Geisinger Medicare
2026
Part B Step Therapy List & Criteria

TABLE OF CONTENTS

AVASTIN (BEVACIZUMAB)

Affected Drugs
AVASTIN INTRAVENOUS SOLUTION 100MG/4ML VIAL
AVASTIN INTRAVENOUS SOLUTION 400MG/16ML VIAL

Step Therapy Criteria

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to two (2) of the following: Alymsys (bevacizumab-maly), Mvasi (bevacizumab-awwb), Vegzelma (bevacizumab-adcd), Zirabev (bevacizumab-bvzr).

AUTHORIZATION DURATION:
For adjuvant treatment of Stage III or IV Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer following initial surgical resection:
Authorization will be for one (1) 21 month approval. Authorization of Avastin for adjuvant treatment should not exceed the FDA-approved treatment duration of 21 months (28 cycles). For requests exceeding the above limit, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

For all other indications:
Authorization will be open-ended

Step 1 Drugs
Alymsys (bevacizumab-maly)
Mvasi (bevacizumab-awwb)
Vegzelma (bevacizumab-adcd)
Zirabev (bevacizumab-bvzr)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

BELRAPZO (BENDAMUSTINE)

Affected Drugs
BELRAPZO INTRAVENOUS SOLUTION 100MG/4ML VIAL
BENDAMUSTINE INTRAVENOUS SOLUTION 100MG/4ML VIAL (GENERIC BELRAPZO)

Bendamustine products for the Medicare line of business	
Preferred Agents	**Non-Preferred Agents**
Bendamustine (generic Treanda)	Treanda* (bendamustine)
	Bendamustine* (generic Belrapzo)
	Belrapzo* (bendamustine)
	Bendeka* (bendamustine)
	Vivimusta* (bendamustine)
*clinical prior authorization required	

Step Therapy Criteria

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to the preferred agent

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Step 1 Drugs
Bendamustine (generic Treanda)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

BENDEKA (BENDAMUSTINE)

Affected Drugs
BENDEKA INTRAVENOUS SOLUTION 100MG/4ML VIAL

Bendamustine products for the Medicare line of business	
Preferred Agents	**Non-Preferred Agents**
Bendamustine (generic Treanda)	Treanda* (bendamustine)
	Bendamustine* (generic Belrapzo)
	Belrapzo* (bendamustine)
	Bendeka* (bendamustine)
	Vivimusta* (bendamustine)
*clinical prior authorization required	

Step Therapy Criteria

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to the preferred agent

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Step 1 Drugs
Bendamustine (generic Treanda)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

BEOVU (BROLUCIZUMAB)

Affected Drugs
BEOVU INTRAVITREAL SOLUTION 6MG/0.05ML PREFILLED SYRINGE

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of diabetic macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 12mg per 25 days (6mg per eye per 25 days)

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

BYOOVIZ (RANIBIZUMAB-NUNA)

Affected Drugs
BYOOVIZ INTRAVITREAL SOLUTION 0.5MG/0.05ML VIAL

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of diabetic retinopathy with or without macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **OR** myopic choroidal neovascularization
  AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.1mL (1mg) per 28 days (0.5mg per eye per 28 days)

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

CIMERLI (RANIBIZUMAB-EQRN)

Affected Drugs
CIMERLI INTRAVITREAL SOLUTION 0.5MG/0.05ML VIAL
CIMERLI INTRAVITREAL SOLUTION 0.3MG/0.05ML VIAL

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of diabetic retinopathy with or without macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **OR** myopic choroidal neovascularization
  AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.1mL (1mg) per 28 days (0.5mg per eye per 28 days)

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

EYLEA (AFLIBERCEPT)

Affected Drugs
EYLEA INTRAVITREAL SOLUTION 2MG/0.05ML VIAL
EYLEA INTRAVITREAL SOLUTION 2MG/0.05ML PREFILLED SYRINGE

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of diabetic retinopathy with or without macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Avastin **OR** medical record documentation of baseline best-corrected visual acuity 20/50 or worse

OR

- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of retinopathy of prematurity (ROP)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.1mL (4mg) per 25 days (2mg per eye per 25 days)

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

EYLEA HD (AFLIBERCEPT)

Affected Drugs
EYLEA HD INTRAVITREAL SOLUTION 8MG/0.07ML VIAL

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) of the following: Eylea*, Beovu*, Lucentis*, Byooviz*, or Cimerli* **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Vabysmo*

OR

- Medical record documentation of a diagnosis of diabetic retinopathy with or without macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) of the following: Eylea*, Beovu*, Lucentis*, Byooviz*, or Cimerli* **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Vabysmo*

*Prior authorization required

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.14mL (16mg) per 21 days (8mg per eye per 21 days)

Step 1 Drugs
Neovascular age-related macular degeneration:
Intravitreal Eylea (aflibercept)
Intravitreal Lucentis (ranibizumab)
Intravitreal Beovu (brolucizumab)
Intravitreal Byooviz (ranibizumab-nuna)
Intravitreal Cimerli (ranibizumab-eqrn)

Diabetic Retinopathy/Diabetic Macular Edema:
Intravitreal Eylea (aflibercept)
Intravitreal Lucentis (ranibizumab)
Intravitreal Byooviz (ranibizumab-nuna)
Intravitreal Cimerli (ranibizumab-eqrn)

Step 2 Drugs
Neovascular age-related macular degeneration/Diabetic Retinopathy/Diabetic Macular Edema:
Vabysmo (faricimab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

GEL-ONE (CROSS-LINKED HYALURONATE)

Affected Drugs
GEL-ONE INTRA-ARTICULAR 30MG/3ML PREFILLED SYRINGE

Step Therapy Criteria

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of “bone-on-bone”, morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; **AND**

- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; **AND**

- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; **AND**

- Physician documentation that there has been no significant improvement following pharmacologic therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if NSAID’s are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; **AND**

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; **AND**

- Physician documentation of failure on, intolerance to or contraindication to two (2) of the following: Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

AUTHORIZATION DURATION: Initial approval will be for six (6) months. Subsequent approvals will be for six (6) months when members meet the following criteria:

- Medical record documentation of significant improvement in pain and function following the previous injection; **AND**
- Documented reduction of the doses of nonsteroidals or analgesics during the six-month period following the last injection in the previous series as well as no need for accompanying intra-articular steroid injections; **AND**
- Six months or longer have elapsed since the last injection in the previous series.

