BlueCross BlueShield of North Carolina

Medicare Part B Prior Authorization

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

HCPCS	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
Rituximab			
Q5119	Ruxience	12 months	L35026
Q5115	Truxima	12 months	L35026
Long-Acting Colony Stimulating Factors			
Q5111	Udenyca	12 months	L37176
Q5120	Ziextenzo	12 months	L37176
Short-Acting Colony Stimulating Factors			
Q5110	Nivestym	12 months	L37176

HCPCS	Medication	Length of Approval	NCD/LCD
Q5101	Zarxio	12 months	L37176
J2820	Leukine	12 months	L37176
Immune Globulins			
J1554	Asceniv (IV)	12 months	L34580
J1556	Bivigam (IV)	12 months	L34580
J1566	Carimune NF (IV)	12 months	L34580
J1551	Cutaquig (SC)	12 months	L33794
J1555	Cuvitru (SC)	12 months	L33794
J1572	Flebogamma (IV)	12 months	L34580
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
J1557	Gammaplex (IV)	12 months	L34580
J1561	Gamunex-C (IV or SC)	12 months	L34580 L33794
J1559	Hizentra (SC)	12 months	L33794
J1575	HyQvia (SC)	12 months	L33794
J1568	Octagam (IV)	12 months	L34580
J1576	Panzyga (IV)	12 months	L34580
J1459	Privigen (IV)	12 months	L34580
J1558	Xembify (SC)	12 months	L33794
J1599	Immune Globulin, intravenous, not otherwise specified	12 months	L34580
Infliximab			
Q5121	Avsola	12 months	L35677
Q5103	Inflectra	12 months	L35677
Miscellaneous			
J3490	Empaveli	12 months	N/A
J3590 C9399	Enspryng	12 months	N/A
J9332	Vyvgart	12 months	N/A
J9334	Vyvgart Hytrulo	12 months	N/A
J1303	Ultomiris	12 months	N/A
J1823	Uplizna	12 months	N/A
J2507	Krystexxa	12 months	N/A
J3241	Tepezza	6 months	N/A
J0896	Reblozyl	12 months	N/A

Revision History

May 2024: Coding change: Removed NOC codes J1599 from Asceniv, Bivigam, Carimune NF, Flebogamma, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen effective 5/2/2024; Removed HCPCS code J1569 from Gammagard S/D effective 5/2/2024. Added J1599-Immune Globulin, intravenous, not otherwise specified effective 5/2/2024; Added HCPCS code J9334 for Vyvgart Hytrulo effective 5/2/2024. Added HCPCS code J3490 for Empaveli; Added HCPCS codes J3590 and C9399 for Enspryng effective 5/2/2024.