Medications/Drugs (Outpatient/Part B)

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➲ Instructions for Use

Table of Contents **Page**

Related Medicare Advantage Policy Guidelines

- Immune Globulin
- Testosterone Pellets (Testopel®)
- Xgeva®, Prolia® (Denosumab)

Coverage Guidelines

Outpatient/Part B medications/drugs are covered when Medicare coverage criteria are met.

DME Face-to-Face Requirement: Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including implantable infusion pumps; implantable programmable infusion pump; external ambulatory infusion pump and nebulizers). For DME Face-to-Face Requirement information, refer to the Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid.

Note: The guidelines in this Coverage Summary are for specific procedures/medications only. For procedures/ medications not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations, and Local Coverage Articles). (Accessed July 1, 2024)

Outpatient Medications/Drugs

Part B Medications/Drugs

Outpatient (Part B) medications/drugs, in accordance with Medicare coverage criteria, are covered when furnished "incident" to a physician service for drugs that are "Not Usually Self-Administered By the Patient." Refer to the definition of Not Usually Self-Administered By the Patient.

Coverage is Usually limited to drugs or biologicals Administered by infusion or injection. However, if the injection is generally Self-Administered (e.g., Imitrex), it is not covered under Part B. Despite the general limitation on coverage for outpatient drugs under Part B, some Self-Administered medications/drugs are also covered. For examples, refer to the Medications/Drugs Covered Under Part B and Medications/Drugs Not Covered sections.

For Medicare's detailed coverage criteria for medications/drugs under Part B, refer to the Medicare Benefit Policy Manual, Chapter 15, §50 – Drugs and Biologicals. (Accessed July 1, 2024)

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Part D Medications/Drugs

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication.

A drug for which coverage is available under Part A or Part B, as it is being "prescribed and dispensed or Administered" with respect to the individual, is excluded from the definition of a Part D drug and, therefore, cannot be included in Part D basic coverage. CMS interprets this to mean that if payment could be available under Part A or Part B to the individual for such drug, then it will not be covered under Part D.

Section 1860D-2(e)(4) of the Act defines "medically-accepted indication," in part by reference to section 1927(k)(6) of the Act, to any use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. The recognized compendia are:

- American Hospital Formulary Service Drug Information, and
- DRUGDEX® Information System.

Refer to the Medicare Prescription Drug Benefit Manual Chapter 6, §10.6 – Medically Accepted Indication.

Note: Some members may have coverage for Part D drugs under UnitedHealthcare. Refer to the Member's Pharmacy Booklet or contact the Prescription Solutions Customer Service Department to determine coverage eligibility for Part D prescription drug plan benefit.

For Medicare's detailed coverage information for medications/drugs under Part D, refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, §10 – Definition of Part D Drugs. (Accessed July 1, 2024)

Part B vs. Part D Medications/Drugs

For Part B vs. Part D medications/drugs guidelines, refer to the specific medications listed under the Medications/Drugs Covered Under Part B section.

Unlabeled Use of a Part B Drug

Unlabeled use of a drug may be covered only if a UnitedHealthcare Medical Director or his/her designee determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.2 – Unlabeled Use of Drug.

For the list of the major drug compendia for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen, refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.5.B – Recent Revision to Compendia List.

In the case of drugs used in anti-cancer chemotherapeutic regimen, refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.5 – Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen.

Notes:

- The above information is for determining coverage for the unlabeled use of medication covered under Part B only, not Part D. Refer to the Member's Pharmacy Booklet or contact the Prescription Solutions Customer Service Department for further information on Part D coverage, if any.
- **Definition of Compendium**: CMS revised the definition of "compendium" to include this public transparency requirement. In this revised definition, a compendium:
  - Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; and
  - Is indexed by drug or biological; and
  - Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50 – Drugs and Biologicals §50.4.5.1.A.
(Accessed July 1, 2024)

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Medications/Drugs Covered Under Part B

Examples of medications/drugs that are covered under Part B include, but not limited to, the following medications/drugs.

Durable Medical Equipment (DME) Supply Drugs

Payment may be made for supplies that are necessary for the effective use of durable medical equipment. This includes drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of the equipment. Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.3 – Coverage of Supplies and Accessories.

Part B vs. Part D Guideline

Nebulizer Inhalation Drugs (e.g., Albuterol Sulfate, Ipratropium Bromide)

Certain inhalation drugs are generally covered under Part B when used with a nebulizer in the home. These drugs would not be covered under Part D for use with a nebulizer. However, if these drugs were delivered with a metered dose inhaler or other non-nebulized administration, they would be Part D drugs.

In the case of a member in a hospital, or a SNF bed, (1) who does not have Part A coverage, (2) whose Part A coverage for the stay has run out or (3) whose stay is non-covered-infusible DME supply drugs are not covered under Part B because the law limits coverage under Part B's DME benefit to those items that are furnished for use in a patient's home, and specifies that a hospital or SNF cannot be considered the member's "home" for this purpose. In this case, coverage for the drugs would be available under Part D.

In addition to a hospital, a SNF or a distinct part SNF, the following facilities cannot be considered a home for purposes of receiving the Medicare DME benefit:

- A nursing home that is dually certified as both a Medicare SNF and a Medicaid nursing facility (NF); and
- A Medicaid-only NF that primarily furnishes skilled care; and
- A non-participating nursing home (i.e., neither Medicare or Medicaid) that provides primarily skilled care; and
- An institution which has a distinct part SNF and which also primarily furnishes skilled care.

Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues.

For the list of nebulizer drugs covered under Part B, refer to the DME MAC LCD for Nebulizers (L33370). Compliance with these policies is required where applicable. (Accessed July 1, 2024)

Infusion Pump Medications (e.g., Some Chemotherapeutic Agents)

In general, the supplier would bill Part B if the drug was Administered using an infusion pump and bill the Part D plan for infusion using other methods (e.g., IV push). While professional services and supplies related to the administration of the infused drug are not payable under Part D, some coverage may be available under Part A or B home health benefits, under Medicaid, or from secondary commercial health benefits.

