




 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
Updated: 07/01/2024		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits we covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	05121	AVSOLA - non-preferred	infliximab-axiq	Yes, through the Plan Pharmacy Plan after failed trial of REMLEKX. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialists with authorization.	<a href="#">AVSOLA (infliximab-axiq)</a>	<a href="#">AVSOLA (infliximab-axiq)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	A9590	AZEDRA	ibigresumab 1-131	Yes, through the Plan Pharmacy Services	<a href="#">AZEDRA (ibigresumab 1-131)</a>	<a href="#">AZEDRA (ibigresumab 1-131)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#023	BAVENCIO	avelumab	Yes, through the Plan Pharmacy Services	<a href="#">BAVENCIO (avelumab)</a>	<a href="#">BAVENCIO (avelumab)</a>	
Medical	#002	BILEODAQ	belinostat	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BILEODAQ (belinostat)</a>	<a href="#">BILEODAQ (belinostat)</a>	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	#036	BELRAPZO	benidamine	Yes, through the Plan Pharmacy Services	<a href="#">BELRAPZO (benidamine)</a>	<a href="#">BELRAPZO (benidamine)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#034	BENDELA	benidamine	Yes, through the Plan Pharmacy Services	<a href="#">BENDELA (benidamine)</a>	<a href="#">BENDELA (benidamine)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#040	BENLYSTA (IV)	belimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	<a href="#">BENLYSTA IV (belimumab)</a>	<a href="#">BENLYSTA IV (belimumab)</a>	Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals
Pharmacy	#040	BENLYSTA (SC)	belimumab	Yes, through Navitas. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	<a href="#">BENLYSTA SC (belimumab)</a>	<a href="#">BENLYSTA SC (belimumab)</a>	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	#0179	BEOVU	brovacizumab-dfbl	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	<a href="#">BEOVU (brovacizumab-dfbl)</a>	<a href="#">BEOVU (brovacizumab-dfbl)</a>	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	#929	BESPONSA	induximab coagmimcin	Yes, through the Plan Pharmacy Services	<a href="#">BESPONSA (induximab coagmimcin)</a>	<a href="#">BESPONSA (induximab coagmimcin)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#350	BEQVEZ	fidanacogene elaparovvec-dtst	EFFECTIVE 08/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	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	1556	BIVIGAM (IVIG, IMMUNE GLOBULIN)	immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	<a href="#">BIVIGAM (IVIG)</a>	<a href="#">BIVIGAM (IVIG)</a>	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	#039	BLINCYTO	blinatumomab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">BLINCYTO (blinatumomab)</a>	<a href="#">BLINCYTO (blinatumomab)</a>	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	#022	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	<a href="#">BLUEPOINT (pemetrexed)</a>	<a href="#">BLUEPOINT (pemetrexed)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#044	BORTEZOMIB		Yes, through the Plan Pharmacy Services	<a href="#">BORTEZOMIB</a>	<a href="#">BORTEZOMIB</a>	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	#045	BOTOX	onabotulinumab	No prior authorization is required.	<a href="#">BOTOX (onabotulinumab)</a>	<a href="#">BOTOX (onabotulinumab)</a>	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	12054	BREYANZI	Isocarbtagene maraleucel	Yes, through the Plan Pharmacy Services	<a href="#">BREYANZI (isocarbtagene maraleucel)</a>	<a href="#">BREYANZI (isocarbtagene maraleucel)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	2329	BRUMVI	ubritumab-syly	Yes, through the Plan Pharmacy Services.	<a href="#">BRUMVI (ubritumab-syly)</a>	<a href="#">BRUMVI (ubritumab-syly)</a>	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	#067, C0014	BRINEURA	cerliponase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the Late Infantile Ceroid lipofuscinosis with authorization.	<a href="#">BRINEURA (cerliponase alfa)</a>	<a href="#">BRINEURA (cerliponase alfa)</a>	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	05124	BYDOVIZ	ranibizumab	Yes, through the Plan Pharmacy Services	<a href="#">BYDOVIZ (ranibizumab)</a>	<a href="#">BYDOVIZ (ranibizumab)</a>	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	#043	CABZITAXEL	Cabazitaxel (jovtana)	Yes, through the Plan Pharmacy Services	<a href="#">CABZITAXEL (jovtana)</a>	<a href="#">CABZITAXEL (jovtana)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	C2056	CARVYKI	cartilagene acetosuccinyl	Yes, through the Plan Pharmacy Services	<a href="#">CARVYKI (cartilagene acetosuccinyl)</a>	<a href="#">CARVYKI (cartilagene acetosuccinyl)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	3590	CASGEVY	exagamglogene autotemcel	Yes, through the Plan Pharmacy Services	<a href="#">CASGEVY (exagamglogene autotemcel)</a>	<a href="#">CASGEVY (exagamglogene autotemcel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1786	CERKZYME	imglucerase (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, DP, with authorization.	<a href="#">CERKZYME (imglucerase) (intravenous)</a>	<a href="#">CERKZYME (imglucerase) (intravenous)</a>	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	05128	CIMERLI	ranibizumab	Yes, through the Plan Pharmacy Services	<a href="#">CIMERLI (ranibizumab)</a>	<a href="#">CIMERLI (ranibizumab)</a>	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO.
Pharmacy	#071	CIMZIA	certolizumab pegol	PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.	<a href="#">CIMZIA (certolizumab pegol)</a>	<a href="#">CIMZIA (certolizumab pegol)</a>	
Medical	2786	CINQAR	reslizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	<a href="#">CINQAR (reslizumab)</a>	<a href="#">CINQAR (reslizumab)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	1932	CIPLA	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	<a href="#">CIPLA (lanreotide depot)</a>	<a href="#">CIPLA (lanreotide depot)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#9286	COLUMVI	glifritamab-gabm	Yes, through the Plan Pharmacy Services	<a href="#">COLUMVI™ (glifritamab-gabm)</a>	<a href="#">COLUMVI™ (glifritamab-gabm)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	1548	COSELA	trilaciclib	Yes, through the Plan Pharmacy Services	<a href="#">COSELA (trilaciclib)</a>	<a href="#">COSELA (trilaciclib)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	3247	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	<a href="#">COSENTYX IV (secukinumab)</a>	<a href="#">COSENTYX IV (secukinumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#054	CRYSVITA	bursumab	Yes, through the Plan Pharmacy Services. Restricted to Endocrinologist, Nephrologist, Medical Geneticist, or Specialist experienced in treatment of Metabolic Bone Disorders with authorization.	<a href="#">CRYSVITA (bursumab)</a>	<a href="#">CRYSVITA (bursumab)</a>	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	1555	CUVITRU (SODI, IMMUNE GLOBULIN)	immune globulin (cuvitru)	Yes, through the Plan Pharmacy Services	<a href="#">CUVITRU (SODI)</a>	<a href="#">CUVITRU (SODI)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs


 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
Updated: 07/01/2024		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits we covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed or not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	#308	CYRAMZA	ramucicicab	Yes, through the Plan Pharmacy Services	<a href="#">CYRAMZA (ramucicicab)</a>	<a href="#">CYRAMZA (ramucicicab)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#348	DANYELZA	navitamab	Yes, through the Plan Pharmacy Services	<a href="#">DANYELZA (navitamab)</a>	<a href="#">DANYELZA (navitamab)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#945	DARZALEX	daratumumab	Yes, through the Plan Pharmacy Services	<a href="#">DARZALEX (daratumumab)</a>	<a href="#">DARZALEX (daratumumab)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#944, C9062	DARZALEX FASPRO	daratumumab/hyaluronidase-rlj	Yes, through the Plan Pharmacy Services	<a href="#">DARZALEX FASPRO (daratumumab/hyaluronidase-rlj)</a>	<a href="#">DARZALEX FASPRO (daratumumab/hyaluronidase-rlj)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#589	DAXXIFY	davobolunimab-na	None. Please see attached policy for criteria.	<a href="#">DAXXIFY (davobolunimab-na)</a>		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#7318	DIUROLANE - non-preferred	sodium hyaluronate	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRELIRON will be the preferred product. Coverage of DIUROLANE requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services, and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">DIUROLANE (sodium hyaluronate)</a>	<a href="#">DIUROLANE (sodium hyaluronate)</a>	See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#586	DYSPORT	abobotulinumab-na	No prior authorization is required.	<a href="#">DYSPORT (abobotulinumab-na)</a>		See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	#304	EAGLE	pemetrexed	Yes, through the Plan Pharmacy Services	<a href="#">EAGLE (pemetrexed)</a>	<a href="#">EAGLE (pemetrexed)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#063	ELAHERE	mirvetuximab soravictam-gym	Yes, through the Plan Pharmacy Services	<a href="#">ELAHERE (mirvetuximab soravictam-gym)</a>	<a href="#">ELAHERE (mirvetuximab soravictam-gym)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#1743	ELAPRASE	elursulfase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis II with authorization.	<a href="#">ELAPRASE (elursulfase)</a>	<a href="#">ELAPRASE (elursulfase)</a>	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	#443	ELEVIVS	delandisrogene moxeparovivoc-rokl	None. Not Covered	<a href="#">ELEVIVS (delandisrogene moxeparovivoc-rokl)</a>		