QUANTITY LIMIT: One (1) treatment course to the affected knee(s) (bilateral injections may be allowed if both knees meet the required coverage criteria)

LIMITATIONS:

- Gel-One treatment course is limited to 1 injection in a 6-month period.

CONTRAINDICATIONS:

- The use of these products for injection into any joint other than the knee.
- Injection of these products for indications other than the diagnosis of osteoarthritis
- Documented allergy to chickens or eggs.
- Knee joint infection, skin disease or infection around the area where the injection will be given.
- The insured individual has known sensitivity or contraindication to the use of either sodium hyaluronate or hylan G-F 20, e.g., crystal synovitis or hypersensitivity to hyaluronan preparations

Step 1 Drugs
Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

GENVISC (SODUM HYALURONATE)

Affected Drugs
GENVISC 850 INTRA-ARTICULAR 25MG/2.5ML PREFILLED SYRINGE

Step Therapy Criteria

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of “bone-on-bone”, morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; **AND**

- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; **AND**

- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; **AND**

- Physician documentation that there has been no significant improvement following pharmacologic therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if NSAID’s are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; **AND**

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; **AND**

- Physician documentation of failure on, intolerance to or contraindication to two (2) of the following: Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

AUTHORIZATION DURATION: Initial approval will be for six (6) months. Subsequent approvals will be for six (6) months when members meet the following criteria:

- Medical record documentation of significant improvement in pain and function following the previous injection; **AND**
- Documented reduction of the doses of nonsteroidals or analgesics during the six-month period following the last injection in the previous series as well as no need for accompanying intra-articular steroid injections; **AND**
- Six months or longer have elapsed since the last injection in the previous series.

QUANTITY LIMIT: One (1) treatment course to the affected knee(s) (bilateral injections may be allowed if both knees meet the required coverage criteria)

LIMITATIONS:

- GenVisc treatment course is limited to 5 injections in a 6-month period.

CONTRAINDICATIONS:

- The use of these products for injection into any joint other than the knee.
- Injection of these products for indications other than the diagnosis of osteoarthritis
- Documented allergy to chickens or eggs.
- Knee joint infection, skin disease or infection around the area where the injection will be given.
- The insured individual has known sensitivity or contraindication to the use of either sodium hyaluronate or hylan G-F 20, e.g., crystal synovitis or hypersensitivity to hyaluronan preparations

Step 1 Drugs
Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

HERCEPTIN (TRASTUZUMAB)

Affected Drugs
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED 150MG VIAL

Step Therapy Criteria

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to at least two (2) of the following: trastuzumab-anns (Kanjinti), trastuzumab-dkst (Ogivri), trastuzumab-dttb (Ontruzant), trastuzumab-qyyp (Trazimera), trastuzumab-strf (Hercessi), and/or trastuzumab-pkrb (Herzuma)

AUTHORIZATION DURATION:
For adjuvant treatment:
Authorization will be for one (1) 12-month approval. Authorization of Herceptin for adjuvant treatment should not exceed the FDA-approved treatment duration of 1 year (12 months). For requests exceeding the above limit, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

For all other indications:
Authorization will be open-ended

Step 1 Drugs
Hercessi (trastuzumab-strf), Herzuma (trastuzumab-pkrb), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Trazimera (trastuzumab-qyyp)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

HYMOVIS (HIGH MOLECULAR WEIGHT VISCOELASTIC HYALURONAN)

Affected Drugs
HYMOVIS INTRA-ARTICULAR SOLUTION 24MG/3ML PREFILLED SYRINGE

Step Therapy Criteria

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of “bone-on-bone”, morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; **AND**

- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; **AND**

- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; **AND**

- Physician documentation that there has been no significant improvement following pharmacologic therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if NSAID’s are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; **AND**

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; **AND**

- Physician documentation of failure on, intolerance to or contraindication to two (2) of the following: Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

AUTHORIZATION DURATION: Initial approval will be for six (6) months. Subsequent approvals will be for six (6) months when members meet the following criteria:

- Medical record documentation of significant improvement in pain and function following the previous injection; **AND**
- Documented reduction of the doses of nonsteroidals or analgesics during the six-month period following the last injection in the previous series as well as no need for accompanying intra-articular steroid injections; **AND**
- Six months or longer have elapsed since the last injection in the previous series.

QUANTITY LIMIT: One (1) treatment course to the affected knee(s) (bilateral injections may be allowed if both knees meet the required coverage criteria)

LIMITATIONS:

- Hymovis treatment course is limited to 2 injections in a 6-month period.

CONTRAINDICATIONS:

- The use of these products for injection into any joint other than the knee.
- Injection of these products for indications other than the diagnosis of osteoarthritis
- Documented allergy to chickens or eggs.
- Knee joint infection, skin disease or infection around the area where the injection will be given.
- The insured individual has known sensitivity or contraindication to the use of either sodium hyaluronate or hylan G-F 20, e.g., crystal synovitis or hypersensitivity to hyaluronan preparations

Step 1 Drugs
Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

INFLIXIMAB (REMICADE OR UNBRANDED INFLIXIMAB)

Affected Drugs

REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG VIAL
INFLIXIMAB INTRAVENOUS SOLUTION RECONSTITUTED 100MG VIAL

Step Therapy Criteria

For Treatment of Rheumatoid Arthritis:

- Must be 18 years of age or greater **AND**
- Requesting provider must be a rheumatologist **AND**
- Diagnosis of moderate to severe rheumatoid arthritis according to the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Continuation of effective dose of methotrexate during infliximab therapy **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For Treatment of Crohn's Disease, Pediatric Crohn's Disease, and/or Fistulizing Crohn's Disease:

- Must be 6 years of age or older; **AND**
- Prescription is written by a gastroenterologist **AND**
- Medical record documentation of a diagnosis of moderate to severe Crohn's disease **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For Treatment of Ulcerative Colitis:

- Must be at least 6 years of age; **AND**
- Must be prescribed by a gastroenterologist; **AND**
- Physician provided documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For Treatment of Ankylosing Spondylitis:

- Physician documentation of a diagnosis of ankylosing spondylitis **AND**
- Prescribing physician must be a rheumatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used

concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For the treatment of Plaque Psoriasis:
- Prescribed by a dermatologist **AND**
- Insured individual must be at least 18 years of age **AND**
- Physician provided documentation of a diagnosis of moderate to severe plaque psoriasis characterized by greater than or equal to 5% body surface area involved or disease affecting crucial body areas such as the hands, feet, face, or genitals **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For the treatment of Psoriatic Arthritis:
- Physician provided documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include the following:
    - Documentation of either active psoriatic lesions or a documented history of psoriasis

  AND
- Must be prescribed by a rheumatologist or dermatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

AUTHORIZATION DURATION: Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in the signs and symptoms of the treated indication at six (6) months of infliximab therapy is required.

After the initial six (6) month approval, subsequent approvals for coverage will be for a duration of one (1) year. Reevaluation of coverage will be every one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of the treated indication while on infliximab therapy.

Step 1 Drugs
Avsola (infliximab-axxq), Inflectra (infliximab-dyyb)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

INJECTAFER (FERRIC CARBOXYMALTOSE)

Affected Drugs
INJECTAFER INTRAVENOUS SOLUTION 100MG/2ML VIAL
INJECTAFER INTRAVENOUS SOLUTION 750MG/15ML VIAL
INJECTAFER INTRAVENOUS SOLUTION 1000MG/20ML VIAL

Step Therapy Criteria

- Medical record documentation of iron deficiency anemia as confirmed by ferritin <30 ng/ml no greater than 3 months old or transferrin saturation (TSAT) <20% no greater than 6 months old **AND**
- Medical record documentation that the member is age-appropriate to receive the intravenous iron medication based on the FDA-approved label **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- Medical record documentation of failure on, intolerance to or contraindication to two (2) of the following: iron dextran complex (Infed), iron sucrose (Venofer), sodium ferric gluconate complex (Ferrlecit), ferumoxytol (Feraheme)

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require:

- Medical record documentation of improvement from baseline but the member requires repeat treatment with IV iron **AND**
- Updated iron studies indicating ferritin <30 ng/ml no greater than 3 months old OR transferrin saturation (TSAT) <20% no greater than 6 months old.

The medication will no longer be covered if the patient experiences toxicity or worsening of disease.

Step 1 Drugs
Ferumoxytol (Feraheme)
Iron dextran complex (Infed)
Iron sucrose (Venofer)
Sodium ferric gluconate complex (Ferrlecit)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

KHAPZORY (LEVOLEUCOVORIN)

Affected Drugs
KHAPZORY INTRAVENOUS SOLUTION RECONSTITUED 175 MG VIAL

Step Therapy Criteria
- Medical record documentation of intolerance to or contraindication to preferred levoleucovorin calcium products.

Preferred products: levoleucovorin calcium vial (powder for reconstitution), levoleucovorin calcium vial (solution)

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Step 1 Drugs
levoleucovorin calcium vial (powder for reconstitution), levoleucovorin calcium vial (solution)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

LUCENTIS (RANIBIZUMAB)

Affected Drugs
LUCENTIS INTRAVITREAL SOLUTION 0.5MG/0.05ML PREFILLED SYRINGE
LUCENTIS INTRAVITREAL SOLUTION 0.3MG/0.05ML PREFILLED SYRINGE

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of diabetic retinopathy with or without macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **OR** myopic choroidal neovascularization
  AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.1mL (1mg) per 28 days (0.5mg per eye per 28 days)

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

MONOFERRIC (FERRIC DERISOMALTOSE)

Affected Drugs
MONOFERRIC INTRAVENOUS SOLUTION 1000MG/10ML VIAL

Step Therapy Criteria

- Medical record documentation of iron deficiency anemia as confirmed by ferritin <30 ng/ml no greater than 3 months old or transferrin saturation (TSAT) <20% no greater than 6 months old **AND**
- Medical record documentation that the member is age-appropriate to receive the intravenous iron medication based on the FDA-approved label **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- Medical record documentation of failure on, intolerance to or contraindication to two (2) of the following: iron dextran complex (Infed), iron sucrose (Venofer), sodium ferric gluconate complex (Ferrlecit), ferumoxytol (Feraheme)

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require:

- Medical record documentation of improvement from baseline but the member requires repeat treatment with IV iron **AND**
- Updated iron studies indicating ferritin <30 ng/ml no greater than 3 months old OR transferrin saturation (TSAT) <20% no greater than 6 months old.

The medication will no longer be covered if the patient experiences toxicity or worsening of disease.

Step 1 Drugs
Ferumoxytol (Feraheme)
Iron dextran complex (Infed)
Iron sucrose (Venofer)
Sodium ferric gluconate complex (Ferrlecit)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

MONOVISC (HIGH MOLECULAR WEIGHT HYALURONON)

Affected Drugs
MONOVISC INTRA-ARTICULAR SOLUTION 88MG/4ML PREFILLED SYRINGE

Step Therapy Criteria

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of “bone-on-bone”, morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; **AND**

- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; **AND**

- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; **AND**

- Physician documentation that there has been no significant improvement following pharmacologic therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if NSAID’s are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; **AND**

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; **AND**

- Physician documentation of failure on, intolerance to or contraindication to two (2) of the following: Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

AUTHORIZATION DURATION: Initial approval will be for six (6) months. Subsequent approvals will be for six (6) months when members meet the following criteria:

- Medical record documentation of significant improvement in pain and function following the previous injection; **AND**
- Documented reduction of the doses of nonsteroidals or analgesics during the six-month period following the last injection in the previous series as well as no need for accompanying intra-articular steroid injections; **AND**
- Six months or longer have elapsed since the last injection in the previous series.

QUANTITY LIMIT: One (1) treatment course to the affected knee(s) (bilateral injections may be allowed if both knees meet the required coverage criteria)

LIMITATIONS:
Monovisc treatment course is limited to 1 injection in a 6-month period.