As a rule, drugs infused using an implantable pump would be covered under Part B. Drugs infused in the home using an external pump are covered under Part B if they are included under the local coverage policy of the applicable Medicare DME MAC.

In the case of a member in a hospital, or a SNF bed, (1) who does not have Part A coverage, (2) whose Part A coverage for the stay has run out or (3) whose stay is non-covered infusible DME supply drugs are not covered under Part B because the law limits coverage under Part B's DME benefit to those items that are furnished for use in a patient's home, and specifies that a hospital or SNF cannot be considered the member's "home" for this purpose. In this case, coverage for the drugs would be available under Part D.

In addition to a hospital, a SNF or a distinct part SNF, the following facilities cannot be considered a home for purposes of receiving the Medicare DME benefit:

- A nursing home that is dually certified as both a Medicare SNF and a Medicaid nursing facility (NF); and
- A Medicaid-only NF that primarily furnishes skilled care; and
- A non-participating nursing home (i.e., neither Medicare or Medicaid) that provides primarily skilled care; and
- An institution which has a distinct part SNF and which also primarily furnishes skilled care.

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Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Immunosuppressive Drugs

Immunosuppressive drug therapy following a Medicare covered organ transplant is covered.

Covered drugs include those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA. (This is an exception to the standing drug policy which permits coverage of FDA Approved Drugs for non-labeled uses, where such uses are found to be reasonable and necessary in an individual case.)

Immunosuppressive drugs are substances that suppress or interfere with normal immune responses. They are used in controlling autoimmune diseases and in enhancing the chances for survival of foreign-tissue grafts and transplants.

Examples of FDA-approved immunosuppressive drugs include, but are not limited to:

- Sandimmune (cyclosporine), Sandoz Pharmaceutical.
- Imuran (azathioprine), Burroughs Welcomes.
- Agma (antithymocyte globulin), Upjohn.
- Orthoclone OKT3 (Muromonab-CD3), Ortho Pharmaceutical.
- Prograf (tacrolimus), Fujisawa USA, Inc.
- Celicept (mycophenolate mofetil), Roche Laboratories.
- Daclizumab (Zenapax).
- Cyclophosphamide (Cytoxan).
- Prednisone and Prednisolone.

Notes:

- Prescription drugs, such as prednisone, used in conjunction with immunosuppressive drugs as part of a therapeutic regimen are covered as reflected in FDA approved labeling for immunosuppressive drugs. Therapeutic regimen is a combination of drugs which has been clinically recognized for the treatment of a specific type of disorder or to treat toxicities or side effects of drugs which are used at different times following an approved transplant.
- Immunosuppressive drugs for organ transplants are covered under Part B coverage except when furnished during an inpatient stay or upon discharge from the hospital, then the drugs are covered as Part A.
- CMS expects contractors to keep informed of FDA additions to the list of the immunosuppressive drugs.
- Members may have additional coverage for immunosuppressive drugs under the Part D Prescription Drug Plan which are not covered in this benefit interpretation policy. Refer to the Member's Pharmacy Booklet or contact the Prescription Solutions Customer Services Department to determine coverage eligibility for prescription drug plan benefit.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.5.1 – Immunosuppressive Drugs. (Accessed July 1, 2024)

Part B vs. Part D Guideline

Part B would be billed if the individual had a Medicare-covered transplant; otherwise, the Part D plan would be billed.

Pharmacists would bill Part B or the individual's Part D plan based on information received from the individual or the Part D plan. Part B would be billed if the individual had a Medicare-covered transplant; otherwise, the Part D plan would be billed. Part D plan eligibility systems could contain a marker for members who had a Medicare covered transplant. This information could come from a question included on the Part D sponsor's enrollment or coordination of benefit (COB) survey form.

In determining whether to pay for an immunosuppressive drug under Part D, it would not be appropriate for a Part D sponsor to institute a general policy of requiring a Part B claim rejection, as a substitute for maintaining information on transplant status and paying claims based on that information. Such a policy would be disruptive to beneficiaries and pharmacies and would unnecessarily increase Part B contractor costs. Instead, a prior authorization requirement would be appropriate.

Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

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Hemophilia Blood Clotting Factors

Part B vs. Part D Guideline

Hemophilia blood clotting factors would not be a Part D benefit because of the Part B coverage. Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Oral Anti-Cancer Drugs and Oral Anti-Emetics

Oral anti-cancer drugs and oral anti-nausea (anti-emetic) drugs are covered when criteria are met.

For detailed coverage requirements, refer to the Medicare Benefit Policy Manual, Chapter 15, §50.5.3 Oral Anti-Cancer Drugs.

For claims payment and coding information, refer to the Medicare Claims Processing Manual, Chapter 17, §80.1 Oral Cancer Drugs.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

Note: Members may have additional coverage for oral anti-cancer under the Part D. Prescription Drug Plan, which are not covered in this coverage summary. Refer to the member's pharmacy booklet or contact the Prescription Solutions customer service department to determine coverage eligibility for prescription drug plan benefit. (Accessed July 1, 2024)

Part B vs. Part D Guideline

Certain oral chemotherapy agents used in cancer treatment for which there is an infusible version of the drug.

- Pharmacists would need to determine the reason for treatment. If related to cancer treatment, Part B would be billed; otherwise, the Part D plan should be billed.
- To the extent that a Part B-covered oral anti-cancer drug has no other medically accepted indication besides cancer treatment, Part D sponsors should not include these drugs on their formularies because of Part B coverage. For the drugs that have other medically accepted indications, prior authorization programs or other mechanisms to obtain diagnostic information could be used to ensure appropriate payment.

Oral anti-emetics used in cancer treatment as a full replacement for intravenous treatment.