Medical	#060	ELEVYO	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.	<a href="#">ELEVYO (taliglucerase alfa)</a>	<a href="#">ELEVYO (taliglucerase alfa)</a>	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	#208	ELFABRID	pegunigalsidase-alfa-ivax	Yes, through the Plan Pharmacy Services	<a href="#">ELFABRID (pegunigalsidase-alfa-ivax)</a>	<a href="#">ELFABRID (pegunigalsidase-alfa-ivax)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#123	ELREXFO	elranatamab-bcmn	Yes, through the Plan Pharmacy Services	<a href="#">ELREXFO (elranatamab-bcmn)</a>	<a href="#">ELREXFO (elranatamab-bcmn)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#269	ELZONRIS	lagravofusp-erzs	Yes, through the Plan Pharmacy Services	<a href="#">ELZONRIS (lagravofusp-erzs)</a>	<a href="#">ELZONRIS (lagravofusp-erzs)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#9176	EMPLIKITI	elotuzumab	Yes, through the Plan Pharmacy Services	<a href="#">EMPLIKITI (elotuzumab)</a>	<a href="#">EMPLIKITI (elotuzumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#9358	ENHERTU	fam-trastuzumab deruxtecan-nvkl	Yes, through the Plan Pharmacy Services	<a href="#">ENHERTU (fam-trastuzumab deruxtecan-nvkl)</a>	<a href="#">ENHERTU (fam-trastuzumab deruxtecan-nvkl)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#1302	ENJAYMO	sutimlimab	Yes, through the Plan Pharmacy Services	<a href="#">ENJAYMO (sutimlimab-gmoo)</a>	<a href="#">ENJAYMO (sutimlimab-gmoo)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#3999, J3590	ENSPRYNG	satralizumab-mvge	Yes, through the Plan Pharmacy Services	<a href="#">ENSPRYNG (satralizumab-mvge)</a>	<a href="#">ENSPRYNG (satralizumab-mvge)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#3880	ENTYVO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	<a href="#">ENTYVO (vedolizumab)</a>	<a href="#">ENTYVO (vedolizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#9321	EPKINLY	epcoritamab-bvyp	Yes, through the Plan Pharmacy Services	<a href="#">EPKINLY (epcoritamab-bvyp)</a>	<a href="#">EPKINLY (epcoritamab-bvyp)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#085	EOGEN	epoetin alfa, (for non-esrd use)	As of 04/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Eogen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">EOGEN (epoetin-alfa)</a>	<a href="#">EOGEN (epoetin-alfa)</a>	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	#9055	ERBITUX	cetuximab	Yes, through the Plan Pharmacy Services	<a href="#">ERBITUX (cetuximab)</a>	<a href="#">ERBITUX (cetuximab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#723	EUFLERXA - non-preferred	sodium hyaluronate, 1% As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRELIRON will be the preferred product. Coverage of EUFLERXA requires a failed trial of a preferred product. Prior authorization is required through the Plan Pharmacy Services and is restricted to a Rheumatology, Orthopedic, Sports Medicine, or Pain Medicine specialist with authorization.	<a href="#">EUFLERXA (sodium hyaluronate, 1%)</a>	<a href="#">EUFLERXA (sodium hyaluronate, 1%)</a>	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	#311	EVENITY	romosozumab-aqqg	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Endocrinology or Rheumatology specialists with authorization.	<a href="#">EVENITY (romosozumab-aqqg)</a>	<a href="#">EVENITY (romosozumab-aqqg)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#1305	EVEKEZA	evincumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Cardiologist, Lipidologist, or Endocrinologist specialist with authorization.	<a href="#">EVEKEZA (evincumab)</a>	<a href="#">EVEKEZA (evincumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		EVRYSD	risdiplam	Yes, through Navitas. Restricted to a pediatric neurologist at a Muscular Dystrophy Association care center with authorization.	<a href="#">EVRYSD (risdiplam)</a>		
Medical	#428	EXONDYS 51	etepirsiran	None. Not Covered.	<a href="#">EXONDYS 51 (etepirsiran)</a>		
Medical	#0178	EXLEA	afibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	<a href="#">EXLEA (afibercept)</a>	<a href="#">EXLEA (afibercept)</a>	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	#0177	EXLEA HD	afibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	<a href="#">EXLEA HD (afibercept)</a>	<a href="#">EXLEA HD (afibercept)</a>	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	#0180	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.	<a href="#">FABRYZYME (agalsidase)</a>	<a href="#">FABRYZYME (agalsidase)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#517	FASENRA	bevacizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	<a href="#">FASENRA (bevacizumab)</a>	<a href="#">FASENRA (bevacizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit. It is not intended to be a complete list of all drugs covered under the medical benefit. For a complete list of all drugs covered under the medical benefit, please refer to the Plan Pharmacy Services and for pharmacy submit to WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to WellFirst.</p>				<p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.</p>			
Updated: 07/01/2024							
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	Q0138, Q0139	FERAHEME - preferred	ferumoxytol	As of 08/01/2022: VENOFER, INFED, FERILECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAER, MONOFERRIC, TIFERRIC, and TIFERRIC AINVO are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">FERAHEME (ferumoxytol)</a>		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	22916	FERRILECT - preferred	sodium ferric gluconate complex	As of 08/01/2022: VENOFER, INFED, FERILECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAER, MONOFERRIC, TIFERRIC, and TIFERRIC AINVO are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">FERRILECT (sodium ferric gluconate complex)</a>		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	13744	FIRAZYR	icatibant	Yes, through the Plan Pharmacy Services	<a href="#">FIRAZYR (icatibant)</a>	<a href="#">FIRAZYR (icatibant)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11572	FLEBOGAMMA/FLEBOGAMMA DF (IVIG), IMMUNE GLOBULIN	Flbogamma	Yes, through the Plan Pharmacy Services	<a href="#">FLEBOGAMMA/FLEBOGAMMA DF (IVIG)</a>	<a href="#">FLEBOGAMMA/FLEBOGAMMA DF (IVIG)</a>	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	05108	FULPHILA	pegfilgrastim jmbd	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIXTENZO AND FULPHILA before coverage of Neulasta, LIDENCIN, FULNETRA, STIMGENE and ZIXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">FULPHILA (pegfilgrastim jmbd)</a>	<a href="#">FULPHILA (pegfilgrastim jmbd)</a>	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	05641	FUSLEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">FUSLEV (levoleucovorin)</a>	<a href="#">FUSLEV (levoleucovorin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	85331	FYARRO	sirinolimus albumin-bound	Yes, through the Plan Pharmacy Services	<a href="#">FYARRO (sirinolimus albumin-bound)</a>	<a href="#">FYARRO (sirinolimus albumin-bound)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05130	FYLNETRA - non preferred	pegfilgrastim-obbk	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIXTENZO AND FULPHILA before coverage of Neulasta, LIDENCIN, FULNETRA, STIMGENE and ZIXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">FYLNETRA (pegfilgrastim-obbk)</a>	<a href="#">FYLNETRA (pegfilgrastim-obbk)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	89210	GAMIFANT	emagalumab-izag	Yes, through the Plan Pharmacy Services	<a href="#">GAMIFANT* (emagalumab-izag)</a>	<a href="#">GAMIFANT* (emagalumab-izag)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11569	GAMMAGARD (SCIG), IMMUNE GLOBULIN	immune globulin (gammagard liquid)	Yes, through the Plan Pharmacy Services	<a href="#">GAMMAGARD (SCIG)</a>	<a href="#">GAMMAGARD (SCIG)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11557	GAMMAPLEX (IVIG), IMMUNE GLOBULIN	immune globulin (gammaplex liquid)	Yes, through the Plan Pharmacy Services.	<a href="#">GAMMAPLEX (IVIG)</a>	<a href="#">GAMMAPLEX (IVIG)</a>	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	11561	GAMUNEX-C/GAMMAKED (SCIG), IMMUNE GLOBULIN	gamunex injection	Yes, through the Plan Pharmacy Services	<a href="#">GAMUNEX-C/GAMMAKED (SCIG)</a>	<a href="#">GAMUNEX-C/GAMMAKED (SCIG)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	8501	GAZYVA	obinutuzumab	Yes, through the Plan Pharmacy Services	<a href="#">GAZYVA (obinutuzumab)</a>	<a href="#">GAZYVA (obinutuzumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	7326	GEL-ONE - non preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durilane, Gel-One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and GenViscD50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">GEL-ONE (hyaluronate sodium)</a>	<a href="#">GEL-ONE (hyaluronate sodium)</a>	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	7328	GELSYN-3 - non preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durilane, Gel-One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and GenViscD50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">GELSYN-3 (hyaluronate sodium)</a>	<a href="#">GELSYN-3 (hyaluronate sodium)</a>	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	7320	GENVISC-850 - non preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durilane, Gel-One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and GenViscD50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">GENVISC-850 (hyaluronan or derivative)</a>	<a href="#">GENVISC-850 (hyaluronan or derivative)</a>	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	80223	GNLAARI	givostarin	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.	<a href="#">GNLAARI (givostarin)</a>	<a href="#">GNLAARI (givostarin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	80257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	<a href="#">GLASSIA (alpha-1-proteinase inhibitor)</a>	<a href="#">GLASSIA (alpha-1-proteinase inhibitor)</a>	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	ibo-filgrastim	Yes, through the Plan Pharmacy Services	<a href="#">GRANIX (ibo-filgrastim)</a>	<a href="#">GRANIX (ibo-filgrastim)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	7170	HEMLIBRA	emicizumab	Yes, through WellFirst. Refer to members pharmacy benefit formulary for coverage.	<a href="#">HEMLIBRA (emicizumab)</a>	<a href="#">HEMLIBRA (emicizumab)</a>	
