



**UNIVERSITY OF MICHIGAN
HEALTH PLAN**
UNIVERSITY OF MICHIGAN HEALTH

**University of Michigan Health Plan
Prior Authorization Criteria for
Medicare Part B Drugs**

2025 Part B Drugs Requiring Prior Authorization

Drug	HCPC code
Actemra (tocilizumab) IV	J3262
Aduhelm (aducanumab-avwa)	J0172
Avsola (infliximab-axxq)	Q5121
Benlysta (belimumab)	J0490
Bkemv (eculizumab-aeab) – <i>effective 10/1/25</i>	Q5152
Botulinum toxins (Botox, Dysport, Myobloc, Xeomin)	Botox J0585 Dysport J0586 Myobloc J0587 Xeomin J0588
Cerezyme (imiglucerase)	J1786
Cinqair (reslizumab)	J2786
Diabetes Testing Supplies (non-preferred)**	A4253, E0607
Duopa (carbidopa/levodopa)	J7340
Entyvio (vedolizumab)	J3380
Epoprostenol (Flolan, Veletri)	J1325

Epysqli (Eculizumab-aagh) – effective 1/1/26	Q5151
ESA (erythropoietin, Aranesp, Mircera, Retacrit)	Epogen/Procrit non-ESRD J0885 Epogen/Procrit ESRD Q4081 Aranesp non-ESRD J0881 Aranesp ESRD J0882 Mircera non-ESRD J0888 Mircera ESRD J0887 Retacrit non-ESRD Q5106 Retacrit ESRD Q5105

Fabrazyme (agalsidase)	J0180
Factor products	J7170 (Hemlibra), J7179 (Vonvendi), J7180 (Corifact), J7181 (Tretten), J7182 (Novoeight), J7183 (Wilate), J7185 (Xyntha), J7186 (Alphanate/VWF complex), J7187 (Humate-P), J7189 (NovoSeven RT), J7190 (Koate-DVI, Hemofil M)), J7192 (Factor VIII Advate, Kogenate FS, Recombinate), J7193 (AlphaNine SD), J7194 (Profilnine/Profilnine SD), J7195 (BeneFix), J7198 (Feiba/Feiba NF), J7200 (Rixubis), J7201 (Alprolix), J7202 (Idelvion), J7203 (Rebinyn), J7205 (Eloctate), J7207 (Adynovate), J7208 (Jivi), J7209 (Nuwiq), J7210 (Afstyla), J7211 (Kovaltry), J7213 (Ixinity)
Fasenra (benralizumab)	J0517
Feraheme (ferumoxytol)	Q0138 (non-ESRD) Q0139 (ESRD)

<p>Hyaluronan Intra-articular Injections</p>	<p>Durolane J7318 Euflexxa J7323 Gel-one J7326 Gelsyn-3 J7328 GenVisc 850 J7320 Hyalgan J7321 Hymovis J7322 Monovisc J7327 Orthovisc J7324 Supartz J7321 Synojoynt J7331 Synvisc/Synvisc-One J7325 Triluron J7332 Trivisc J7329 Visco-3 J7321</p>
<p>Ilaris (canakinumab)</p>	<p>J0638</p>
<p>Immune Globulin (Intravenous)</p>	<p>Asceniv J1554 Alyglo J1552- <i>effective 1/1/26</i> Bivigam J1556 Flebogamma/Flebogamma DIF J1572 Gammagard J1569 Gammagard S/D J1566 Gammaked/Gamunex-C J1561 Gammaplex J1557 Octagam J1568 Panzyga J1576 Privigen J1459</p>
<p>Immune Globulin (Subcutaneous)</p>	<p>Cutaquiq J1551 Cuvitru J1555 Hizentra J1559 Hyqvia J1575 Xembify J1558</p>