CONTRAINDICATIONS:

- The use of these products for injection into any joint other than the knee.
- Injection of these products for indications other than the diagnosis of osteoarthritis
- Documented allergy to chickens or eggs.
- Knee joint infection, skin disease or infection around the area where the injection will be given.
- The insured individual has known sensitivity or contraindication to the use of either sodium hyaluronate or hylan G-F 20, e.g., crystal synovitis or hypersensitivity to hyaluronan preparations

Step 1 Drugs
Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

NIKTIMVO (AXATILIMAB-CSFR)

Affected Drugs
NIKTIMVO INTRAVENOUS SOLUTION 9MG/0.18ML VIAL
NIKTIMVO INTRAVENOUS SOLUTION 22MG/0.44ML VIAL

Step Therapy Criteria

- Medical record documentation that Niktimvo is prescribed by a hematologist, oncologist, or transplant specialist **AND**
- Medical record documentation of chronic graft-versus-host disease (cGVHD) **AND**
- Medical record documentation of therapeutic failure on, contraindication to, or intolerance to two prior lines of systemic therapy, one of which must be rituximab **AND**
- Medical record documentation that the patient weighs greater than or equal to 40kg **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- Medical record documentation that Niktimvo will not be used in combination with any of the following: ruxolitinib (Jakafi), ibrutinib (Imbruvica), belumosudil (Rezurock), rituximab

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

QUANTITY LIMIT: Maximum of two 22mg/0.44mL vials OR four 9mg/0.18mL vials per 14 days. Note: the FDA approved maximum dose is 35mg per 14 days.

Step 1 Drugs
Ruxience (rituximab-pvvr)
Riabni (rituximab-arrx)
Truxima (rituximab-abbs)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

OCREVUS (OCRELIZUMAB)

Affected Drugs
OCREVUS INTRAVENOUS SOLUTION 300MG/10ML VIAL

Step Therapy Criteria
- Medical record documentation of age > 18 years **AND**
- Medical record documentation Ocrevus or Ocrevus Zunovo is prescribed by a neurologist **AND**
- Medical record documentation of hepatitis B screening **AND**
- One of the following:
    - Medical record documentation of a diagnosis of primary progressive MS (PPMS) **OR**
    - Medical record documentation of a diagnosis of a relapsing form of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease **AND**
- For members with a diagnosis of a relapsing form of multiple sclerosis:
    - Medical record documentation that member has failed, is intolerant to, or has a contraindication to a preferred rituximab product **AND**
    - If intolerant to the preferred rituximab product, documentation of previous history of severe or potentially life-threatening adverse event during or following administration and the adverse event cannot be managed using pre-medication(s) or adjusting the rate of infusion.

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

QUANTITY LIMIT:
- Initial authorization: 12-month duration with quantity limit of 3 doses
- Re-authorization: 12-month duration with quantity limit of 2 doses

Step 1 Drugs
Ruxience (rituximab-pvvr)
Riabni (rituximab-arrx)
Truxima (rituximab-abbs)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

OCREVUS ZUNOVO (OCRELIZUMAB/HYALURONIDASE-OCSQ)

Affected Drugs
OCREVUS ZUNOVO SUBCUTANEOUS SOLUTION 920MG/2300U/23ML VIAL

Step Therapy Criteria
- Medical record documentation of age > 18 years **AND**
- Medical record documentation Ocrevus or Ocrevus Zunovo is prescribed by a neurologist **AND**
- Medical record documentation of hepatitis B screening **AND**
- One of the following:
    - Medical record documentation of a diagnosis of primary progressive MS (PPMS) **OR**
    - Medical record documentation of a diagnosis of a relapsing form of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease **AND**
- For members with a diagnosis of a relapsing form of multiple sclerosis:
    - Medical record documentation that member has failed, is intolerant to, or has a contraindication to a preferred rituximab product **AND**
    - If intolerant to the preferred rituximab product, documentation of previous history of severe or potentially life-threatening adverse event during or following administration and the adverse event cannot be managed using pre-medication(s) or adjusting the rate of infusion.

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

QUANTITY LIMIT: Initial authorization and Re-authorization: 12-month duration with quantity limit of 2 doses

Step 1 Drugs
Ruxience (rituximab-pvvr)
Riabni (rituximab-arrx)
Truxima (rituximab-abbs)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

PAVBLU (AFLIBERCEPT-AYYH)

Affected Drugs
PAVBLU INTRAVITREAL SOLUTION 2MG/0.05ML VIAL
PAVBLU INTRAVITREAL SOLUTION 2MG/0.05ML PREFILLED SYRINGE

Step Therapy Criteria
- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of diabetic retinopathy with or without macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Avastin **OR** medical record documentation of baseline best-corrected visual acuity 20/50 or worse

OR

- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin)

OR

- Medical record documentation of a diagnosis of retinopathy of prematurity (ROP)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.1mL (4mg) per 25 days (2mg per eye per 25 days)

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

QUZYTTIR (CETIRIZINE HYDROCHLORIDE INJECTION)

Affected Drugs
QUZYTTIR INTRAVENOUS SOLUTION 10MG/1ML VIAL

Step Therapy Criteria
- Medical record documentation of a diagnosis of acute urticaria **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to intravenous diphenhydramine.

AUTHORIZATION DURATION: 6 weeks

QUANTITY LIMIT: 1mL (10mg) per day

Step 1 Drugs
intravenous diphenhydramine

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

RENFLEXIS (INFLIXIMAB-ABDA)

Affected Drugs
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG VIAL

Step Therapy Criteria

For Treatment of Rheumatoid Arthritis:
- Must be 18 years of age or greater **AND**
- Requesting provider must be a rheumatologist **AND**
- Diagnosis of moderate to severe rheumatoid arthritis according the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Continuation of effective dose of methotrexate during infliximab therapy **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For Treatment of Crohn's Disease, Pediatric Crohn's Disease, and/or Fistulizing Crohn's Disease:
- Must be 6 years of age or older; **AND**
- Prescription is written by a gastroenterologist **AND**
- Medical record documentation of a diagnosis of moderate to severe Crohn's disease **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For Treatment of Ulcerative Colitis:
- Must be at least 6 years of age; **AND**
- Must be prescribed by a gastroenterologist; **AND**
- Physician provided documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For Treatment of Ankylosing Spondylitis:
- Physician documentation of a diagnosis of ankylosing spondylitis **AND**
- Prescribing physician must be a rheumatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For the treatment of Plaque Psoriasis:

- Prescribed by a dermatologist **AND**
- Insured individual must be at least 18 years of age **AND**
- Physician provided documentation of a diagnosis of moderate to severe plaque psoriasis characterized by greater than or equal to 5% body surface area involved or disease affecting crucial body areas such as the hands, feet, face, or genitals **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

For the treatment of Psoriatic Arthritis:

- Physician provided documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include the following:
    - Documentation of either active psoriatic lesions or a documented history of psoriasis

  AND
- Must be prescribed by a rheumatologist or dermatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra) and infliximab-axxq (Avsola)

AUTHORIZATION DURATION: Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in the signs and symptoms of the treated indication at six (6) months of infliximab therapy is required.

After the initial six (6) month approval, subsequent approvals for coverage will be for a duration of one (1) year. Reevaluation of coverage will be every one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of the treated indication while on infliximab therapy.

Step 1 Drugs
Avsola (infliximab-axxq), Inflectra (infliximab-dyyb)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

RITUXAN (RITUXIMAB)

Affected Drugs
RITUXAN INTRAVENOUS SOLUTION 100 MG/10 ML VIAL
RITUXAN INTRAVENOUS SOLUTION 500 MG/50 ML VIAL

Step Therapy Criteria
For Rheumatoid Arthritis:

- Physician documentation of a diagnosis of moderate to severe rheumatoid arthritis in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis; **AND**
- At least 18 years of age or older; **AND**
- Prescription written by a rheumatologist; **AND**
- Medical record documentation that an effective dose of methotrexate will be continued during rituximab therapy; **AND**
- Medical record documentation that Rituxan is not being used concurrently with a TNF blocker **AND**
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Chronic Immunothrombocytopenia (ITP):

- Diagnosis of primary chronic ITP **AND**
- Platelet count of < 30,000/mm3 with active bleeding; or platelet count < 30,000/mm3 and a documented history of significant bleeding; or < 20,000/mm3 **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to corticosteroids and/or IVIG* (*prior authorization required)
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Acute Lymphoblastic Leukemia, Hairy Cell Leukemia, and Chronic Lymphoid Leukemia:

- Medical record documentation of a diagnosis of Chronic Lymphocytic Leukemia (CLL)
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Microscopic Polyarteritis Nodosa (PAN)

- Medical record documentation of a diagnosis of microscopic polyarteritis nodosa used in combination with glucocorticoids
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA)

- Medical record documentation of a diagnosis of Granulomatosis with Polyangiitis (GPA) (Wegener's granulomatosis) or Microscopic Polyangiitis (MPA) used in combination with glucocorticoids
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Non-Hodgkin Lymphoma

- Medical record documentation of a diagnosis of Non-Hodgkin Lymphoma
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Hodgkin Lymphoma

- Medical record documentation of a diagnosis of Hodgkin Lymphoma
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Multiple Sclerosis (MS)

- Medical record documentation of a diagnosis of Multiple Sclerosis
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Refractory Chronic Debilitating Myasthenia Gravis

- Medical record documentation of refractory Chronic Debilitating Myasthenia Gravis **AND**
- Prescribed by or in consultation with a neuromuscular specialist **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one corticosteroid **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one cholinesterase inhibitor **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one non-steroidal immunosuppressive therapy
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

For Pemphigus Vulgaris (PV)

- Prescription written by a dermatologist **AND**
- Member is 18 years of age or older **AND**
- Medical record documentation of a diagnosis of moderate to severe pemphigus vulgaris
  AND

- Medical record documentation of use in combination with corticosteroids or a contraindication or intolerance to corticosteroids
  AND
- For rituximab reference product requests (i.e. Rituxan), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two (2) of the following: rituximab-pvvr (Ruxience), rituximab-arrx (Riabni), or rituximab-abbs (Truxima).

AUTHORIZATION DURATION:
For Multiple Sclerosis: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.
For all other indications: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Step 1 Drugs
Ruxience (rituximab-pvvr)
Riabni (rituximab-arrx)
Truxima (rituximab-abbs)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

SUSVIMO (RANIBIZUMAB)

Affected Drugs
SUSVIMO (IMPLANT 1ST FILL) INTRAVITREAL SOLUTION 10MG/0.1ML VIAL
SUSVIMO OCULAR IMPLANT INTRAVITREAL IMPLANT
SUSVIMO (IMPLANT REFILL) INTRAVITREAL SOLUTION 10MG/0.1ML VIAL

Step Therapy Criteria

- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation patient has previously responded to at least two (2) intravitreal doses of a Vascular Endothelial Growth Factor (VEGF) inhibitor medication **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin) **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) additional intravitreal VEGF inhibitor (e.g. Eylea, Beovu, or Lucentis)

AND

- Medical record documentation that Susvimo (ranibizumab) will not be given in combination with an intravitreal Vascular Endothelial Growth Factor (VGEF) inhibitor **OR**
- If the request is for use in combination with an intravitreal VEGF inhibitor, all of the following must be met:
    - Medical record documentation Susvimo (ranibizumab) will be given in combination with intravitreal ranibizumab injection (Lucentis) **AND**
    - Medical record documentation intravitreal ranibizumab injection will be administered on an as needed basis, as determined by the prescriber

AUTHORIZATION DURATION: Approval will be given for an **initial duration of two years (2) years** or less if the reviewing provider feels it is medically appropriate. After the initial two (2) year approval, subsequent approvals will be for a **lifetime duration** or less if the reviewing provider feels it is medically appropriate, and will require:

- Medical record documentation that Susvimo (ranibizumab) will not be given in combination with an intravitreal Vascular Endothelial Growth (VGEF) inhibitor

QUANTITY LIMIT: 0.2mL (2 vials) per 24 weeks (to allow 2mg per 24 weeks per treated eye)

LIMITATION: Susvimo (ranibizumab) to be given in combination with intravitreal ranibizumab (Lucentis) injections after 92 weeks from the start of Susvimo therapy has not been studied in clinical trials and will require prior authorization.