Medical	89355	HERCEPTIN	trastuzumab injection	Heruzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kadcycla and Ontruzumab require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">HERCEPTIN (trastuzumab injection)</a>	<a href="#">HERCEPTIN (trastuzumab injection)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	89356	HERCEPTIN HYLECTA	trastuzumab and hyaluronidase-eyyk	Yes, through the Plan Pharmacy Services	<a href="#">HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-eyyk)</a>	<a href="#">HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-eyyk)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11411	HEMGENIX	etranacogene dezaparvoec-drib	Yes, through the Plan Pharmacy Services	<a href="#">HEMGENIX (etranacogene dezaparvoec-drib)</a>	<a href="#">HEMGENIX (etranacogene dezaparvoec-drib)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05113	HERZUMA	trastuzumab-derb	Heruzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kadcycla and Ontruzumab require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">HERZUMA (trastuzumab-derb)</a>	<a href="#">HERZUMA (trastuzumab-derb)</a>	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	<a href="#">HIZENTRA (SCIG)</a>	<a href="#">HIZENTRA (SCIG)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs


 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
Updated: 07/01/2024		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit. Drugs are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Novitas.		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	9294	HOSPIRA	penicillate	Yes, through the Plan Pharmacy Services	<a href="#">HOSPIRA (penicillate)</a>	<a href="#">HOSPIRA (penicillate)</a>	MAPD 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, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Duralane, Gel-One, Euflexa, Gelyin-3, Viscot-3, sodium hyaluronate, TRIVIC, Orthovisc, Supartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">HYALGAN (hyaluronate or derivative)</a>		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	9351	HYCAMTIN	topotecan	IV dosage form does not require PA. Oral dosage form requires PA - Restricted to Oncologists with authorization through the Plan Pharmacy Services.		<a href="#">HYCAMTIN (topotecan)</a>	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	17322	HYMOVIS - preferred	hyaluronan	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Duralane, Gel-One, Euflexa, Gelyin-3, Viscot-3, sodium hyaluronate, TRIVIC, Orthovisc, Supartz FX, and GenVisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">HYMOVIS (hyaluronan)</a>		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	11575	HYQVIA (SIG), IMMUNE GLOBULIN	immune globulin (hyqvi)	Yes, through the Plan Pharmacy Services	<a href="#">HYQVIA (SIG)</a>	<a href="#">HYQVIA (SIG)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	93245	ILUMYA	tiludronate sodium	Yes, through the Plan Pharmacy Services	<a href="#">ILUMYA (tiludronate sodium)</a>	<a href="#">ILUMYA (tiludronate sodium)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	91173	IMFINZI	durvalumab	Yes, through the Plan Pharmacy Services	<a href="#">IMFINZI (durvalumab)</a>	<a href="#">IMFINZI (durvalumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9347	IMJUDO	tremelimumab-act	Yes, through the Plan Pharmacy Services	<a href="#">IMJUDO (tremelimumab-act)</a>	<a href="#">IMJUDO (tremelimumab-act)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9325	IMLYGIC	raltegravir ciplidine	Yes, through the Plan Pharmacy Services	<a href="#">IMLYGIC (raltegravir ciplidine)</a>	<a href="#">IMLYGIC (raltegravir ciplidine)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9359	INDELTRA	baricitinib-dile	EFFECTIVE 09/01/2024. Yes, through the Plan Pharmacy Services	<a href="#">INDELTRA</a>	<a href="#">INDELTRA</a>	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	11750	INFED - preferred	iron dextran	As of 08/01/2022: VENDOR, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">INFED (iron dextran)</a>		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05103	INFLECTA - non-preferred	infliximab-dyyb	Yes, through the Plan Pharmacy Services after failed trial of REMLEVIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<a href="#">INFLECTA (infliximab-dyyb)</a>	<a href="#">INFLECTA (infliximab-dyyb)</a>	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	91598	INFUGEM	premixed ganciclovir in sodium chloride solution	Yes, through the Plan Pharmacy Services	<a href="#">INFUGEM (premixed ganciclovir in sodium chloride solution)</a>	<a href="#">INFUGEM (premixed ganciclovir in sodium chloride solution)</a>	MAPD 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	feric carboxymaltose	As of 08/01/2022: VENDOR, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONOFERRIC, TRIFERIC, and TRIFERIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">INJECTAFER (feric carboxymaltose)</a>	<a href="#">INJECTAFER (feric carboxymaltose)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	<a href="#">INSULIN PUMPS</a>	<a href="#">INSULIN PUMPS</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, GARDIMUNE NF)	immune globulin, powder	Yes, through the Plan Pharmacy Services	<a href="#">IVIG (Immune Globulin)</a>	<a href="#">IVIG (Immune Globulin)</a>	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	11599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services	<a href="#">IVIG (Immune Globulin)</a>	<a href="#">IVIG (Immune Globulin)</a>	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	12782	IZERWAY	zincacapsad pegol	Yes, through the Plan Pharmacy Services	<a href="#">IZERWAY (zincacapsad pegol)</a>	<a href="#">IZERWAY (zincacapsad pegol)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9281	JELMYTO	nitroglycerin	Yes, through the Plan Pharmacy Services	<a href="#">JELMYTO (nitroglycerin)</a>	<a href="#">JELMYTO (nitroglycerin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9272	JEMPERLI	dostarlimab	Yes, through the Plan Pharmacy Services	<a href="#">JEMPERLI (dostarlimab-gdy)</a>	<a href="#">JEMPERLI (dostarlimab-gdy)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9043	JEVYANA	cabazitaxel	Yes, through the Plan Pharmacy Services	<a href="#">JEVYANA (cabazitaxel)</a>	<a href="#">JEVYANA (cabazitaxel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9550	JURBONTI	denosumab	Yes, through the Plan Pharmacy Services	<a href="#">JURBONTI (denosumab)</a>	<a href="#">JURBONTI (denosumab)</a>	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	9354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services	<a href="#">KADCYLA (ado-trastuzumab emtansine)</a>	<a href="#">KADCYLA (ado-trastuzumab emtansine)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12390	KALBITOR	Kalbitor (ecallantide)	Yes, through the Plan Pharmacy Services	<a href="#">KALBITOR (ecallantide)</a>	<a href="#">KALBITOR (ecallantide)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05117	KANJINTI	trastuzumab-anns	Yes, through the Plan Pharmacy Services	<a href="#">KANJINTI (trastuzumab-anns)</a>	<a href="#">KANJINTI (trastuzumab-anns)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12640	KANUMA IV	cebiloxin alpha	Yes, through the Plan Pharmacy Services	<a href="#">KANUMA IV (cebiloxin alpha)</a>	<a href="#">KANUMA IV (cebiloxin alpha)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	14490	KETAMINE for Chronic Pain and Mental Health and Substance Related Disorders		None. Not Covered	<a href="#">KETAMINE FOR CHRONIC PAIN</a>		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	<a href="#">KEYTRUDA (pembrolizumab)</a>	<a href="#">KEYTRUDA (pembrolizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9274	KIMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	<a href="#">KIMTRAK (tebentafusp-tebn)</a>	<a href="#">KIMTRAK (tebentafusp-tebn)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs


 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