Imuldosa (Ustekinumab-srlf) – effective 1/1/26	Q5098 (IV injection)
Inflectra (infliximab-dyyb)	Q5103
Injectafer (ferric carboxymaltose)	J1439
Kisunla (donanemab-azbt) – effective 8/1/25	J0175
Lemtrada (alemtuzumab)	J0202
Leqembi (lecanemab-irmb)	J0174
Monoferric (ferric derisomaltose)	J1437
Nplate (romiplostim)	J2802
Ocrevus (ocrelizumab)	J2350
Orencia (abatacept)	J0129
Radicava (edaravone)	J1301
Remicade (infliximab)	J1745
Remodulin (treprostinil)	J3285
Renflexis (infliximab –abda)	Q5104

Revatio (sildenafil)	J3490
Simponi Aria (golimumab)	J1602
Skyrizi (risankizumab-rzaa)	J2327
Soliris (eculizumab)	J1299
Stelara (ustekinumab)	J3358 (IV injection)
Steqeyma (Ustekinumab-stba) – effective 1/1/26	Q5099 (IV injection)
Tysabri (natalizumab)	J2323
Tyvaso (treprostinil)	J7686
Ventavis (iloprost)	Q4074
VPRIV (velaglucerase alfa)	J3385
Wezlana (ustekinumab-auub) – effective 10/1/25	Q5138 (IV injection)
Xiaflex (collagenase clostridium histolyticum)**	J0775
Xolair (omalizumab)	J2357
Yesintek (Ustekinumab-kfce) – effective 1/1/26	Q5100 (IV injection)

This list is used for the purposes of utilization management of drugs covered under Medicare Part B.

Hierarchy for review:

1. Medicare National Coverage Determination (NCD)/Local Coverage Determination (LCD) (visit CMS.gov for criteria)
2. InterQual (criteria available on the marketing portal at phpmedicare.com)
3. **Lumeris (see criteria below)

Approval Timeframes (for NCD/LCD/InterQual)

- One year approval timeframe with the exception of the following:
 - Iron Infusions (Injectafer, Feraheme, Monoferric) – 3 months
 - Hyaluronan Intra-articular Injections – 3 months
 - ESA (Perioperative use) – 1 month
 - Stelara, Wezlana, Imuldosa, Steqeyma, Yesintek – 3-month IV induction dose only
 - Skyrizi – 3-month IV induction dose only

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DIABETES TESTING SUPPLIES: Benefit Exception for Blood Glucose Meters and Test Strips

Covered Uses:

*Refer to client specific coverage for which brand is covered.

The health plan covers*:

- LifeScan glucose meters and strips through network pharmacies, including ONETOUCH VERIO FLEX and ONETOUCH VERIO REFLECT **AND/OR**
- Abbott glucose meters and strips through network pharmacies, including FREESTYLE LITE and FREESTYLE FREEDOM LITE.

The health plan may make an exception to cover non-LifeScan or non-Abbott products through pharmacies if the criteria listed below are met.

Coverage Duration:

If all conditions are met, the plan may authorize coverage for non-preferred meter and test strips for **Lifetime approval for visual impairment/voice meter and 1 year for all other meters and test strips**. For this policy, the term “inadequate response” means lack of therapeutic effect, and/or inability to tolerate due to adverse effects, or contraindication to therapy.

Required Medical Information:

1. Member has visual impairment and requires a voice meter, and there is no voice meter in the preferred suite of products, **OR**
2. Member requires a meter that communicates with an insulin pump, and there is no such meter in the preferred suite of products, **OR**
3. Requests for other reasons will be considered on a case-by-case basis.

References:

Health Plan Evidence of Coverage

Last Reviewed Date	Updates / Revisions
5/15/20	Addition to part B criteria
2/17/21	None
9/9/21	Update to available products
11/10/21	Update to approval time frame
3/23/22	None
1/27/23	Update to available products
3/26/24	Update to clarify this is a benefit exception criterion
4/16/24	Approved by MMC on 4/16/24
11/27/24	Approved by POC on 11/27/24

XIAFLEX (collagenase clostridium histolyticum) J0775

In its administration of Medicare Advantage plans (Health Plans), the Company shall determine benefits in accordance with the requirements of the Centers for Medicare & Medicaid Services (CMS). Where CMS has established a national coverage policy on an item or service or a local Medicare contractor has done so as authorized by CMS, the Company follows the Medicare coverage criteria. In the absence of fully established Medicare coverage criteria, the Company may develop and implement internal criteria based on current evidence in widely used treatment guidelines or clinical literature. Internal criteria are reviewed and approved by the Pharmacy Oversight Committee and the Medical Management Committee and are made publicly accessible.