- Pharmacists would need to determine the reason for treatment. If both related to cancer treatment and a full replacement for intravenous administration within 48 hours of cancer treatment, Part B would be billed; otherwise, the Part D plan should be billed.
  Note: In order to receive Part B payment, CMS currently requires that the prescribing physician indicate on the prescription that the oral anti-emetic is being used "as a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen."
- If based on a prior authorization program or other mechanism to obtain diagnostic information, a Part D sponsor determined that a) a Part B-covered oral anti-emetic was being billed, and b) the drug was being furnished in the context of cancer treatment for use within 48 hours of cancer treatment, the Part D sponsor should deny payment. Such drugs dispensed for use after the 48-hour period, or any oral anti-emetic prescribed for conditions other than the effects of cancer treatment, would be Part D drugs.

Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Immunizations

Immunizations (e.g., pneumococcal vaccine, Hepatitis B vaccine, and influenza vaccine) are covered when criteria are met. Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2 – Immunizations for coverage criteria. (Accessed July 1, 2024)

Part B vs. Part D Guideline

For Hepatitis B vaccine, physicians would need to determine the level of risk of the individual. If the individual is at high or intermediate risk, Part B would be billed. For all other individuals, prior authorization programs could be used to ensure appropriate level of risk.

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Pneumococcal and influenza vaccines would not be covered under Part D because of Part B coverage. Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Antigens/Antihistamines

Antigens/antihistamines are covered when criteria are met. These are prepared by a physician (Usually an allergist) for a specific patient. The physician or physician's nurse generally administers them in the physician's office. In some cases, the physician prepares antigens and furnishes them to a patient who has been taught to self-administer them at home.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §20.2 – Physician Expense for Allergy Treatment and §50.2 – Determining Self-Administration of Drug or Biological.

- Also refer to the:
  - Medicare Benefit Policy Manual, Chapter 15, §50.4.4.1 – Antigens.
  - Medicare Claims Processing Manual, Chapter 12, §200 – Allergy Testing and Immunotherapy.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/search.aspx.

(Accessed July 1, 2024)

Part B vs. Part D Guideline

Antigens would not be a Part D benefit because of the Part B coverage. Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Parenteral Nutrition

Parenteral nutrition, including Intradialytic Parenteral Nutrition (IDPN), is covered under the prosthetic benefit when criteria are met. Refer to the Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid for coverage criteria.

Part B vs. Part D Guideline

If the therapy was being provided because of a non-functioning digestive tract, Part B would be billed; if not, this would be a Part D drug. Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Intravenous Immune Globulin (IVIG)

Intravenous Immune Globulin (IVIG) in the Home

Intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases is covered in the home under Part B if all of the following criteria are met:

- It is an approved pooled plasma derivative for the treatment of primary immune deficiency disease.
- The patient has a diagnosis of primary immune deficiency disease.
  Note: For specific ICD-10-CM codes that are covered, refer to the Medicare Benefit Policy Manual, Chapter 15, §50.6 – Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home. Also refer to the applicable LCDs/LCAs.
- The IVIG is Administered in the home.
- The treating physician has determined that administration of the IVIG in the patient's home is medically appropriate.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.6– Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for IVIG and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Intravenous Immune Globulin (IVIG). (Accessed July 1, 2024)

Part B vs. Part D Guideline

Part B coverage for IVIG in the home is for individuals whose diagnosis is primary immune deficiency disease. Part D would provide coverage for IVIG in the home for all other medically accepted indications. Prior authorization requirements could be used to ensure appropriate payment in accordance with the Part D sponsor's medical necessity criteria. It would not be appropriate to routinely require a rejection of a claim under Part B before processing a Part D claim. Such a policy would be disruptive to beneficiaries and pharmacies and would unnecessarily increase Part B contractor cost.

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The supplier would bill Part B if the diagnosis is primary immune deficiency disease. IVIG provided in the home for other diagnoses would be a Part D benefit. As discussed above, it would not be appropriate, as a general rule, for Part D sponsors to require a rejection of a claim under Part B before processing a Part D claim. Prior authorization programs could be used to ensure medical necessity in accordance with the Part D sponsor's policy.

Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues. (Accessed July 1, 2024)

Treatment of Autoimmune Mucocutaneous Blistering Diseases

IVIg is covered for the treatment of biopsy-proven:

- Pemphigus Vulgaris.
- Pemphigus Foliaceus.
- Bullous Pemphigoid.
- Mucous Membrane Pemphigoid (a.k.a., Cicatricial Pemphigoid).
- Epidermolysis Bullosa Acquisita.

For more specific coverage guidelines, refer to the National Coverage Determination (NCD) for Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases (250.3).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for IVIG and compliance with these policies is required. For specific LCDs/LCAs, refer to the table for Intravenous Immune Globulin (IVIG). (Accessed July 1, 2024)

Other Indications

Medicare does not have an NCD for other indications other than the ones listed above. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist for all states/territories and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Intravenous Immune Globulin (IVIG).

Injectable Drugs for the Treatment of Osteoporosis

Injectable drugs for the treatment of osteoporosis when provided by the home health agency and the following criteria are met:

- The member is unable to learn the skills needed to self-administer the drug, or is otherwise physically or mentally incapable of administering the drug, and that her family or caregiver are unable or unwilling to administer the drug, as documented by the home health agency, and
- The member sustained a bone fracture that a physician certifies was related to (post-menopausal) osteoporosis; and
- The member is Homebound.

Refer to the:

- Medicare Benefit Policy Manual Chapter 7, §50.4.3 8– Covered Osteoporosis Drugs.
- Coverage Summary titled Home Health Services, Home Health Visits, Respite Care, and Hospice Care.

(Accessed July 1, 2024)

Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (HCPCS Code Q2026)

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Refer to the NCD for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5). (Accessed July 1, 2024)

Drugs for Chelation Therapy for the Treatment of Heavy Metal Toxicity and Non-Overload Conditions

Medicare does not have a National Coverage Determination (NCD) for chelation therapy for lead poisoning. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Chelation Therapy for Non-Overload Conditions.