Updated: 07/01/2024		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits we covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed or not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Nova.		This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	12507	ERYSTEXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	<a href="#">ERYSTEXA (pegloticase)</a>	<a href="#">ERYSTEXA (pegloticase)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	02042	KYMRIAH	Isigalenicefaut	Yes, through the Plan Pharmacy Services	<a href="#">KYMRIAH (isigalenicefaut)</a>	<a href="#">KYMRIAH (isigalenicefaut)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	00467	EYPRODIS	carfilzomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">EYPRODIS (carfilzomib)</a>	<a href="#">EYPRODIS (carfilzomib)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	00217	LAMZEDE	velmanase afa-tycy	Yes, through the Plan Pharmacy Services	<a href="#">LAMZOTI* (velmanase afa-tycy)</a>	<a href="#">LAMZOTI* (velmanase afa-tycy)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3490, C9399	LANREOTIDE	somatuline depot	Yes, through the Plan Pharmacy Services	<a href="#">LANREOTIDE (somatuline depot)</a>	<a href="#">LANREOTIDE (somatuline depot)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3590	LANTIDRA	donitacef injn	Yes, through the Plan Pharmacy Services	<a href="#">LANTIDRA* (donitacef injn)</a>	<a href="#">LANTIDRA* (donitacef injn)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0202	LEMTRADA	alemtuzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialist with authorization. Infusions must be administered at a facility certified for LEMTRADA infusions.	<a href="#">LEMTRADA (alemtuzumab)</a>	<a href="#">LEMTRADA (alemtuzumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3590	LENMELDY	etidarsagene autotemcel	Yes, through the Plan Pharmacy Services	<a href="#">LENMELDY (etidarsagene autotemcel)</a>	<a href="#">LENMELDY (etidarsagene autotemcel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	00274	LEQEMBI	lecanezumab-imb	Yes, through the Plan Pharmacy Services	<a href="#">LEQEMBI* (lecanezumab-imb)</a>	<a href="#">LEQEMBI* (lecanezumab-imb)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13306	LEQVIO	indisiran	None. Not covered.	<a href="#">LEQVIO (indisiran)</a>		
Medical	00641, 00642	LEVOLUCOVORIN	levulinic acid	Yes, through the Plan Pharmacy Services	<a href="#">LEVOLUCOVORIN</a>	<a href="#">LEVOLUCOVORIN</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	00650	N/A	Levothyroxine injection (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	<a href="#">LEVOTHYROXINE INJECTION (INTRAVENOUS)</a>	<a href="#">LEVOTHYROXINE INJECTION (INTRAVENOUS)</a>	
Medical	09119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	<a href="#">LIBTAYO (cemiplimab-act)</a>	<a href="#">LIBTAYO (cemiplimab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	2001		LIDOCaine for Chronic Pain	None. Not Covered	<a href="#">LIDOCANE FOR CHRONIC PAIN</a>		
Medical	32463	LOXTORZI	toripalimab-tpst	Yes, through the Plan Pharmacy Services	<a href="#">LOXTORZI (toripalimab-tpst)</a>	<a href="#">LOXTORZI (toripalimab-tpst)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	22778	LUCENTIS	ranibizumab	Yes, through the Plan Pharmacy Services	<a href="#">LUCENTIS (ranibizumab)</a>	<a href="#">LUCENTIS (ranibizumab)</a>	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	00221	LUMIZYME	alginate-chitosan (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.	<a href="#">LUMIZYME (alginate-chitosan afa)</a>	<a href="#">LUMIZYME (alginate-chitosan afa) (intravenous)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09313	LUMOXITI	roxestromumab pasodifaw tftb	Yes, through the Plan Pharmacy Services	<a href="#">LUMOXITI (roxestromumab pasodifaw tftb)</a>	<a href="#">LUMOXITI (roxestromumab pasodifaw)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09350	LUNSUMMO	rosuxetumumab-aagb	Yes, through the Plan Pharmacy Services	<a href="#">LUNSUMMO (rosuxetumumab-aagb)</a>	<a href="#">LUNSUMMO (rosuxetumumab-aagb)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	00513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services	<a href="#">LUTATHERA (lutetium Lu 177)</a>	<a href="#">LUTATHERA (lutetium Lu 177 dotatate)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	33398	LUXTURNA	voretigene neparvec-rzyl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the retinal dystrophy with authorization.	<a href="#">LUXTURNA (voretigene neparvec-rzyl)</a>	<a href="#">LUXTURNA (voretigene neparvec-rzyl)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3394	LYGENA	lovetbeglogene automecel	Yes, through the Plan Pharmacy Services	<a href="#">LYGENA (lovetbeglogene automecel)</a>	<a href="#">LYGENA (lovetbeglogene automecel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09353	MARGENZA	marigatumab	Yes, through the Plan Pharmacy Services	<a href="#">MARGENZA (marigatumab)</a>	<a href="#">MARGENZA (marigatumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	33997	MEPSEVI	vestronidase afa-vybk (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.	<a href="#">MEPSEVI (vestronidase afa-vybk) (intravenous)</a>	<a href="#">MEPSEVI (vestronidase afa-vybk) (intravenous)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09349	MONJIVI	tafasitamab-caix	Yes, through the Plan Pharmacy Services	<a href="#">MONJIVI (tafasitamab-caix)</a>	<a href="#">MONJIVI (tafasitamab-caix)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11437	MONOFERRIC - non-preferred	ferric derisomaltose	As of 08/01/2022: VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTABE, MONOFERRIC, FERREXIC, and TROBEC AVIVO are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">MONOFERRIC (ferric derisomaltose)</a>	<a href="#">MONOFERRIC (ferric derisomaltose)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	7327	MONOVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TESSURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durzabene, Gel-One, Euflexa, Gelyon-3, Viscotex, sodium hyaluronate, TRIVISC, Orthovisc, Septra FX, and Geniclude are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">MONOVISC (hyaluronan or derivative)</a>	<a href="#">MONOVISC (hyaluronan or derivative)</a>	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	05107	MVASI	bevacizumab-awwb	As of 03/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Aymmys, Mvasi and Veginims prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	<a href="#">MVASI (bevacizumab-awwb)</a>	<a href="#">MVASI (bevacizumab-awwb)</a>	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	02003	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	<a href="#">MYLOTARG (gemtuzumab-ozogamicin)</a>	<a href="#">MYLOTARG (gemtuzumab-ozogamicin)</a>	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	0587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	<a href="#">MYOBLOC (rimabotulinumtoxinB)</a>		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	3490	N/A	Levothyroxine injection (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	<a href="#">LEVOTHYROXINE INTRAVENOUS</a>	<a href="#">LEVOTHYROXINE INTRAVENOUS</a>	


 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed or not covered, please complete the <a href="#">Exception to Coverage form</a> found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</p>				<p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.</p>			
Updated: 07/01/2024							
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	1448	NAGLAZYME	galafuse (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 Macropolysectidosis VI with authorization.	<a href="#">NAGLAZYME (galafuse)</a>	<a href="#">NAGLAZYME (galafuse)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	2506	NEULASTA	pegfilgrastim	Yes, through Navitas	<a href="#">NEULASTA (pegfilgrastim)</a>	<a href="#">NEULASTA (pegfilgrastim)</a>	
Medical	2506	NEULASTA	pegfilgrastim	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENICVA, NYVEPRIA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">NEULASTA (pegfilgrastim)</a>	<a href="#">NEULASTA (pegfilgrastim)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1442	NEUPOGEN	filgrastim	EFFECTIVE 01/01/2023: Nevestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">NEUPOGEN (filgrastim)</a>	<a href="#">NEUPOGEN (filgrastim)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW	New to Market Medical Pharmacy Products currently under clinical review	New policy regarding Medical Pharmacy products under current clinical review	<a href="#">NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW</a>		
Medical	N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS	New to Market Medical Pharmacy Products	New policy regarding New to Market Medical Products	<a href="#">NEW TO MARKET MEDICAL PHARMACY PRODUCTS</a>		
Medical	0219	NEXYAZYME	avagliflozin/alpha	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 DK.	<a href="#">NEXYAZYME (avagliflozin/alpha)</a>	<a href="#">NEXYAZYME (avagliflozin/alpha)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0513D	NIVESTYM	filgrastim-aafi	EFFECTIVE 01/01/2023: Nevestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">NIVESTYM (filgrastim-aafi)</a>	<a href="#">NIVESTYM (filgrastim-aafi)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	2796	NPLATE	romipostim	Yes, through the Plan Pharmacy Services	<a href="#">NPLATE (romipostim)</a>	<a href="#">NPLATE (romipostim)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	2182	NUCALA	meplizumab	Yes, through the Plan Pharmacy Services. Eosinophilic asthma: Restricted to Pulmonology, Allergy, and Immunology specialists with authorization. Eosinophilic granulomatosis with polyangiitis (EGPA): Restricted to a Pulmonology, Immunology, Allergy or Rheumatology specialist with authorization.	<a href="#">NUCALA (meplizumab)</a>	<a href="#">NUCALA (meplizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3490, C9399	NULBRY	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.	