirst Health)	INJECTABLE MEDICINES		SEARCH TIPS:			
		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form Dound on the Wellfirst Health workshe for medical south to the Plan Phenrang Services and for pharmacy submit to Wellfirst Health workshe for medical south to the Plan Phenrang services and for pharmacy submit to the Plan Phenrang southern the Plan Phenrang southern the Plan Phenrang southern the Plan Phenrang southern the Plan Plan Phenrang southern the Plan P			binocular icon on your toolbar. It will then display a search box for you elling, you can start your search by entering just the first few letters of	Medica.	
	Updated: 05/01/2024	WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.		the name	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(tornerly well-list realth)	
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	19332	VYVGART	efgartigimod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	VYVGART (efeartigmoid)	YWGART (efgartigmoid)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19334	VYVGART-HYTRULO	efgartigimod alfa-fcab and hyaluronidase-qvfc	Yes, through the Plan Pharmacy Services	VYVGART* Hytrulo (efgartigimod alfa-fcab and hyaluronidase-gyfc)	VYVGART* Hytrulo (efgartigimod affa-fcab and hyaluronidase-qufc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19153	VYXEOS	daunorubicin and cytarabine – liposome	Yes, through the Plan Pharmacy Services	VYXEOS (daunorubicin and cytarabine – liposome)	VYXEOS (daunorubicin and cytarabine – liposome)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		VYZULTA	latanoprostene bunod	PHARMACY BENEFIT ONLY. Yes, through Navitus.	VYZULTA (latanoprostene bunod)	VYZULTA (latanoprostene bunod)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	WYOST	denosumab	EFFECTIVE 05/31/2024. 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, R, MO
Medical	11558	XEMBIFY (SCIG)	immune globulin	Yes, through the Plan Pharmacy Services	XEMBIFY (SOG)	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.	XENPGZYME™ (olipudase alfa).	XENPOZYME™ (olipudase alfa).	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, E, MO
Medical	J0588	XEOMIN	incobotulinumtoxinA	No prior authorization is required.	XEOMIN (incobotulinumtoxinA)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	10897	XGEVA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	XGEVA (denosumab)	XGEVA (denosumab)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for furisdictions Wi, II, MO
Medical	13299	XIPERE	triamcinolone acetonide injectable suspension	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an opthamalogist specialist with authorization.	VIPERE (triamcinolone acetonide injectable suspension)	XIPERE (triamcinolone acetohnide injectable suspension)	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, §50 Drugs and Biologicals.
Medical	12357	XOLAIR	omalizumab, Smg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	XOLAIR (omalizumath)	ISOLAIR (omalizumab)	MAVO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for suridictions WI, II, MO
Medical	19228	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services	YERVOY (plinumab)	YERVOY (ipilmumab)	MAPO 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 cilcleucel)	YESCARTA (axicabtagene citoleucel)	MAPO 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 From Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 13, 550 Drugs and Biologicals for drugs
Medical	Q5101	ZARXIO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarvio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuido and Grankx, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ZABOO (filipractim-ayour)	ZAROO (Higrastim-ayou).	MAPO 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).	ZEMAIBA/PROLASTIN-C (alpha-1-proteinace inhibitor)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	ZEPZELCA (lurbinectedin)	ZEPZELCA (lurbinoctedin)	MAPO 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	pogfligrastim-bmez	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Peglilgrazim products and do not require prior authorization. Must have a falled visit of ZIEXTEXO DN DULPHILA before coverage of Neulsta. UDENCYA, NYVEPRIA, PXNETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ZEXTENZO (pegffigrantim bress)	ZEXTENZO (pogligracio-bros)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 35, 550 Drugs and Biologicals for dhugs
Medical	Q5118	ZIRABEV - preferred	bevacizumab-bvzr	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Austin, Alymor, Meui and Vegetima prior authorization is required through the Plan Pharmacy Services. ""Prior authorization for beoacizumab is not required when used for ophthalmological indications." See the ALYMSY (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	28ABEV behichumab-borri	ZMARFV (bevarisumab-boxr)	MATO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MD
Medical	C9399, J3590	ZOLGENSMA	onasemnogene abeparvovic-xiol	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.	201GFNSMA (onsemmogene abeparvovec-side)	20LGENSMA (on asemnogene abepanovec)	MAPO 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 Soncactusimab)	ZYNLONTA Bonrastunimab tesirinel	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3590, C9399	ZYNTEGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	ZYNTEGLO* (but begingene autotemcel)	2YNTEGLO* (betibaglogene autotemcel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J9345	ZYNYZ	retifanlimab-dlwr	Yes, through the Plan Pharmacy Services	ZYNYZ (recitanimab-dlwr)	2YNYZ (retifanlimab.dhwr)	MAPO 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 Wellfritz Health drug formulary. The on-line formulary only lists drugs cowered 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 docages. In addition, Welffrist Health has pymmen restrictions consistent with Welffrist Health Medical or Drug Pedicise.		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 Therapeutic (FBA) 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 medicily necessary prior to PRT	
			, , . , . , . , . , ,	* Manager		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 – II, Pharmacy Drug Exception to Coverage Form – MQ	Medical injectable Drug Exception to Coverage Form Ik Medical Injectable Drug Exception to Coverage Form MO