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Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed July 1, 2024)

Drugs Treated as Hospital Outpatient Supplies

In certain circumstances, Medicare pays for drugs that may be considered Usually self-Administered By the Patient when such drugs function as supplies. This is the case when the drugs provided are an integral component of a procedure or are directly related to it, i.e., when they facilitate the performance of or recovery from a particular procedure. Except for the applicable copayment, hospitals may not bill beneficiaries for these types of drugs because their costs, as supplies, are packaged into the payment for the procedure with which they are used. Listed below are examples of when drugs are treated as supplies and hospitals should bill Medicare for the drug as a supply and should not separately bill the member.

- Sedatives Administered to a patient while he or she is in the preoperative area being prepared for a procedure.
- Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic drops/ointments, and ocular hypotensives that are Administered to a patient immediately before, during, or immediately following an ophthalmic procedure; this does not refer to the patient's eye drops that the patient uses pre-and postoperatively.
- Barium or low osmolar contrast media provided integral to a diagnostic imaging procedure.
- Topical solution used with photodynamic therapy furnished at the hospital to treat non-hyperkeratotic actinic keratosis lesions of the face or scalp.
- Antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure.

The following are examples of when a drug is not directly related or integral to a procedure and does not facilitate the performance of or recovery from a procedure. Therefore, the drug is not considered a packaged supply. In many of these cases the drug itself is the treatment instead of being integral or directly related to the procedure or facilitating the performance of or recovery from a particular procedure.

- Drugs given to a patient for his or her continued use at home after leaving the hospital.
- Oral pain medication given to an outpatient who develops a headache while receiving chemotherapy administration treatment.
- Daily routine insulin or hypertension medication given preoperatively to a patient.
- A fentanyl patch or oral pain medication such as hydrocodone, given to an outpatient presenting with pain.
- A laxative suppository for constipation while the patient waits to receive an unrelated X-ray.

These two lists of examples may serve to guide hospitals in deciding which drugs are supplies packaged as a part of a procedure, and thus may be billed under Part B. Hospitals should follow CMS' guidance for billing drugs that are packaged and paid as supplies, reporting coded and uncoded drugs with their charges under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs. Refer to the Medicare Benefit Policy Manual, Chapter 15, §50.2 – Determining Self-Administration of Drug or Biological, M-Drugs Treated as Hospital Outpatient Supplies. (Accessed July 1, 2024)

Hereditary Angioedema (HAE) Treatment (HCPCS Codes J0596, J0597, J0598, and J1290)

Medicare does not have a National Coverage Determination (NCD) for Hereditary Angioedema (HAE) treatment. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled Hereditary Angioedema (HAE), Treatment and Prophylaxis.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed July 1, 2024)

Medications/Drugs Not Covered

Examples of medications/drugs that are not covered are:

Vitamin B12 Injections

Vitamin B12 injections to strengthen tendons, ligaments, etc., of the foot are not covered under Medicare because:

- There is no evidence that vitamin B12 injections are effective for the purpose of strengthening weakened tendons and ligaments, and
- This is non-surgical treatment under the subluxation exclusion.

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Accordingly, Vitamin B12 injections are not considered reasonable and necessary. Refer to the NCD for Vitamin B12 Injections to Strengthen Tendons, Ligaments, etc., of the Foot (150.6). (Accessed July 1, 2024)

Investigational or Experimental Drugs

Investigational or experimental drugs are not covered. Refer to the Medical Benefit Policy Manual, Chapter 15, §50.4.3 – Examples of Not Reasonable and Necessary. (Accessed July 1, 2024)

Placebos

Placebos are not covered.

Outpatient Prescription Drugs

Outpatient prescription drugs are not covered except those medications/drugs covered under the Member's Part D Prescription Drug Plan benefit.

Refer to the Member's Pharmacy Program booklet or contact the Prescription Solutions Customer Services Department to determine coverage eligibility for Part D Prescription Drug benefit.

Medications for the Treatment of Sexual Dysfunction

Medications for the treatment of sexual dysfunction including erectile dysfunction, impotence, anorgasmy, or hypoorgasmy are not covered.

Erectile dysfunction (ED) drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the FDA other than sexual or erectile dysfunction (such as pulmonary hypertension). However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information (or its successor publications), and DRUGDEX® Information System.

Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Section 20.1 – Excluded Categories. (Accessed July 1, 2024)

Medications for Elective Enhancement

Medications for elective enhancement, such as those used for weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance are not covered. Refer to the Medicare Advantage Medical Policy titled Cosmetic and Reconstructive Procedures.

Drugs Included in the CMS Self-Administered Drug Exclusion List

Drugs included in the CMS *Self-Administered Drug Exclusion List* are not covered.

Notes:

- **Self-Administered Drug (SAD) Exclusion List Report**: Local Contractors have Self-Administered drugs exclusion lists. Compliance with these lists is required where applicable. Refer to the Medicare Coverage Database. (Accessed July 1, 2024)
- **PCSK9 Inhibitors**: PCSK9 Inhibitors, i.e., Praluent™ (alirocumab) and Repatha™ (evolocumab) are considered self-Administered drugs and are not covered under the Part B medical benefit. Refer to the Member's Pharmacy Program booklet or contact the Prescription Solutions Customer Service Department to determine coverage eligibility for these drugs under the Part D Prescription Drug benefit.

Off-Label/Unlabeled Drug Use

Off-Label/unlabeled drug use is not covered unless criteria are met. Refer to the Unlabeled Use of a Part B Drug section for coverage criteria and guidelines.

Review at Launch (RAL)

A pre-service organization determination is highly recommended for certain Part B medications (as defined above):

- That are new to the market; and
- That have not yet undergone review by UnitedHealthcare; and
- For which a utilization management strategy has not been established.

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These medications, referred to herein as RAL medications, are identified in the Other Examples of Specific Drugs/Medications table. Upon receipt of a pre-service organization determination, RAL medications will be reviewed against National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs). In the absence of an NCD, LCD or clear Medicare guidance, medical necessity reviews will be conducted using the following:

- A UnitedHealthcare Pharmacy and Therapeutics approved medical drug policy; or
- All of the following:
  - Food and Drug Administration (FDA) approved labeling, including but not limited to indication, patient age requirements, dosing recommendations, contraindications, and clinical trial inclusion criteria (ex. genetic testing, comorbid conditions); and
  - Compendia (if available); and
  - Current standard of care, as per evidenced based literature (if available).