<a href="#">NULBRY (fosdenopterin)</a>	<a href="#">NULBRY (fosdenopterin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05122	NYVEPRIA	pegfilgrastim-avgf	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasta. UDENICVA, NYVEPRIA, FULPHILA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">NYVEPRIA (pegfilgrastim-avgf)</a>	<a href="#">NYVEPRIA (pegfilgrastim-avgf)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	2350	OCREVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	<a href="#">OCREVUS (ocrelizumab)</a>	<a href="#">OCREVUS (ocrelizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1568	OCTAGAM (IVIG), IMMUNE GLOBULIN	immune globulin (octagam liquid)	Yes, through the Plan Pharmacy Services	<a href="#">OCTAGAM (IVIG)</a>	<a href="#">OCTAGAM (IVIG)</a>	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	05114	OGIVRI	trastuzumab-dkst	Heruzma and Trastuzera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjost and Ontuzant require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">OGIVRI (trastuzumab-dkst)</a>	<a href="#">OGIVRI (trastuzumab-dkst)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3590	OMSGRE	omdulcel-ovly	Yes, through the Plan Pharmacy Services	<a href="#">OMSGRE* (omdulcel-ovly)</a>	<a href="#">OMSGRE* (omdulcel-ovly)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	2267	OMYGH	mirikizumab-mvsk	Yes, through the Plan Pharmacy Services	<a href="#">OMYGH (mirikizumab-mvsk)</a>	<a href="#">OMYGH (mirikizumab-mvsk)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0205	ONIVIDE	intravitreal liposome injection	Yes, through the Plan Pharmacy Services	<a href="#">ONIVIDE (intravitreal liposome injection)</a>	<a href="#">ONIVIDE (intravitreal liposome injection)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0222	ONPATRO	patisiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Hematology or Neurology specialist with authorization.	<a href="#">ONPATRO (patisiran)</a>	<a href="#">ONPATRO (patisiran)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05112	ONTRUZANT	trastuzumab-dtb	Heruzma and Trastuzera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjost and Ontuzant require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">ONTRUZANT (trastuzumab-dtb)</a>	<a href="#">ONTRUZANT (trastuzumab-dtb)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0299	OPDIVO	nivolumab	Yes, through the Plan Pharmacy Services	<a href="#">OPDIVO (nivolumab)</a>	<a href="#">OPDIVO (nivolumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0298	OPDUALAG	relatlimab/relatlimab-mvaw	Yes, through the Plan Pharmacy Services	<a href="#">OPDUALAG (relatlimab/relatlimab-mvaw)</a>	<a href="#">OPDUALAG (relatlimab/relatlimab-mvaw)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0129	ORENCIA (IV)	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	<a href="#">ORENCIA (IV) (abatacept)</a>	<a href="#">ORENCIA (IV) (abatacept)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy	0129	ORENCIA (SC)	abatacept	Yes, through Navitas. Restricted to an Rheumatology specialist with authorization.	<a href="#">ORENCIA (SC) (abatacept)</a>	<a href="#">ORENCIA (SC) (abatacept)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	7734	ORTHOVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durstane, Gel One, Euflexa, Gelvivo-3, Visco-3, sodium hyaluronate, Trivisc, Orthovisc, Supartz FX, and GenVisc350 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">ORTHOVISC (hyaluronan or derivative)</a>	<a href="#">ORTHOVISC (hyaluronan or derivative)</a>	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	0224	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	<a href="#">OXLUMO (lumasiran)</a>	<a href="#">OXLUMO (lumasiran)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0529	PACLITAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services	<a href="#">PACLITAXEL PROTEIN-BOUND PARTICLES</a>	<a href="#">PACLITAXEL PROTEIN-BOUND PARTICLES</a>	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	09177	PADCEV	enfortumab vedotin-efv	Yes, through the Plan Pharmacy Services	<a href="#">PADCEV (enfortumab vedotin-efv)</a>	<a href="#">PADCEV (enfortumab vedotin-efv)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs


 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.</p> <p>Updated: 07/01/2024</p>				<p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.</p>			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	0208	PEDMARK	sodium thiosulfate	Yes, through the Plan Pharmacy Services	<a href="#">PEDMARK (sodium thiosulfate)</a>	<a href="#">PEDMARK (sodium thiosulfate)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0304	PEMFEXY	penicillamine	Yes, through the Plan Pharmacy Services	<a href="#">PEMFEXY (penicillamine)</a>	<a href="#">PEMFEXY (penicillamine)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0347	PEPAXTO	imelphalan flufenamide	Yes, through the Plan Pharmacy Services	<a href="#">PEPAXTO (imelphalan flufenamide)</a>	<a href="#">PEPAXTO (imelphalan flufenamide)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0306	PERBETA	pertuzumab	Yes, through the Plan Pharmacy Services	<a href="#">PERBETA (pertuzumab)</a>	<a href="#">PERBETA (pertuzumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	<a href="#">PHESGO (pertuzumab, trastuzumab, hyaluronidase)</a>	<a href="#">PHESGO (pertuzumab, trastuzumab, hyaluronidase)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05699	PLUVICTO	luteinium Lu 177 vipivotide tetraacetate	Yes, through the Plan Pharmacy Services	<a href="#">PLUVICTO (luteinium Lu 177 vipivotide tetraacetate)</a>	<a href="#">PLUVICTO (luteinium Lu 177 vipivotide tetraacetate)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0309	POLIVY	polatuzumab vedotin-piq	Yes, through the Plan Pharmacy Services	<a href="#">POLIVY (polatuzumab vedotin-piq)</a>	<a href="#">POLIVY (polatuzumab vedotin-piq)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1303	POMBILTI	cipagliflozin afa-atga	Yes, through the Plan Pharmacy Services	<a href="#">POMBILTI (cipagliflozin afa-atga)</a>	<a href="#">POMBILTI (cipagliflozin afa-atga)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0295	PORTRAZZA	nectumumab	Yes, through the Plan Pharmacy Services	<a href="#">PORTRAZZA (nectumumab)</a>	<a href="#">PORTRAZZA (nectumumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0204	POTLUGEO	pegatumumab-tpke	Yes, through the Plan Pharmacy Services	<a href="#">POTLUGEO (pegatumumab-tpke)</a>	<a href="#">POTLUGEO (pegatumumab-tpke)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1149	PRIVIGEN (IVIG, IMMUNE GLOBULIN)	privigen	Yes, through the Plan Pharmacy Services	<a href="#">PRIVIGEN (IVIG)</a>	<a href="#">PRIVIGEN (IVIG)</a>	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, MD.
Pharmacy	0885	PROCRIT - non-preferred	epoetin alfa, (for non-erd use)	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.	<a href="#">PROCRIT (epoetin alfa)</a>	<a href="#">PROCRIT (epoetin alfa)</a>	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, MD.
Medical	0885, Q4082	PROCRIT	epoetin alfa, (for non-erd use)	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epopgen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">PROCRIT (epoetin alfa, for non-erd use)</a>	<a href="#">PROCRIT (epoetin alfa, for non-erd use)</a>	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, MD.
Medical	0815	PROLURIN	aldesleukin	Yes, through the Plan Pharmacy Services	<a href="#">PROLURIN (aldesleukin)</a>	<a href="#">PROLURIN (aldesleukin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0897	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.	<a href="#">PROLIA (denosumab)</a>	<a href="#">PROLIA (denosumab)</a>	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, MD.
Medical	02043	PROVENGE	sipuleucel-T	Yes, through the Plan Pharmacy Services	<a href="#">PROVENGE (sipuleucel-T)</a>	<a href="#">PROVENGE (sipuleucel-T)</a>	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, MD.
Medical	1304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	<a href="#">QALSODY (tofersen)</a>	<a href="#">QALSODY (tofersen)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1301	RADICAVA	edaravone	Yes, through the Plan Pharmacy Services. Restricted to an Neurology specialist with authorization.	<a href="#">RADICAVA (edaravone)</a>	<a href="#">RADICAVA (edaravone)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0896	REBLIZYL	lupatropert	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	<a href="#">REBLIZYL (lupatropert aam)</a>	<a href="#">REBLIZYL (lupatropert aam)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	02515	RELEKVO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarzio are the preferred Filgrastim products and do not require prior authorization. Neogen, Relelex and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">RELEKVO (filgrastim-ayow)</a>	<a href="#">RELEKVO (filgrastim-ayow)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1745	REMIKADE - non-preferred	infliximab	Yes, through the Plan Pharmacy Services after failed trial of REMLEKX. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<a href="#">REMIKADE (infliximab)</a>	<a href="#">REMIKADE (infliximab)</a>	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, MD.
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.	<a href="#">REMODULIN IV (treprostinil)</a>	<a href="#">REMODULIN IV (treprostinil)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05104	RENFLIXIS - preferred infliximab product	infliximab-abda	As of 10/01/2019: Prior authorization for the preferred infliximab product will only require provider attestation to an appropriate indication through the Plan Pharmacy Services. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	<a href="#">RENFLIXIS (infliximab)</a>	<a href="#">RENFLIXIS (infliximab)</a>	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, MD.
Pharmacy	05105	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.	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	
Medical	05106	RETACRIT	epoetin alfa-epbx	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epopgen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	<a href="#">RETACRIT (epoetin alfa-epbx)</a>	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, MD.
