

PART B PRIOR AUTHORIZATION CRITERIA FOR APPROVAL

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

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

Length of Approval: See Table 1 below

NOTES:

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

Table 1: Part B Prior Authorization

HPCS	Medication	Length of Approval	NCD/LCD
Bevacizumab (Oncology)			
Q5107	Mvasi	12 months	N/A
Q5118	Zirabev	12 months	N/A
Trastuzumab			
Q5117	Kanjinti	12 months	N/A
Q5114	Ogivri	12 months	N/A
Q5116	Trazimera	12 months	N/A
Rituximab			
Q5123	Riabni	12 months	L35026
Q5119	Ruxience	12 months	L35026
Q5115	Truxima	12 months	L35026

HPCPS	Medication	Length of Approval	NCD/LCD
Long-Acting Colony Stimulating Factors			
Q5108	Fulphila	12 months	L37176
Q5111	Udenyca/Udenyca Onbody	12 months	L37176
Short-Acting Colony Stimulating Factors			
J2820	Leukine	12 months	L37176
Q5110	Nivestym	12 months	L37176
Q5101	Zarxio	12 months	L37176
Immune Globulins			
J1551	Cutaquig (SC)	12 months	L33794
J1569	Gammagard Liquid (IV or SC)	12 months	L34580 L33794
J1566	Gammagard S/D (IV)	12 months	L34580
J1561	Gammaked (IV or SC)	12 months	L34580 L33794
J1561	Gamunex-C (IV or SC)	12 months	L34580 L33794
J1559	Hizentra (SC)	12 months	L33794
J1575	HyQvia (SC)	12 months	L33794
J1599	Immune Globulin, intravenous, not otherwise specified	12 months	L34580
J1553	Yimmugo (IV)	12 months	L34580
J1568	Octagam (IV)	12 months	L34580
J1459	Privigen (IV)	12 months	L34580
J1558	Xembify (SC)	12 months	L33794
Infliximab			
Q5121	Avsola	12 months	L35677
Q5103	Inflectra	12 months	L35677
Complement C3 or C5 Inhibitors			
J3490	Empaveli	12 months	N/A
Q5151	Epysqli	12 months	N/A
J1303	Ultomiris	12 months	N/A
Neonatal Fc Receptor Antagonist			
J9333	Rystiggo	12 months	N/A
J9332	Vyvgart	12 months	N/A
J9334	Vyvgart Hytrulo	12 months	N/A
Miscellaneous			
J3590 C9399	Enspryng	12 months	N/A
J2507	Krystexxa	12 months	N/A
J0896	Reblozyl	12 months	N/A
G2082 G2083	Spravato	6 months	N/A

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HCPCS	Medication	Length of Approval	NCD/LCD
J3241	Tepezza	6 months	N/A
Miscellaneous			
J1823	Uplizna	12 months	N/A

Please refer to separate medical drug policies for the following medications: Amvuttra, Biltyos, Bilprevda, Givlaari, Jubbonti, Onpattro, Osenvelt, Oxlumo, Roctavian, Stoboclo and Wyost.

Revision History

Date	Summary of Changes
2/5/2026	• Changes to Prior Authorization: ○ Added the following drugs to Prior Authorization: Biltyos, Bilprevda, Osenvelt, Stoboclo and Wyost (refer to separate medical drug policies) ○ Prolia transitioned from Prior Authorization to Step Therapy (refer to separate medical drug policies)
3/27/2026	• Code Update ○ HCPCS code update: Added J1553 (immune globulin [Yimmugo]) to align with CMS permanent code assignment effective 4/1/2026. Yimmugo was previously reviewed and adjudicated under J1599. No changes to coverage criteria or clinical intent.