Step 1 Drugs
Intravitreal Avastin (bevacizumab)

Step 2 Drugs
Intravitreal Beovu (brolucizumab)
Intravitreal Byooviz (ranibizumab-nuna)

Intravitreal Cimerli (ranibizumab-eqrn)
Intravitreal Eylea (aflibercept)
Intravitreal Lucentis (ranibizumab)
Intravitreal Pavblu (aflibercept-ayyh)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

TREANDA (BENDAMUSTINE)

Affected Drugs
TREANDA INTRAVENOUS SOLUTION RECONSTITUTED 25 MG VIAL
TREANDA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG VIAL

Bendamustine products for the Medicare line of business	
Preferred Agents	**Non-Preferred Agents**
Bendamustine (generic Treanda)	Treanda* (bendamustine)
	Bendamustine* (generic Belrapzo)
	Belrapzo* (bendamustine)
	Bendeka* (bendamustine)
	Vivimusta* (bendamustine)
*clinical prior authorization required	

Step Therapy Criteria

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to the preferred agent

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Step 1 Drugs
Bendamustine (generic Treanda)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

TRILURON (SODIUM HYALURONATE)

Affected Drugs
TRILURON INTRA-ARTICULAR SOLUTION 20MG/2ML PREFILLED SYRINGE

Step Therapy Criteria

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of “bone-on-bone”, morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; **AND**

- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; **AND**

- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; **AND**

- Physician documentation that there has been no significant improvement following pharmacologic therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if NSAID’s are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; **AND**

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; **AND**

- Physician documentation of failure on, intolerance to or contraindication to two (2) of the following: Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

AUTHORIZATION DURATION: Initial approval will be for six (6) months. Subsequent approvals will be for six (6) months when members meet the following criteria:

- Medical record documentation of significant improvement in pain and function following the previous injection; **AND**
- Documented reduction of the doses of nonsteroidals or analgesics during the six-month period following the last injection in the previous series as well as no need for accompanying intra-articular steroid injections; **AND**
- Six months or longer have elapsed since the last injection in the previous series.

QUANTITY LIMIT: One (1) treatment course to the affected knee(s) (bilateral injections may be allowed if both knees meet the required coverage criteria)

LIMITATIONS:
Triluron treatment course is limited to 3 injections in a 6-month period.

CONTRAINDICATIONS:

- The use of these products for injection into any joint other than the knee.
- Injection of these products for indications other than the diagnosis of osteoarthritis
- Documented allergy to chickens or eggs.
- Knee joint infection, skin disease or infection around the area where the injection will be given.
- The insured individual has known sensitivity or contraindication to the use of either sodium hyaluronate or hylan G-F 20, e.g., crystal synovitis or hypersensitivity to hyaluronan preparations

Step 1 Drugs
Durolane, Euflexxa, Gelsyn-3, Hyalgan, Orthovisc, Supartz, Synvisc/Synvisc-One, Synojoynt, TriVisc, and Visco-3

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

VABYSMO (FARICIMAB)

Affected Drugs
VABYSMO INTRAVITREAL SOLUTION 6MG/0.05ML VIAL
VABYSMO INTRAVITREAL SOLUTION 6MG/0.05ML PREFILLED SYRINGE

Step Therapy Criteria
- Medical record documentation of a diagnosis of neovascular age-related macular degeneration **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin) **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) additional intravitreal VEGF inhibitor (e.g. Eylea, Beovu, or Lucentis)

OR
- Medical record documentation of a diagnosis of diabetic macular edema **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin) **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) additional intravitreal VEGF inhibitor (e.g. Eylea or Lucentis)

OR
- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to intravitreal bevacizumab (Avastin) **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) additional intravitreal VEGF inhibitor (e.g. Eylea or Lucentis)

AUTHORIZATION DURATION: Approvals will be given for a lifetime duration.

QUANTITY LIMIT: 0.1mL (12mg) per 21 days (6mg per eye per 21 days)

Step 1 Drugs
Neovascular age-related macular degeneration, Diabetic Macular Edema & Retinal Vein Occlusion:
Intravitreal Avastin (bevacizumab)

Step 2 Drugs
Neovascular age-related macular degeneration:
Intravitreal Beovu (brolucizumab)
Intravitreal Byooviz (ranibizumab-nuna)
Intravitreal Cimerli (ranibizumab-eqrn)
Intravitreal Eylea (aflibercept)
Intravitreal Lucentis (ranibizumab)
Intravitreal Pavblu (aflibercept-ayyh)

Diabetic Macular Edema:
Intravitreal Byooviz (ranibizumab-nuna)
Intravitreal Cimerli (ranibizumab-eqrn)
Intravitreal Eylea (aflibercept)
Intravitreal Lucentis (ranibizumab)
Intravitreal Pavblu (aflibercept-ayyh)

Retinal Vein Occlusion:
Intravitreal Eylea (aflibercept)
Intravitreal Lucentis (ranibizumab)
Intravitreal Pavblu (aflibercept-ayyh)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

VIVIMUSTA (BENDAMUSTINE)

Affected Drugs
VIVIMUSTA INTRAVENOUS SOLUTION 100MG/4ML VIAL

Bendamustine products for the Medicare line of business	
Preferred Agents	**Non-Preferred Agents**
Bendamustine (generic Treanda)	Treanda* (bendamustine)
	Bendamustine* (generic Belrapzo)
	Belrapzo* (bendamustine)
	Bendeka* (bendamustine)
	Vivimusta* (bendamustine)
*clinical prior authorization required	

Step Therapy Criteria

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to the preferred agent **AND**
- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to Bendeka* OR Belrapzo (brand or generic)*

*prior authorization required

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Step 1 Drugs
Bendamustine (generic Treanda)

Step 2 Drugs
Treanda
Belrapzo
Bendamustine (generic Belrapzo)
Bendeka

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

VYVGART (EFGARTIGIMOD ALFA-FCAB)

Affected Drugs
VYVGART INTRAVENOUS SOLUTION 400MG/20ML VIAL

Step Therapy Criteria
Generalized Myasthenia Gravis (gMG)