Medical	07311	RETSERT	fluciclovone acetamide intravitreal implant	None - Not Covered.	<a href="#">RETSERT (fluciclovone acetamide intravitreal implant)</a>	<a href="#">RETSERT (fluciclovone acetamide intravitreal implant)</a>	
Medical	0350	RETHYMIC	allogeneic processed thymus tissue-aggc	Yes, through the Plan Pharmacy Services	<a href="#">RETHYMIC (allogeneic processed thymus tissue-aggc)</a>	<a href="#">RETHYMIC (allogeneic processed thymus tissue-aggc)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals
Medical	0350, C0399	REVCODI	elapagademase-hlr	Yes, through the Plan Pharmacy Services	<a href="#">REVCODI (elapagademase-hlr)</a>	<a href="#">REVCODI (elapagademase-hlr)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitus.	<a href="#">RHOPRESSA (netarsudil)</a>	<a href="#">RHOPRESSA (netarsudil)</a>	
Medical	05123	RIABNI	rituximab-arms	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria.	<a href="#">RIABNI (rituximab-arms)</a>	<a href="#">RIABNI (rituximab-arms)</a>	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, MD.
Medical	04490	RIVFLOZA	nedosiran	Yes, through the Plan Pharmacy Services	<a href="#">RIVFLOZA (nedosiran)</a>	<a href="#">RIVFLOZA (nedosiran)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	09312	RITUXAN	rituximab	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria.	<a href="#">RITUXAN (rituximab)</a>	<a href="#">RITUXAN (rituximab)</a>	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, MD.



 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits we covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed or not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.</p> <p>Updated: 07/01/2024</p>				<p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.</p>			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	9311	RITUXAN HYCELA	rituximab and hyaluronidase human	Yes, through the Plan Pharmacy Services	<a href="#">RITUXAN HYCELA (rituximab and hyaluronidase human)</a>	<a href="#">RITUXAN HYCELA (rituximab and hyaluronidase human)</a>	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, MD
Medical	9312	RITUXIMAB IV	rituximab, ruvidonem rabel	Yes, through the Plan Pharmacy Services	<a href="#">RITUXIMAB IV (rituximab, ruvidonem rabel)</a>	<a href="#">RITUXIMAB IV (rituximab, ruvidonem rabel)</a>	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, MD
Medical	11412	ROCTAVIAN	valoctocogene rosapavovec-rvdx	Yes, through the Plan Pharmacy Services	<a href="#">ROCTAVIAN® (valoctocogene rosapavovec-rvdx)</a>	<a href="#">ROCTAVIAN® (valoctocogene rosapavovec-rvdx)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11449	ROLVEDON	efpegastatim-xvst	Yes, through the Plan Pharmacy Services	<a href="#">ROLVEDON™ (efpegastatim-xvst)</a>	<a href="#">ROLVEDON™ (efpegastatim-xvst)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	02519	RUXIENCE	rituximab-pwr	As of 01/01/2023: Ruxience and Trusima are the preferred Rituximab products and does not require prior authorization. Robi and Rituxan prior authorization is required. Please see medical policy for criteria	<a href="#">RUXIENCE (rituximab-pwr)</a>	<a href="#">RUXIENCE (rituximab-pwr)</a>	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, MD.
Medical	9061	RYBREVANT	amivantamab-vmwj	Yes, through the Plan Pharmacy Services	<a href="#">RYBREVANT (amivantamab-vmwj)</a>	<a href="#">RYBREVANT (amivantamab-vmwj)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	2998	RYPLAZIM	plasminogen, human-tyrh	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.	<a href="#">RYPLAZIM (plasminogen, human-tyrh)</a>	<a href="#">RYPLAZIM (plasminogen, human-tyrh)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9333	RYSTIGGO	rosanzolzumab-noli	Yes, through the Plan Pharmacy Services	<a href="#">RYSTIGGO® (rosanzolzumab-noli)</a>	<a href="#">RYSTIGGO® (rosanzolzumab-noli)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9361	RYZNEUTA	efbemerizograftim-afz-vvux	Yes, through the Plan Pharmacy Services	<a href="#">RYZNEUTA (efbemerizograftim-afz-vvux)</a>	<a href="#">RYZNEUTA (efbemerizograftim-afz-vvux)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		SANDOSTATIN	octreotide	Yes, through Navitus. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or Gastroenterologist specialist with authorization.	<a href="#">SANDOSTATIN (octreotide, ex-tate)</a>		
Medical	12353	SANDOSTATIN LAR	octreotide suspension	Yes, through the Plan Pharmacy Services	<a href="#">SANDOSTATIN LAR (octreotide suspension)</a>	<a href="#">SANDOSTATIN LAR (octreotide suspension)</a>	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	<a href="#">SANDOSTATIN octreotide suspension (non-depot form)</a>	<a href="#">SANDOSTATIN octreotide suspension (non-depot form)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Services	<a href="#">SANDOZ (pemetrexed)</a>	<a href="#">SANDOZ (pemetrexed)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	0491	SAPHNELO	anifrolumab-fria	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology specialist with authorization.	<a href="#">SAPHNELO (anifrolumab-fria)</a>	<a href="#">SAPHNELO (anifrolumab-fria)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9227	SARCLISA	isatumab-ircf	Yes, through the Plan Pharmacy Services	<a href="#">SARCLISA (isatumab-ircf)</a>	<a href="#">SARCLISA (isatumab-ircf)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 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 Geneticist, or a Physician specializing in the treatment of cutaneous porphyrias with authorization.	<a href="#">SCENESSE (afamelanotide)</a>	<a href="#">SCENESSE (afamelanotide)</a>	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.	<a href="#">SELF-ADMINISTERED DRUGS</a>		
Medical	12502	SIGNIFOR LAR	pasireotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist specialist with authorization.	<a href="#">SIGNIFOR LAR (pasireotide)</a>	<a href="#">SIGNIFOR LAR (pasireotide)</a>	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 consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	<a href="#">SIMPONI ARIA (golimumab)</a>	<a href="#">SIMPONI ARIA (golimumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		SIMPONI ARIA	golimumab	Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, Psoriatic Arthritis) or Gastroenterology specialist with authorization.	<a href="#">SIMPONI ARIA (golimumab)</a>	<a href="#">SIMPONI ARIA (golimumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical		SITE OF SERVICE		Yes, through the Plan Pharmacy Services. Requests for select specialty drugs as listed in the list in section "Drugs in Scope" to be administered in a hospital outpatient setting may be directed to a preferred alternative site of care, such as home infusion provider or a physician office.	<a href="#">SITE OF SERVICE</a>		
Medical	12327	SKYRIZ IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterology.	<a href="#">SKYRIZ IV (risankizumab)</a>	<a href="#">SKYRIZ IV (risankizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	3590	SKYSONA	elivalogene autotemcel	Yes, through the Plan Pharmacy Services	<a href="#">SKYSONA™ (elivalogene autotemcel)</a>	<a href="#">SKYSONA™ (elivalogene autotemcel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11300	SOLIRIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Neuro-Ophthalmologist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	<a href="#">SOLIRIS (eculizumab)</a>	<a href="#">SOLIRIS (eculizumab)</a>	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, MD
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.	<a href="#">SOMATULINE (lanreotide depot)</a>	<a href="#">SOMATULINE (lanreotide depot)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11747	SPEVIGO	speolimab	Yes, through the Plan Pharmacy Services	<a href="#">SPEVIGO™ (speolimab)</a>	<a href="#">SPEVIGO™ (speolimab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13490	SPRAVATO	esketamine	Yes, through the Plan Pharmacy Services	<a href="#">SPRAVATO (esketamine)</a>	<a href="#">SPRAVATO (esketamine)</a>	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.	<a href="#">SPINRAZA (nusinersen)</a>	<a href="#">SPINRAZA (nusinersen)</a>	MAPD 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.	<a href="#">STELARA IV (ustekinumab)</a>	<a href="#">STELARA IV (ustekinumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed or not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</p> <p>Updated: 07/01/2024</p>				<p>This is a large document, but you can search quickly and easily by clicking on the bioocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.</p>			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Pharmacy	3358	STELARA (SC)	ustekinumab	Yes, through Navitas. Restricted to an Gastroenterology specialist with authorization.	<a href="#">STELARA SC (ustekinumab)</a>	<a href="#">STELARA SC (ustekinumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	3590	STIMUFEND	pegfilgrastim-ebkb	EFFECTIVE 04/01/2024: FULPHILA and NYVEFRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIKENTEND AND FULPHILA before coverage of Neulasta. UDENCYA, FYXNETRA, STIMUFEND and ZIKENTEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">STIMUFEND (pegfilgrastim-ebkb)</a>	<a href="#">STIMUFEND (pegfilgrastim-ebkb)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Pharmacy		Sublingual Immunotherapy (SLIT) for ALLERGY products	GRASTEK (Timothy grass pollen allergen extract), RAGWITEK (Short ragweed pollen allergen extract), ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollen allergen extract), ODCACTRA (House Dust Mite allergen extract)	Yes, through Navitas. 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.	<a href="#">SLIT for Allergy Products</a>	<a href="#">SLIT for Allergy Products</a>	
Medical	7321	SUPARTZ FX - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Duralane, Gel One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and Genvisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">SUPARTZ FX (hyaluronan or derivative)</a>	<a href="#">SUPARTZ FX (hyaluronan or derivative)</a>	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, MD
Medical	1627	SUSTOL	granisetron extended-release	Yes, through the Plan Pharmacy Services	<a href="#">SUSTOL (granisetron extended-release)</a>	<a href="#">SUSTOL (granisetron extended-release)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	2781	SYFOVRE	pegcetacoplan	No. Please see medical policy for criteria.	<a href="#">SYFOVRE (pegcetacoplan)</a>		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	1260	SILVANT	siltuximab	Yes, through the Plan Pharmacy Services	<a href="#">SILVANT (siltuximab)</a>	<a href="#">SILVANT (siltuximab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	90378	SYNAGIS	palivizumab	Yes, through the Plan Pharmacy Services. Restricted to NCU Physician, Neonatologist, or Pediatric specialist (including family practice, general pediatrics, pediatric pulmonology, and pediatric cardiology) with authorization.	<a href="#">SYNAGIS (palivizumab)</a>	<a href="#">SYNAGIS (palivizumab)</a>	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, MD.