Providers are strongly encouraged to seek a pre-service organization determination for any RAL medication that has been identified in the Other Examples of Specific Drugs/Medications table. This will help to avoid gaps in coverage in the event that a prior authorization program becomes effective at a later date. If a provider believes an item or service may not be covered, or could only be covered under specific conditions, the appropriate process is to request a pre-service organization determination.

Step Therapy Program

Certain classes of medical benefit injectables covered under Medicare Part B will include preferred and non-preferred therapies. Non-preferred therapies will generally require history of use of a preferred therapy among other criteria. This step therapy requirement will apply to some, but not all, Medicare Advantage Plans.

A medical injectable is subject to step therapy when it is listed in the Other Examples of Specific Drugs/Medications table and a notation to refer to the UnitedHealthcare Medicare Advantage Drug Policy titled: Medicare Part B Step Therapy Programs is provided in the Step Therapy column.

Maximum Dosage and Frequency

Provides information about the maximum dosage per administration and dosing frequency for certain medications Administered by a medical professional. Most medications have a maximum dosage and frequency based upon body surface area or patient weight or a set maximal dosage and frequency independent of patient body size.

A medication is subject to maximum dosage and frequency when it is listed in the Other Examples of Specific Drugs/Medications table and a notation to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency is provided in the Maximum Dosage and Frequency column.

Note: Any LCD/LCA maximum dosage and frequency criteria would be applicable, if available.

Other Specific Medications (Not Listed Above)

For Oncology Medications

- Check for available NCDs, LCDs or LCAs at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. If there are no applicable NCDs, LCDs or LCAs found, refer to Supporting Information table within this Coverage Summary.
- Also refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4 Reasonableness and Necessity.
  - For any off label drug or biological with a NCCN Category 2B indication refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage.

For Non-Oncologic Medications

- Check for available NCDs, LCDs or LCAs at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. If there are no applicable NCDs, LCDs or LCAs found, refer to Supporting Information table within this Coverage Summary.
- For all other drugs or biologicals (non-oncologic) not listed in this Coverage Summary, for which there are no applicable NCDs, LCDs or LCAs, refer to the relevant UnitedHealthcare Commercial Medical Benefit Drug Policy. If there is no UnitedHealthcare Commercial Drug Policy, then use the compendia and evidence-based medical literature for coverage guidance.
  - For available UnitedHealthcare Commercial Medical Benefit Drug Policies, refer to https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html.

(Accessed July 1, 2024)

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Definitions

FDA Approved Drug: A drug that has received final marketing approval by the Food and Drug Administration (FDA) and as a part of its labeling contains its recommended uses and dosages as well as adverse reactions and recommended precautions in using it. Medicare Benefit Policy Manual, Chapter 15, §50.4.1 – Approved Use of Drug.

Homebound: An individual shall be considered "confined to the home" (Homebound) if the following two criteria are met:

- The patient must either:
  - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, **or**
  - Have a condition such that leaving his or her home is medically contraindicated.
- If the patient meets one of the conditions above, then the patient must **also** meet two additional requirements defined below.
  - There must exist a normal inability to leave home, **and**
  - Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered Homebound if the absences from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive health care treatment.

Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Medicare Benefit Policy Manual, Chapter 15, §60.4.1 – Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit.

Not Usually Self-Administered By the Patient (as defined by Medicare):

- **Administered**: The term "Administered" refers only to the physical process by which the drug enters the patient's body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs (including intravenous drugs) are typically eligible for inclusion under the "incident to" benefit. With limited exclusions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications are all considered to be Usually Self-Administered By the patient.
- **Usually**: For the purposes of applying this exclusion, the term "Usually" means more than 50 percent of the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is Self-Administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage and you may not make any Medicare payment for it.
- **By the Patient**: The term "By the Patient" means Medicare beneficiaries as a collective whole. Include only the patients themselves and not other individuals (which do not include spouses, friends, or other caregivers). Medicare Benefit Policy Manual, Chapter 15, §50.2 – Determining Self-Administration of Drug or Biological.

Unlabeled Use of Drug: A use that is not included as an indication of the drug's label as approved by FDA. Medicare Benefit Policy Manual, Chapter 15, §50.4.2 – Unlabeled Use of Drug. (Accessed July 1, 2024)

Supporting Information

Other Examples of Specific Drugs/Medications
Accessed July 1, 2024
***Also refer to the MACs with corresponding States/Territories.**