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that the medication is prescribed by or in consultation with a neurologist **AND**
- Medical record documentation of a diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive **AND**
- Medical record documentation of Myasthenia Gravis Foundation of America Clinical Classification (MGFA) Class II to IV **AND***
- Medical record documentation of a baseline Myasthenia Gravis-Activities of Daily Living (MG-ADL) score of 5 or more**

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that the medication is prescribed by or in consultation with a neurologist **AND**
- Documented evidence of focal or symmetric neurologic deficits that are slowly progressive or relapsing over 2 months or longer **AND**
- Physician provided documentation of EMG abnormalities consistent with the diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy with the presence of at least ONE of the following:
    - Motor distal latency prolongation ≥ 50% above upper limit of normal (ULN) in two nerves (excluding median neuropathy at the wrist from carpal tunnel syndrome) **OR**
    - Reduction of motor conduction velocity ≥ 30% below lower limit of normal (LLN) in two nerves **OR**
    - Prolongation of F-wave latency ≥ 20% above ULN in two nerves (> 50% if amplitude of distal negative peak compound muscle action potential (CMAP) <80% of LLN values) **OR**
    - Absence of F-waves in two nerves if these nerves have distal negative peak CMAP amplitudes ≥ 20% of LLN + ≥ 1 other demyelinating parameter in ≥ 1 other nerve **OR**
    - Partial motor conduction block: ≥ 30% amplitude reduction of the proximal negative peak CMAP relative to distal, if distal negative peak CMAP ≥ 20% of LLN, in two nerves, or in one nerve + ≥1 other demyelinating parameter in ≥ 1 other nerve **OR**
    - Abnormal temporal dispersion (>30% duration increase between the proximal and distal negative peak CMAP) in ≥ 2 nerves **OR**
    - Distal CMAP duration (interval between onset of the first negative peak and return to baseline of the last negative peak) increase in ≥ 1 nerve (median ≥ 6.6 ms, ulnar ≥ 6.7 ms, peroneal ≥ 7.6 ms, tibial ≥ 8.8 ms) + ≥ 1 other demyelinating parameter in ≥ 1 other nerve

AND

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to one (1) intravenous or subcutaneous immune globulin (IVIG/SCIG) therapy **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to one (1) non-steroidal immunosuppressive therapy (can include but is not limited to azathioprine, cyclophosphamide, cyclosporine, methotrexate, mycophenolate) **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to rituximab

AUTHORIZATION DURATION:

Generalized Myasthenia Gravis (gMG)

Initial approval will be for 6 months. Subsequent approvals will be for 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression **AND**
- Medical record documentation that the member is responding positively to therapy as evidenced by a 2-point reduction from baseline in Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score**

The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

**Note: Class I Myasthenia gravis is indicated by any eye muscle weakness, possible ptosis (drooping or falling of the upper eyelid) and no other evidence of muscle weakness elsewhere, Class II to IV include muscle weakness in areas of the body beyond the eye.*

***MG Activities of Daily Living (MG-ADL)*

Grade	0	1	2	3	Score
Talking	Normal	Intermittent slurring or nasal speech	Constant slurring or nasal, but can be understood	Difficult to understand speech	
Chewing	Normal	Fatigue with solid food	Fatigue with soft food	Gastric tube	
Swallowing	Normal	Rare episode of choking	Frequent choking necessitating changes in diet	Gastric tube	
Breathing	Normal	Shortness of breath with exertion	Shortness of breath at rest	Ventilator dependence	
Impairment of ability to brush teeth or comb hair	None	Extra effort, but no rest periods needed	Rest periods needed	Cannot do one of these functions	
Impairment of ability to arise from a chair	None	Mild, sometimes uses arms	Moderate, always uses arms	Severe, requires assistance	
Double vision	None	Occurs, but not daily	Daily, but not constant	Constant	
Eyelid droop	None	Occurs, but not daily	Daily, but not constant	Constant	
				Total score _____	

Step 1 Drugs
Ruxience (rituximab-pvvr)
Riabni (rituximab-arrx)
Truxima (rituximab-abbs)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

VYVGART HYTRULO (EFGARTIGIMOD ALFA & HYALURONIDASE-QVFC)

Affected Drugs
VYVGART HYTRULO SUBCUTANEOUS SOLUTION 1000MG-10000U/5ML PREFILLED SYRINGE
VYVGART HYTRULO SUBCUTANEOUS SOLUTION 180MG-2000U/1ML VIAL

Step Therapy Criteria
Generalized Myasthenia Gravis (gMG)

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that the medication is prescribed by or in consultation with a neurologist **AND**
- Medical record documentation of a diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive **AND**
- Medical record documentation of Myasthenia Gravis Foundation of America Clinical Classification (MGFA) Class II to IV **AND****
- Medical record documentation of a baseline Myasthenia Gravis-Activities of Daily Living (MG-ADL) score of 5 or more******

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that the medication is prescribed by or in consultation with a neurologist **AND**
- Documented evidence of focal or symmetric neurologic deficits that are slowly progressive or relapsing over 2 months or longer **AND**
- Physician provided documentation of EMG abnormalities consistent with the diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy with the presence of at least ONE of the following:
    - Motor distal latency prolongation ≥ 50% above upper limit of normal (ULN) in two nerves (excluding median neuropathy at the wrist from carpal tunnel syndrome) **OR**
    - Reduction of motor conduction velocity ≥ 30% below lower limit of normal (LLN) in two nerves **OR**
    - Prolongation of F-wave latency ≥ 20% above ULN in two nerves (> 50% if amplitude of distal negative peak compound muscle action potential (CMAP) <80% of LLN values) **OR**
    - Absence of F-waves in two nerves if these nerves have distal negative peak CMAP amplitudes ≥ 20% of LLN + ≥ 1 other demyelinating parameter in ≥ 1 other nerve **OR**
    - Partial motor conduction block: ≥ 30% amplitude reduction of the proximal negative peak CMAP relative to distal, if distal negative peak CMAP ≥ 20% of LLN, in two nerves, or in one nerve + ≥1 other demyelinating parameter in ≥ 1 other nerve **OR**
    - Abnormal temporal dispersion (>30% duration increase between the proximal and distal negative peak CMAP) in ≥ 2 nerves **OR**
    - Distal CMAP duration (interval between onset of the first negative peak and return to baseline of the last negative peak) increase in ≥ 1 nerve (median ≥ 6.6 ms, ulnar ≥ 6.7 ms, peroneal ≥ 7.6 ms, tibial ≥ 8.8 ms) + ≥ 1 other demyelinating parameter in ≥ 1 other nerve