Medical	7325	SYNISC - preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Duralane, Gel One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and Genvisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">SYNISC (hyaluronan or derivative)</a>		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, MD
Medical	7325	SYNISC ONE - preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Duralane, Gel One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and Genvisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">SYNISC ONE (hyaluronan or derivative)</a>		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, MD
Medical	18055	TALVEY	talquetamab-tgvs	Yes, through the Plan Pharmacy Services	<a href="#">TALVEY (talquetamab-tgvs)</a>	<a href="#">TALVEY (talquetamab-tgvs)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	02053	TECARTUS	brexucabtagene autoleucel	Yes, through the Plan Pharmacy Services	<a href="#">TECARTUS (brexucabtagene autoleucel)</a>	<a href="#">TECARTUS (brexucabtagene autoleucel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	8022	TECENTRIQ	atezolizumab	Yes, through the Plan Pharmacy Services	<a href="#">TECENTRIQ (atezolizumab)</a>	<a href="#">TECENTRIQ (atezolizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	03148	TECVAYLI	teclistamab-cqyv	Yes, through the Plan Pharmacy Services	<a href="#">TECVAYLI (teclistamab-cqyv)</a>	<a href="#">TECVAYLI (teclistamab-cqyv)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	3241	TEPEZZA	teprotumumab-trbw	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Ophthalmologist and Endocrinologist specialist with authorization.	<a href="#">TEPEZZA (teprotumumab-trbw)</a>	<a href="#">TEPEZZA (teprotumumab-trbw)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	8914	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	<a href="#">TEVA (pemetrexed)</a>	<a href="#">TEVA (pemetrexed)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	8999, C9399	TEVIMBRA	tisotumumab-vgjr	Yes, through the Plan Pharmacy Services	<a href="#">TEVIMBRA (tisotumumab-vgjr)</a>	<a href="#">TEVIMBRA (tisotumumab-vgjr)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	2356	TEZSPRE	tezepelumab	Yes, through the Plan Pharmacy Services	<a href="#">TEZSPRE (tezepelumab)</a>	<a href="#">TEZSPRE (tezepelumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	0273	TIVDAK	tisotumab vedotin-efrb	Yes, through the Plan Pharmacy Services	<a href="#">TIVDAK (tisotumab vedotin-efrb)</a>	<a href="#">TIVDAK (tisotumab vedotin-efrb)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	05133	TOFIDENCE	tocilizumab-bawi	Yes, through the Plan Pharmacy Services	<a href="#">TOFIDENCE (tocilizumab-bawi)</a>	<a href="#">TOFIDENCE (tocilizumab-bawi)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	05116	TRAZIMERA	trastuzumab-qypv	Heruzma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Opdivo, Kadmon and Ontruzum require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">TRAZIMERA (trastuzumab-qypv)</a>	<a href="#">TRAZIMERA (trastuzumab-qypv)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	9063	TREANDA	benzamustine	Yes, through the Plan Pharmacy Services	<a href="#">TREANDA (benzamustine)</a>	<a href="#">TREANDA (benzamustine)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	7332	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.	<a href="#">TRILURON (sodium hyaluronate)</a>		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, MD
Medical	7329	TRIVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Duralane, Gel One, Euflexa, Gelyn-3, Visco-3, sodium hyaluronate, TRIVISC, Orthovisc, Supartz FX, and Genvisc50 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">TRIVISC (hyaluronan or derivative)</a>	<a href="#">TRIVISC (hyaluronan or derivative)</a>	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, MD

 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES		SEARCH TIPS:			
<p>This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.</p> <p>Updated: 07/01/2024</p>				<p>This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.</p>			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	#937	TRODELVY	sacituzumab ipovicitcan-hzly	Yes, through the Plan Pharmacy Services	<a href="#">TRODELVY (sacituzumab ipovicitcan-hzly)</a>	<a href="#">TRODELVY (sacituzumab ipovicitcan-hzly)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1746	TROGARZO	balizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Infectious Disease specialist with authorization.	<a href="#">TROGARZO (balizumab)</a>	<a href="#">TROGARZO (balizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05115	TRUXIMA	rituximab-abbs	As of 01/01/2023: Rituxience and Truxima are the preferred Rituximab products and does not require prior authorization. Rituxin and Rituxan prior authorization is required. Please see medical policy for criteria	<a href="#">TRUXIMA (rituximab-abbs)</a>	<a href="#">TRUXIMA (rituximab-abbs)</a>	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	05134	TYRUKO	nataлизumab	Yes, through the Plan Pharmacy Services	<a href="#">TYRUKO (nataлизumab)</a>	<a href="#">TYRUKO (nataлизumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12323	TYSABRI	nataлизumab injection	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	<a href="#">TYSABRI (nataлизumab)</a>	<a href="#">TYSABRI (nataлизumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	03149	TZIELD	teplizumab-mwav	Yes, through the Plan Pharmacy Services	<a href="#">TZIELD (teplizumab-mwav)</a>	<a href="#">TZIELD (teplizumab-mwav)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	05111	UDENYCA	pegfilgrastim-cbqv	EFFECTIVE 01/01/2024: FULPHLA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZENITENDO AND FULPHLA before coverage of Udenyca. UDENYCA, PYNATRES, STIMUFREN and ZENITENDO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">UDENYCA (pegfilgrastim-cbqv)</a>	<a href="#">UDENYCA (pegfilgrastim-cbqv)</a>	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	ravulizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematology, Oncology, or Immunology specialist with authorization.	<a href="#">ULTOMIRIS (ravulizumab)</a>	<a href="#">ULTOMIRIS (ravulizumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1823	UPLIZNA	inebilizumab-cdon	Yes, through the Plan Pharmacy Services	<a href="#">UPLIZNA (inebilizumab-cdon)</a>	<a href="#">UPLIZNA (inebilizumab-cdon)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	8499	UPTRAVI-IV	selepiqag	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a cardiologist or pulmonologist with authorization.	<a href="#">UPTRAVI-IV (selepiqag)</a>	<a href="#">UPTRAVI-IV (selepiqag)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharmacy		UPTRAVI	selepiqag	Yes, through Navitas. Restricted to (in at least consultation with) a cardiologist or pulmonologist with authorization.	<a href="#">UPTRAVI (selepiqag)</a>	<a href="#">UPTRAVI (selepiqag)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12777	VABYSMO	faricimab-svaq	Yes, through the Plan Pharmacy Services	<a href="#">VABYSMO (faricimab-svaq)</a>	<a href="#">VABYSMO (faricimab-svaq)</a>	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	#9303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	<a href="#">VECTIBIX (panitumumab)</a>	<a href="#">VECTIBIX (panitumumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	9041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	<a href="#">VELCADE (bortezomib - preferred)</a>	<a href="#">VELCADE (bortezomib - preferred)</a>	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	05129	VIGZELMA	bevacizumab-adcf	As of 03/01/2024: Zirbeve is the preferred Bevacizumab product and does not require prior authorization. Avastin, Avastin, Avastin, and Vegfrelma prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** see the ALTIMEDS (Bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	<a href="#">VIGZELMA (bevacizumab-adcf)</a>	<a href="#">VIGZELMA (bevacizumab-adcf)</a>	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	11756	VENOFER - preferred	Iron sucrose	As of 08/01/2022: VENOFER, INFED, FERRELECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTABER, MINDROFERIC, TIBERIC, and TIBERIC AS100 are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	<a href="#">VENOFER (iron sucrose)</a>		MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#9376	VEDPOZ	pozalimab-bbfg	Yes, through the Plan Pharmacy Services	<a href="#">VEDPOZ (pozalimab-bbfg)</a>	<a href="#">VEDPOZ (pozalimab-bbfg)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	1427	VILTEPSO	viltolarsen	Note. Not Covered.	<a href="#">VILTEPSO (viltolarsen)</a>		
Medical	11323	VIMIZIM	elosulfate (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.	<a href="#">VIMIZIM (elosulfate)</a>	<a href="#">VIMIZIM (elosulfate)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	17321	VISC0-3 - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMADVIS, and TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durilane, Gel One, Euflexa, Gelvis-3, Visc0-3, sodium hyaluronate, Trivisc, Orthovisc, Supartz FX, and Genvisc950 are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">VISC0-3 (hyaluronan or derivative)</a>	<a href="#">VISC0-3 (hyaluronan or derivative)</a>	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	#9999	VIVIMUSTA	bendamustine	Yes, through the Plan Pharmacy Services	<a href="#">VIVIMUSTA (bendamustine)</a>	<a href="#">VIVIMUSTA (bendamustine)</a>	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	13185	VPRV	vibglucerase 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 DR with authorization.	<a href="#">VPRV (vibglucerase alfa)</a>	<a href="#">VPRV (vibglucerase alfa)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10012	VYEPTI	epinezumab-gjmr	Yes, through the Plan Pharmacy Services	<a href="#">VYEPTI (epinezumab-gjmr)</a>	<a href="#">VYEPTI (epinezumab-gjmr)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	13401	VYLUVEK	beremagene gepaprec-svdt	Yes, through the Plan Pharmacy Services	<a href="#">VYLUVEK (beremagene gepaprec-svdt)</a>	<a href="#">VYLUVEK (beremagene gepaprec-svdt)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	14249	VYONDYS E3	golodirsen	Note. Not Covered.	<a href="#">VYONDYS E3 (golodirsen)</a>		
Medical	#9332	VYVGART	efgartigmod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	<a href="#">VYVGART (efgartigmod alfa-fcab)</a>	<a href="#">VYVGART (efgartigmod alfa-fcab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	#9334	VYVGART-HYTRULO	efgartigmod alfa-fcab and hyaluronidase-qfvc	Yes, through the Plan Pharmacy Services	<a href="#">VYVGART (efgartigmod alfa-fcab and hyaluronidase-qfvc)</a>	<a href="#">VYVGART (efgartigmod alfa-fcab and hyaluronidase-qfvc)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs

 <small>(Formerly WellFirst Health)</small>		INJECTABLE MEDICINES			SEARCH TIPS:			
Updated: 07/01/2024		This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefits are covered, not covered, or not yet reviewed and whether a prior authorization is required. For coverage review of any drug listed or not covered, please complete the Exception to Coverage form found on the WellFirst Health website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Navitas.			This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.			