Drug/ Medication	NCD, Medicare Manual, LCDs/LCAs*	Default Policy for States Without LCDs/LCAs	Review at Launch (RAL)	Step Therapy	Maximum Dosage and Frequency*
Aduhelm™ (aducanumab-avwa)	NCD for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD) 200.3 For payment rules for NCDs requiring CED,	Not Applicable (N/A)	No	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Aduhelm™ (aducanumab-avwa)	refer to the Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)	Not Applicable (N/A)	No	No	No
Adzynma (ADAMTS13, recombinant-krhn)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Adzynma (ADAMTS13, Recombinant-Krhn)	No	No	No
Amvuttra™ (vutrisiran)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled RNA-Targeted Therapies (Amvuttra® and Onpattro®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Antiemetics (oral) for Oncology - Neurokinin 1 Receptor Antagonist (NK1 RA), 5-hydroxytrypta-mine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA combination • Akynzeo® (netupitant and palono-setron) capsule • Emend® (aprepitant) capsule • Kytril® (granisetron) tablets • Varubi® (rolapitant) tablet • Zuplenz, Zofran ODT®, and Zofran® (ondanset-ron) tablets	Medicare Benefit Policy Manual, Chapter 15, §50.5.4 – Oral Anti-Nausea (Anti Emetic) Drugs DME MAC L33827	N/A	No	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Antiemetics (injectable) for Oncology - Neurokinin 1 Receptor Antagonist (NK1 RA), 5-hydroxytrypta-mine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA combination • Akynzeo® (netupitant and palonosetron) injection • Aloxi® (palonosetron hydrochlor-ide) injection • Cinvanti® (aprepitant) injectable emulsion • Emend® (fosaprepitan) injection • Kytril® (granisetron) injection • Sustol® (granisetron) injection • Zuplenz, Zofran ODT®, and Zofran® (ondansetron) injection	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Antiemetics for Oncology	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Adakveo® (crizanlizumab-tmca)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Adakveo® (Crizanlizumab-Tmca)	No	No	No
Beqvez (fidanacogene elaparvovec-dzkt)	None	UnitedHealthcare Commercial Medical Drug Policy titled Gene Therapies for Hemophilia B	**Yes** Refer to Review at Launch (RAL)	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Bevacizumab • Alymsys® (bevacizumab-maly) • Avastin® (bevacizu-mab) • Mvasi® (bevacizumab-Awwb) • Vegzelma® (bevacizumab-adcd) • Zirabev® (bevacizumab-bvzr) – Oncology Use Only	**NGS** L33394 (A52370)	UnitedHealthcare Commercial Medical Drug Policy titled Oncology Medication Clinical Coverage	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Botulinum toxin • Botox® (onabotulinum-toxinA) • Daxxify® (daxibotulinum-toxinA-lanm) • Dysport® (abobotulinum-toxinA) • Myobloc® (rimabotulinum-toxinB) • Xeomin® (incobotulinum-toxinA)	**CGS** L33949 (A56472) **First Coast** L33274 (A57715) **NGS** L33646 (A52848) **Noridian** L35170 (A57185) L35172 (A57186) **Novitas** L38809 (A58423) **Palmetto** L33458 (A56646) **WPS*** L34635 (A57474) **Note**: Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable	All states/territories have LCDs/LCAs	No	No	No
Briumvi™ (ublituximab-xiiy)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Briumvi® (Ublituximab-Xiiy)	No	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
CAR-T Cellular Therapy • Abecma® (idecaptagene cicleucel) • Breyanzi® (lisocabtagene maraluecel) • Carvykti™ (ciltacabtagene autoleucel) • Kymriah® (tisagenlecleucel) • Tecartus® (brexucabtagene autoleucel) • Yescarta® (axicabtagene ciloleucel)	None	Optum Clinical Guidelines titled Chimeric Antigen Receptor T-cell Therapy	No	No	No
Cellular Therapy • Amtagvi™ (lifeucel)	None	Optum Clinical Guidelines titled Tumor-Infiltrating Lymphocyte (TIL) Cell Therapy	No	No	No
Colony stimulating factors **Short acting** • Granix® (tbo-filgrastim) • Neupogen® (filgrastim) • Nivestym® (filgrastim-aafi) • Releuko® (filgrastim-ayow) • Zarxio® (filgrastim-sndz) **Long acting** • Fulphila® (pegfilgrastim-jmdb) • Fylnetra® (pegfilgrastim-pbbk) • Neulasta® (pegfilgrastim) • Nyvepria™ (pegfilgrastim-apgf) • Rolvedon™ (eflapegrastim-xnst)	**Palmetto** L37176 (A56748) (A54682)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled White Blood Cell Colony Stimulating Factors	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
• Stimufend® (pegfilgrastim-fpgk) • Udenyca® (pegfilgrastim-cbqv) • Ziextenzo® (pegfilgrastim-bmez)	**Palmetto** L37176 (A56748) (A54682)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled White Blood Cell Colony Stimulating Factors	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Cosentyx® IV (secukinumab)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Cosentyx® (Secukinumab)	No	No	No
Crysvita® (burosumab-twza)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Crysvita® (Burosumab-Twza)	No	No	No
Denosumab • Xgeva® • Prolia®	**NGS** L33394 (A52399) (A52855)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Denosumab (Prolia® & Xgeva®)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Elevidys® (delandistrogene moxeparvovec-rokl)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Elevidys™ (Delandistrogene Moxparvovec-Rokl)	No	No	No
Enjaymo™ (sutimlimab-jome)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Enjaymo® (Sutimlimab-Jome)	No	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Evenity® (Romosozumab-Aqqg)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Evenity® (Romosozumab-Aqqg)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Entyvio® (vedolizumab)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Entyvio® (Vedolizumab)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Erythropoietin for Cancer Related Conditions	NCD for Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (110.21) **Note**: Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.	N/A	No	No	No
Erythropoietin for Non-cancer Related Conditions	**CGS** L34356 (A56462) **Palmetto** L39237 (A58982) **WPS*** L34633 (A56795)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Erythropoiesis-Stimulating Agents	No	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Evkeeza® (Evinacumab-Dgnb)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Evkeeza® (Evinacumab-Dgnb)	No	No	No
Gemcitabine Infugem™ (gemcitabine)	None	UnitedHealthcare Commercial Medical Drug Policy titled Oncology Medication Clinical Coverage	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Gene Therapy (ex vivo) • Casgevy™ (exagamglogene autotemcel) • Lenmeldy™ (atidarsagene autotemcel) • Lyfgenia™ (lovotibeglogene autotemcel) • Skysona® (elivaldogene autotemcel) • Zynteglo® (betibeglogene autotemcel)	None	Optum Clinical Guidelines titled Gene Therapy	No	No	No
Givlaari® (givosiran)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Givlaari® (Givosiran)	No	No	No
Gonadotropin Releasing Hormone Analogs • Leuprolide Acetate	**NGS** L33394 (A52453)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Gonadotropin Releasing Hormone Analogs	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Hemgenix® (etranacogene dezaparvovec-drlb)	None	UnitedHealthcare Commercial Medical Drug Policy titled Gene Therapies for Hemophilia B	No	No	No
Infliximab • Avsola™ (infliximab-axxq) • Inflectra® (infliximab-dyyb) • Infliximab • Remicade® (infliximab) • Renflexis® (infliximab-abda) • Zymfentra™ (infliximab-dyyb)	**NGS** L33394 (A52423) **Palmetto** L35677 (A56432)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Intravenous Immune Globulin (IVIG)	Refer to the Intravenous Immune Globulin (IVIG) table	N/A	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Intravenous iron therapy for **dialysis patients**	NCD for Intravenous Iron Therapy (110.10)	N/A	No	No	No
Intravenous iron therapy for **non-dialysis patients**	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Intravitreal vascular endothelial growth factor (VEGF) inhibitors • Cimerli™ (ranibizumab-eqrn) • Compounded Avastin® (bevacizu-mab) • Lucentis® (ranibizumab) • Eylea® (aflibercept) • Eylea® HD (aflibercept) • Beovu® (brolucizumab-dbll) • Byooviz™ (ranibizumab-nuna), • Susvimo™ (ranibizumab injection) • Vabysmo™ (faricimab-svoa)	**NGS** L33394 (A52370, A52451) **Noridian** A53008, A53009 **Palmetto** A53387	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Izervay™ (avacincaptad pegol intravitreal solution)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Ophthalmologic Complement Inhibitors	No	No	No
Kisunla™ (donanemab-azbt)	NCD for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD) 200.3 For payment rules for NCDs requiring CED, refer to the Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)	N/A	**Yes** Refer to Review at Launch (RAL)	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Krystexxa® (Pegloticase)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Krystexxa® (Pegloticase)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Lantidra™ (donislecel)	None	Optum Clinical Guidelines titled Solid Organ Transplantation	No	No	No
Leqembi™ (lecanemab)	NCD for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD) (200.3) For payment rules for NCDs requiring CED, refer to the Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)	N/A	No	No	No
Leqvio® (inclisiran)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Leqvio® (Inclisiran)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Leucovorin/ Levoleucovorin • Fusilev® (levoleuco-vorin) • Khapzory™ (levoleuco-vorin)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Luxturna™ (voretigene neparvovec-rzyl)	**Palmetto** L37863 (A56419)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Luxturna® (Voretigene Neparvovec-Rzyl)	No	No	No
Ocrevus® (ocrelizumab)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Ocrevus® (Ocrelizumab)	No	No	No
Omvoh™ (mirikizumab-mrkz)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Omvoh™ (Mirikizumab-mrkz)	No	No	No
Onpattro® (patisiran)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled RNA-Targeted Therapies (Amvuttra® and Onpattro®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Orencia® (abatacept)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Orencia® (Abatacept) Injection for Intravenous Infusion	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Oxlumo™ (lumasiran)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oxlumo® (Lumasiran) and Rivfloza™ (Nedosiran)	No	No	No
Primacor® (milrinone) – **use in home setting** **Note**: There are safety and efficacy issue regarding the use of Milrinone in the home setting. Read the LCDs/ LCAs before authorizing.	**DME MAC LCD for External Infusion Pumps** L33794	All states/territories have LCDs/LCAs	No	No	No
Qalsody™ (tofersen)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Qalsody® (Tofersen)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Radicava® (edaravone)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Radicava® (Edaravone)	No	No	No
Rituximab • Riabni™ (rituximab-aarx) • Rituxan® (rituximab) • Ruxience® (rituximab-pvvr) • Truxima® (rituximab-abbs) **for non-chemo-therapeutic indications**	**CGS** L38920 (A58582) L38268 (A57160) **NGS** L39297 (A59101) **Palmetto** L35026 (A56380) **WPS*** A55639	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Rituximab (Riabni™, Rituxan®, Ruxience®, & Truxima®)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Rituximab • Riabni™ (rituximab-aarx) • Rituxan® (rituximab) • Rituxan Hycela® (rituximab and hyaluronic-dase) • Ruxience®(rituximab-pvvr) • Truxima® (rituximab-abbs) **for chemo-therapeutic indications**	**NGS** L39297 (A59101) **Palmetto** L35026 (A56380)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Rivfloza™ (nedosiran)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oxlumo® (Lumasiran) and Rivfloza™ (Nedosiran)	No	No	No
Reblozyl® (luspatercept-aamt)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Reblozyl® (Luspatercept-Aamt)	No	No	No
Roctavian™ (valoctocogene roxaparvovec-rvox)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Roctavian™ (Valoctocogene Roxaparvovec-Rvox)	No	No	No
Ryplazim® (plasminogen, human-tvmh)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Ryplazim® (Plasminogen, Human-Tvmh)	No	No	No