AND

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to one (1) intravenous or subcutaneous immune globulin (IVIG/SCIG) therapy **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to one (1) non-steroidal immunosuppressive therapy (can include but is not limited to azathioprine, cyclophosphamide, cyclosporine, methotrexate, mycophenolate) **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to rituximab

AUTHORIZATION DURATION:

Generalized Myasthenia Gravis (gMG)

Initial approval will be for 6 months. Subsequent approvals will be for 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression **AND**
- Medical record documentation that the member is responding positively to therapy as evidenced by a 2-point reduction from baseline in Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score**

The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

**Note: Class I Myasthenia gravis is indicated by any eye muscle weakness, possible ptosis (drooping or falling of the upper eyelid) and no other evidence of muscle weakness elsewhere, Class II to IV include muscle weakness in areas of the body beyond the eye.*

***MG Activities of Daily Living (MG-ADL)*

Grade	0	1	2	3	Score
Talking	Normal	Intermittent slurring or nasal speech	Constant slurring or nasal, but can be understood	Difficult to understand speech	
Chewing	Normal	Fatigue with solid food	Fatigue with soft food	Gastric tube	
Swallowing	Normal	Rare episode of choking	Frequent choking necessitating changes in diet	Gastric tube	
Breathing	Normal	Shortness of breath with exertion	Shortness of breath at rest	Ventilator dependence	
Impairment of ability to brush teeth or comb hair	None	Extra effort, but no rest periods needed	Rest periods needed	Cannot do one of these functions	
Impairment of ability to arise from a chair	None	Mild, sometimes uses arms	Moderate, always uses arms	Severe, requires assistance	
Double vision	None	Occurs, but not daily	Daily, but not constant	Constant	
Eyelid droop	None	Occurs, but not daily	Daily, but not constant	Constant	
				Total score _____	

Step 1 Drugs
Ruxience (rituximab-pvvr)
Riabni (rituximab-arrx)
Truxima (rituximab-abbs)

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

ZILRETTA (TRIAMCINOLONE ACETONIDE ER INJECTION)

Affected Drugs
ZILRETTA INTRA-ARTICULAR ER SUSPENSION RECONSTITUTED 32MG VIAL

Step Therapy Criteria
- Prescribed by a rheumatologist or orthopedic specialist **AND**
- Patient is 18 years of age or older **AND**
- Medical record documentation of a diagnosis of osteoarthritic pain of the knee **AND**
- Medical record documentation that patient has not received a previous administration of Zilretta to the requested knee **AND**
- Medical record documentation that non-pharmacologic modalities (e.g. Weight loss, aerobic/resistance land-based exercise or aquatic exercise, other physical therapy modalities or exercises) have not promoted satisfactory symptomatic relief **AND**
- Medical record documentation that there has been no significant improvement following a 10-12 week trial of full-dose nonsteroidal anti-inflammatory drug (NSAID) therapy, with or without supplemental acetaminophen OR if NSAIDs are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period **AND**
- Medical record documentation of a therapeutic failure on or intolerance to two different intra-articular steroid injections (e.g. triamcinolone, methylprednisolone, betamethasone, dexamethasone).

AUTHORIZATION DURATION: One injection per knee per lifetime (Facets RX count 32 per knee per lifetime)

NOTES:
The safety and efficacy of repeat administrations of Zilretta have not been studied.
The safety and efficacy of Zilretta for management of osteoarthritis pain in joints other than the knee have not been studied.
Zilretta is for intra-articular use only and should not be administered by epidural, intrathecal, intravenous, intraocular, intramuscular, intradermal, or subcutaneous routes.

Step 1 Drugs
Intra-articular triamcinolone, methylprednisolone, betamethasone, dexamethasone

Number of days for claims review for select or first line drugs: 365 days, Geisinger Health Plan new starts only

Devised: 9/15/20

Revised: 6/18/21 (Renflexis, Inflectra, Remicade), 1/18/22 (Rituxan), 3/15/22 (Susvimo, Vabysmo, Beovu), 5/17/22 (VEGf QL), 7/19/22 (VEGf Best-Corrected VA), 9/13/22 (RTX ITP duration/alts), 10/25/22 (VEGf QL, Beovu DME indication), 12/21/22 (Beovu affected drugs, clarified intravitreal bevacizumab (Avastin), Inflectra/Remicade delete, Renflexis alternatives edit), 1/17/23 (Byooviz, Cimerli), 6/23/23 (Eylea ROP), 7/18/23 (Herceptin), 8/25/23 (Gel-One, Hymovis, Monovisc, Synojoynt, Triluron, TriVisc), 11/21/23 (added infliximab/Remicade, Renflexis alternatives edit, Susvimo/Vabysmo step drugs), 4/19/24 (added Avastin [per 1/16/24 P&T], RTX indications), 7/16/24 (Vabysmo RVO, Eylea alt for RVO, Lucentis/Byooviz/Cimerli alt for RVO & MCN), 11/29/24 (added Khapzory [per 1/16/24 P&T], added Zilretta, Rituxan Hodgkin lymphoma alts), 3/11/25 (Pavblu, Quzyttir), 5/13/25 (Injectafer, Monoferric), 1/1/26 (Belrapzo, Bendeka, Treanda, Vivimusta, Ocrevus, Ocrevus Zunovo, Hercessi alt [per 8/19/25 P&T]; GenVisc, Vyvgart, Vyvgart Hytrulo added, TriVisc and Synojoynt removed [per 10/17/25 P&T], intra-articular for Zilretta, Avastin criteria)

Reviewed:

MA UM Committee approval: 12/31/23, 5/22/24, 8/30/24, 12/31/24, 4/29/25, 6/9/25, 9/10/25, 10/27/25