CMS has not established coverage criteria for Xiaflex. Therefore, the Company has developed and implemented this coverage criteria to ensure that patients receive clinically appropriate, medically necessary care at the appropriate level, which allows for the best clinical outcome. The purpose of this policy is to describe the circumstances under which treatment with Xiaflex would be considered medically necessary.

Covered Uses:

FDA-approved indications and off-label indications as specified in NCD or LCD, or supported in the medical compendia. Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Coverage Duration:

If all conditions are met, the plan may authorize coverage for Xiaflex (collagenase clostridium histolyticum) for **3 months (Dupuytren's Contracture) and 6 months (Peyronie's Disease)**. For this policy, the term "inadequate response" means lack of therapeutic effect, inability to tolerate due to adverse effects, or contraindication to therapy.

FDA Approved Indication(s):
<ol style="list-style-type: none">1. Treatment of adult patients with Dupuytren's contracture with a palpable cord2. Treatment of adult men with Peyronie's disease with a palpable plaque and curvature deformity of at least 30 degrees at the start of therapy.
Because of the risks of corporal rupture or other serious penile injury, XIAFLEX is available for the treatment of Peyronie's disease only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the XIAFLEX REMS Program

Required Medical Information:

1. Dupuytren's contracture

- a. Documented diagnosis of Dupuytren's contracture with palpable cord, **AND**
- b. Provider must be a healthcare provider who is experienced with injection procedures of the hand and in treatment of Dupuytren's contracture (i.e. orthopedic physician/hand specialist), **AND**
- c. at baseline (prior to initial injection of Xiaflex), the patient had contracture of a metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint of at least 20 degrees, **AND**
- d. The patient will not be treated with more than a total of three injections (maximum) per affected cord as part of the current treatment course, **AND**
- e. Patient must be 18 years old or older

1. Peyronie's disease in men

- a. Palpable plaque, **AND**
- b. Patient meets ONE of the following:
 - at baseline (prior to use of Xiaflex), the patient has a penile curvature deformity of at least 30 degrees **OR**
 - in a patient who has received prior treatment with Xiaflex, the patient has a penile curvature deformity of at least 15 degrees **AND** the patient has not previously been treated with a complete course (8 injections) of Xiaflex for Peyronie's disease, **AND**
- c. Administered by a healthcare provider experienced in the treatment of male urological diseases, **AND**
- d. Patient must be 18 years old or older, **AND**
- e. The prescriber has completed Xiaflex training as provided by the Risk Evaluation and Mitigation Strategy (REMS) program

Exclusion Criteria:

1. Treatment of Peyronie's plaques that involve the penile urethra
2. History of hypersensitivity to Xiaflex or to collagenase used in any other therapeutic applications
3. Retreatment for Peyronie's Disease (i.e., treatment beyond eight injections).
4. Coverage excluded for any indications that are not supported in FDA labeling, NCD, LCD, or medical compendia.

References:

Xiaflex prescribing information
ESI Standard MEDD Prior Authorization Policy - Xiaflex

Version History

Last Reviewed Date	Updates / Revisions
12/6/16	None
12/18/17	Update to required information for Peyronie's Disease
11/5/18	None
12/10/19	None
11/10/20	None
11/10/21	Addition to required medical information and exclusion criteria, Update to approval timeframe
11/2/22	Update to required medical information
12/5/23	None
3/26/24	Added statement of criteria purpose in compliance with CMS requirements
4/16/24	Approved by MMC on 4/16/24
11/27/24	Update to FDA-approved indication, required medical information, and exclusion criteria. Approved by POC on 11/27/24