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD	
Medical	9153	VYXEOS	daunorubicin and cytarabine – liposome	Yes, through the Plan Pharmacy Services	<a href="#">VYXEOS (daunorubicin and cytarabine – liposome)</a>	<a href="#">VYXEOS (daunorubicin and cytarabine – liposome)</a>	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 Navitas.	<a href="#">VYZULTA (latanoprostene bunod)</a>	<a href="#">VYZULTA (latanoprostene bunod)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	3590	WEZLANA	ustekinumab	Yes, through the Plan Pharmacy Services.	<a href="#">WEZLANA (ustekinumab)</a>	<a href="#">WEZLANA (ustekinumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	3590	WYOST	denosumab	Yes, through the Plan Pharmacy Services	<a href="#">WYOST (denosumab)</a>	<a href="#">WYOST (denosumab)</a>	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	1158	XIMBIFY (SCIG)	immune globulin	Yes, through the Plan Pharmacy Services	<a href="#">XIMBIFY (SCIG)</a>	<a href="#">XIMBIFY (SCIG)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	80218	XENPOZYME	olipase alfa	Yes, through the Plan Pharmacy Services.	<a href="#">XENPOZYME® (olipase alfa)</a>	<a href="#">XENPOZYME® (olipase alfa)</a>	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	0588	XEDMIN	incobotulinumtoxinA	No prior authorization is required.	<a href="#">XEDMIN (incobotulinumtoxinA)</a>		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	8097	XGEVA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (a) least in consultation with a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	<a href="#">XGEVA (denosumab)</a>	<a href="#">XGEVA (denosumab)</a>	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	32299	XIPERE	triamcinolone acetate injectable suspension	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an ophthalmologist specialist with authorization.	<a href="#">XIPERE (triamcinolone acetate injectable suspension)</a>	<a href="#">XIPERE (triamcinolone acetate injectable suspension)</a>	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	2357	XOLAIR	omalizumab, 5mg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	<a href="#">XOLAIR (omalizumab)</a>	<a href="#">XOLAIR (omalizumab)</a>	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	9928	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services	<a href="#">YERVOY (ipilimumab)</a>	<a href="#">YERVOY (ipilimumab)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	02041	YESCARTA	axicabtagene cilolecel	Yes, through the Plan Pharmacy Services	<a href="#">YESCARTA (axicabtagene cilolecel)</a>	<a href="#">YESCARTA (axicabtagene cilolecel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	9352	YONDELIS	trabectedin	Yes, through the Plan Pharmacy Services	<a href="#">YONDELIS (trabectedin)</a>	<a href="#">YONDELIS (trabectedin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	0101	ZARXO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nevestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Reltuvo and Granix, require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	<a href="#">ZARXO (filgrastim-ayow)</a>	<a href="#">ZARXO (filgrastim-ayow)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	80256	ZEMAIRA/PROLASTIN-C	alpha-1-proteinase inhibitor (human)	Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	<a href="#">ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)</a>	<a href="#">ZEMAIRA/PROLASTIN-C (alpha-1-proteinase inhibitor)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	9923	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	<a href="#">ZEPZELCA (lurbinectedin)</a>	<a href="#">ZEPZELCA (lurbinectedin)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	01520	ZIEXTENDO - preferred	pegfilgrastim-bmez	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegfilgrastim products and do not require prior authorization. Must have a failed trial of ZIEXTENDO AND FULPHILA before coverage of Neulasta, LIDENYCA, FYNETRA, STIMPRENE and ZIEXTENDO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	<a href="#">ZIEXTENDO (pegfilgrastim-bmez)</a>	<a href="#">ZIEXTENDO (pegfilgrastim-bmez)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	01518	ZIRABEV - preferred	bevacizumab-bbv	As of 01/01/2024: Zirabev is the preferred Bevacizumab product and does not require prior authorization. Avastin, Alimpy, Mvasi and Vegrinix prior authorization is required through the Plan Pharmacy Services. ***Prior authorization for bevacizumab is not required when used for ophthalmological indications.*** See the ALYMSYS (bevacizumab) Policy for a list of applicable ophthalmological diagnoses.	<a href="#">ZIRABEV (bevacizumab-bbv)</a>	<a href="#">ZIRABEV (bevacizumab-bbv)</a>	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	03999, 13590	ZOLGENSMA	onasemnogene asepavonov-aco	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.	<a href="#">ZOLGENSMA (onasemnogene asepavonov-aco)</a>	<a href="#">ZOLGENSMA (onasemnogene asepavonov-aco)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	9939	ZYNLONTA	loncastumab tesirine	Yes, through the Plan Pharmacy Services	<a href="#">ZYNLONTA (loncastumab)</a>	<a href="#">ZYNLONTA (loncastumab tesirine)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	1393	ZYNTIGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	<a href="#">ZYNTIGLO® (betibeglogene autotemcel)</a>	<a href="#">ZYNTIGLO® (betibeglogene autotemcel)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
Medical	9945	ZYNZ	retifanlimab-dlwr	Yes, through the Plan Pharmacy Services	<a href="#">ZYNZ (retifanlimab-dlwr)</a>	<a href="#">ZYNZ (retifanlimab-dlwr)</a>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs	
<b>Notes:</b>								
			These drugs are all medical injectable drugs, and are not listed on the WellFirst Health drug formulary. The on-line formulary only lists drugs covered by the pharmacy benefit.	There are claim specific edits for many of these drugs. The edits limit the uses of these drugs to approved indications and dosages. In addition, WellFirst Health has payment restrictions consistent with WellFirst Health Medical or Drug Policies.		The Health Plan will not cover U.S. Food and Drug Administration (FDA) approved drugs that are new to the market until the Pharmacy and Therapeutics (P&T) Committee formally reviews and grants approval, within a maximum timeframe of 1 year from FDA approval. If a provider believes that use of a new drug is medically necessary prior to P&T Committee approval, they may submit an exception to coverage form request.		
			J3590 and J3490 are miscellaneous codes used for drugs that do not have a J code assigned by the FDA. New drugs may take between 12-18 months to get a J code assigned	Any drug submitted under either J3590 or J3490 with a cost of \$750 or greater will be reviewed post-claim by WellFirst Health.	It is recommended that any use of the miscellaneous codes be pre-approved ahead of time through WellFirst Health Utilization Management, especially for off-label uses from FDA indications.	<a href="#">Pharmacy Drug Exception to Coverage Form - IL</a> <a href="#">Pharmacy Drug Exception to Coverage Form - MO</a>	<a href="#">Medical Injectable Drug Exception to Coverage Form - IL</a> <a href="#">Medical Injectable Drug Exception to Coverage Form - MO</a>	