

## PART B PRIOR AUTHORIZATION CRITERIA FOR APPROVAL

The requested Part B medication will be approved when BOTH of the following are met:

1. ONE of the following:
  - A. There is an applicable national coverage determination (NCD) or local coverage determination (LCD) from the Medicare Administrative Contractor (MAC) for the jurisdiction and the patient meets all of the requirements listed within the NCD or LCD
  - OR**
  - B. There is NOT an applicable NCD or LCD and the requested medication is being used according to FDA labeling or in accordance with a CMS supported compendia (i.e., NCCN, Clinical Pharmacology, Lexicomp Lexi-Drugs, Merative Micromedex, & AHFS-DI) or published peer-reviewed literature
- AND**
2. ONE of the following:
  - A. The requested medication is being evaluated for approval for the first time
  - OR**
  - B. The request is for continuation of therapy and the patient has shown beneficial response to therapy

**Length of Approval:** See Table 1 below

**NOTES:**

- Length of approval may be shorter due to provider network participation status.

Table 1: Part B Prior Authorization

HCPCS	Medication	Length of Approval	NCD/LCD
<b>Bevacizumab (Oncology)</b>			
Q5107	Mvasi	12 months	N/A
Q5118	Zirabev	12 months	N/A
<b>Trastuzumab</b>			
Q5117	Kanjinti	12 months	N/A
Q5114	Ogivri	12 months	N/A
<b>Rituximab</b>			
Q5119	Ruxience	12 months	L35026
Q5115	Truxima	12 months	L35026
<b>Long-Acting Colony Stimulating Factors</b>			
Q5111	Udenyca	12 months	L37176
Q5120	Ziextenzo	12 months	L37176
<b>Short-Acting Colony Stimulating Factors</b>			

Q5110	Nivestym	12 months	L37176
Q5101	Zarxio	12 months	L37176
J2820	Leukine	12 months	L37176
<b>Immune Globulins</b>			
J1554 J1559	Asceniv (IV)	12 months	L34580
J1556 J1599	Bivigam (IV)	12 months	L34580
J1566 J1599	Carimune NF (IV)	12 months	L34580
J1551	Cutaquig (SC)	12 months	L33794
J1555	Cuvitru (SC)	12 months	L33794
J1572 J1599	Flebogamma (IV)	12 months	L34580
J1569 J1599	Gammagard Liquid (IV or SC)	12 months	L34580, L33794
J1569 J1566 J1599	Gammagard S/D (IV)	12 months	L34580
J1569 J1599	Gammaked (IV or SC)	12 months	L34580, L33794
J1557 J1599	Gammaplex (IV)	12 months	L34580
J1561 J1599	Gamunex-C (IV or SC)	12 months	L34580, L33794
J1559	Hizentra (SC)	12 months	L33794
J1575	HyQvia (SC)	12 months	L33794
J1568 J1599	Octagam (IV)	12 months	L34580
J1576	Panzyga (IV)	12 months	L34580
J1459 J1599	Privigen (IV)	12 months	L34580
J1558	Xembify (SC)	12 months	L33794
<b>Infliximab</b>			
Q5121	Avsola	12 months	L35677
Q5103	Inflectra	12 months	L35677
<b>Miscellaneous</b>			
TBD	Empaveli	12 months	N/A
TBD	Enspryng	12 months	N/A
J9332	Vyvgart	12 months	N/A
J1303	Ultomiris	12 months	N/A
J1823	Uplizna	12 months	N/A
J2507	Krystexxa	12 months	N/A
J3241	Tepezza	6 months	N/A
J0896	Reblozyl	12 months	N/A