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Rystiggo® (rozanolixizumab-noli)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Saphnelo™ (anifrolumab-fnia)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Saphnelo® (Anifrolumab-Fnia)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Skyrizi® (Risankizumab-rzaa)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Skyrizi® (Risankizumab-Rzaa)	No	No	No
Sodium hyaluronate injections **for osteoarthritis of knee**	**NGS** L33394 (A52420) **Palmetto** L39260 (A59030) **WPS*** L39529 **NGS** L33394 (A52420) **Palmetto** L39260 (A59030) **WPS*** L39529	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Sodium Hyaluronate	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Soliris® (eculizumab)	**NGS** L33394 (A54548)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Complement Inhibitors (Soliris® & Ultomiris®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Soliris® (eculizumab)	**NGS** L33394 (A54548)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Complement Inhibitors (Soliris® & Ultomiris®)	No	No	Dosage and Frequency
Spevigo® (spesolimab-sbzo)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Spevigo® (Spesolimab-Sbzo)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Spinraza® (nusinersen)	**Noridian** A58578, A58579	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Spinraza® (Nusinersen)	No	No	No
Subcutaneous Immune Globulin (SCIG)	**CGS** L33794 (A52507) **Noridian** L33794 (A52507) **WPS*** L34771 (A57554)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Immune Globulin (IVIG and SCIG)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	No
Syfovre™ (pegcetacoplan injection)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Ophthalmologic Complement Inhibitors	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Tepezza® (teprotumumab-trbw)	**First Coast** L34007 (A57778) **Novitas** L35093 (A56786)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Tepezza® (Teprotumumab-Trbw)	No	No	No
Teplizumab • Tzield™ (teplizumab-mzwv)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Tzield® (Teplizumab-Mzwv)	No	No	No
Testopel® (testosterone pellet) (CPT code 11980 and HCPCS code J3490) Refer to the FDA Warning Letter/Notice for Testopel® (testosterone pellet).	**Noridian** L36569 (A57616) L36538 (A57615) **Palmetto** L39086 (A58828)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Testosterone Replacement or Supplementation Therapy	No	No	No
Tezspire™ (tezepelumab-ekko)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Tezspire® (Tezepelumab-Ekko)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Trastuzumab • Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk) • Herceptin® (trastuzumab) • Herzuma® (trastuzumab-pkrb) • Kanjinti® (trastuzumab-anns) • Ogivri® (trastuzumab-dkst)	**First Coast** L34026 (A56660)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
• Ontruzant® (trastuzumab-dttb) • Trazimera® (trastuzumab-qyyp)	**First Coast** L34026 (A56660)	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Ultomiris® (ravulizumab)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Complement Inhibitors (Soliris® & Ultomiris®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Uplizna® (inebilizumab-cdon)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Uplizna® (Inebilizumab-Cdon)	No	No	No
Vyjuvek™ (beremagene geperpavec-svdt)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Vyjuvek® (Beramagene Geperpavec-Svdt)	No	No	No
Vyepti® (Eptinezumab- Jjmr)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Vyepti® (Eptinezumab-Jjmr)	No	**Yes** Refer to the United-Healthcare Medicare Advantage Drug Policy titled Medicare Part B Step Therapy Programs	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency

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Other Examples of Specific Drugs/Medications Accessed July 1, 2024 *Also refer to the MACs with corresponding States/Territories.					
Drug/ Medication	**NCD, Medicare Manual, LCDs/LCAs***	**Default Policy for States Without LCDs/LCAs**	**Review at Launch (RAL)**	**Step Therapy**	**Maximum Dosage and Frequency***
Vyvgart™ (efgartigimod)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	No	No	**Yes** Refer to the United-Healthcare Commercial Medical Benefit Drug Policy titled Maximum Dosage and Frequency
Zolgensma® (onasemnogene abeparvovec-xioi)	None	UnitedHealthcare Commercial Medical Benefit Drug Policy titled Zolgensma® (Onasemnogene Abeparvovec-Xioi)	No	No	No
Back to Guidelines					

Medicare Administrative Contractors (MACs) with Corresponding States/Territories	
MACs	**States/Territories**
CGS	KY, OH
First Coast	FL, PR, VI
NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
Noridian	AK, AS, AZ, CA, GU, HI, ID, MT, ND, NV, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas	AR, AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto	AL, GA, NC, SC, TN, VA, WV
WPS*	IA, IN, KS, MI, MO, NE
***Note**: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers	
DME MACs	**States/Territories**
CGS (17013)	IL, IN, KY, MI, MN, OH, WI
CGS (18003)	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV
Noridian (16013)	CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT

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Medicare Administrative Contractors (MACs) with Corresponding States/Territories	
DME MACs	**States/Territories**
Noridian (19003)	AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY

Back to Guidelines

Intravenous Immune Globulin (IVIG) Accessed July 1, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L35891 (A56779)	Intravenous Immune Globulin	Part A and B MAC	CGS Administrators, LLC	KY, OH
L34007 (A57778)	Immune Globulin	Part A and B MAC	First Coast Service Options, Inc.	FI, PR, VI
L39314 (A59105)	Off-Label Use of Intravenous Immune Globulin (IVIG)	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME MN, NH, NY, RI, VT, WI
L34074 (A57194)	Immune Globulin Intravenous (IVIg)	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L34314 (A57187)	Immune Globulin Intravenous (IVIg)	Part A and B MAC	Noridian Healthcare Solutions, LLC	CA, AS, GU, HI, MP, NV
L35093 (A56786)	Immune Globulin	Part A and B MAC	Novitas Solutions, Inc.	CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA
L34580 (A56718)	Intravenous Immunoglobulin (IVIG)	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L34771 (A57554)	Immune Globulins	Part A and B MAC	*Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
L33610 (A52509)	Intravenous Immune Globulin	DME MAC	Noridian Healthcare Solutions, LLC (16013)	CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
			CGS Administrators, LLC (18003)	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, WV
			Noridian Healthcare Solutions, LLC (19003)	AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MT, ND, NE, MP, NV, OR, SD, UT, WA, WY
			CGS Administrators (17013)	IL, IN, KY, MI, MN, OH, WI

Back to Guidelines

Policy History/Revision Information

Date	Summary of Changes
09/01/2024	**Related Policies** • Removed reference link to the Medicare Advantage Policy Guideline titled *Halaven® (Eribulin Mesylate)* **Coverage Guidelines** • Updated reference link to reflect the current policy type for *Cosmetic and Reconstructive Procedures*

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Date	Summary of Changes
08/01/2024	**Coverage Guidelines** ***Other Specific Medications*** For Oncology Medications • Added reference link to the Medicare Benefit Policy Manual, Chapter 15, §50.4: Reasonableness and Necessity For Non-Oncologic Medications • Replaced instruction to "refer to the relevant UnitedHealthcare Commercial Medical Benefit Drug Policy for all other drugs or biologicals not listed in this Medicare Advantage Coverage Summary, for which there are no applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or Local Coverage Articles (LCAs)" with "refer to the relevant UnitedHealthcare Commercial Medical Benefit Drug Policy for all other drugs or biologicals *(non-oncologic)* not listed in this Medicare Advantage Coverage Summary, for which there are no applicable NCDs, LCDs, or LCAs" **Other Examples of Specific Drugs/Medications** • Added coverage guidelines for Kisunla™ (donanemab-azbt) to indicate a pre-service review [Review at Launch (RAL)] is required • Revised coverage guidelines for Beqvez (fidanacogene elaparvovec-dzkt); added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Gene Therapies for Hemophilia B* **Supporting Information** • Updated list of applicable LCDs/LCAs to reflect the most current information **Administrative** • Archived previous policy version MCS057.31

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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