PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

PROVIDENCE MEDICARE ADVANTAGE PLANS

2022 STEP THERAPY CRITERIA FOR PART B DRUGS

This list pertains to the following Providence Medicare Advantage Plans:

BRIDGE 1 + Rx (HMO-POS), BRIDGE 2 + Rx (HMO-POS), CHOICE + Rx 001 (HMO-POS), CHOICE + Rx 002 (HMO-POS), COMPASS + Rx (HMO-POS), COTTONWOOD + Rx (HMO-POS), DUAL PLUS (HMO D-SNP), ENRICH + Rx (HMO), EXTRA PART B ONLY + Rx (HMO), EXTRA + Rx 001 (HMO), EXTRA + Rx 002 (HMO), FOCUS MEDICAL (HMO), HARBOR + Rx (HMO), LATITUDE +Rx (HMO-POS), PINE + Rx (HMO), PRIME + Rx (HMO), SELECT MEDICAL (HMO-POS), SUMMIT + Rx (HMO-POS), TIMBER + Rx (HMO), ALIGN GROUP PLANS + RX (HMO), DISCOVER GROUP PLAN + RX (HMO-POS), EXPLORE GROUP PLAN + RX (HMO-POS)

Last Updated 11/25/2022

For more recent information or other questions, please contact Providence Health Assurance Customer Service at 503-574-8000 or 1-800-603-2340 (TTY users should call 711), seven days a week, between 8 a.m. and 8 p.m. (Pacific Time), or visit ProvidenceHealthAssurance.com.

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Medicare Part B Step Therapy

- Some medically administered Part B medications, like injectable drugs or biologics, may have special requirements or coverage limits, such as step therapy.
- Step therapy requires a trial of a preferred drug to treat a medical condition before covering a non-preferred drug.
- The step therapy requirement does not apply to members who have already received treatment with the non-preferred drug within the past 365 days.
- Both preferred and non-preferred drugs may still be subject to prior authorization or quantity limits.
- The step therapy criteria outlined in this document may also involve a combination of Part B and Part D drugs. For example, we may not cover a Part B drug unless you try a Part D drug first. Or, we may not cover a Part D drug unless you try a Part B drug first. This is dependent on the therapy described to treat your medical condition. This document contains the Step Therapy protocols for Medicare Part B drugs that are associated with your plan.

How Step Therapy Works

In the list below, you'll see drugs labeled as either Step 1 (Preferred drug), Step 2 (Non-Preferred drug) or Step 3 (Non-Preferred drug). Step 2 and Step 3 drugs require step therapy.
For example: Before you can get a Step 3 drug, you have to first try a Step 1 and a Step 2 drug.

Step 1 drugs usually require prior authorization. That means before you can take this drug, your doctor has to send us information that explains why you need it. If a Step 1 drug doesn't require prior authorization, we tell you in the list below.

Step 2 drugs always require prior authorization. Your doctor also needs to let us know one of the following:

- Why the Step 1 drug didn't work for you or why you can't take the Step 1 drug
- Why the Step 2 drug is best for your needs
- Details from your doctor to show that you've taken the Step 2 drug in the past 365 days

Step 3 drugs always require prior authorization. Your doctor also needs to let us know one of the following:

- Why the Step 1 and Step 2 drugs didn't work for you or why you can't take them.
- Why the Step 3 drug is best for your needs
- Details from your doctor to show that you've taken the Step 1 and/or the Step 2 drug in the past 365 days

The drugs within this list may change at any time. You will receive notice when necessary.

2022 Medicare Part B Step Therapy Drug List
*Prior Authorization required

HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
Allergy And Asthma Agents				
J2357	XOLAIR*	Omalizumab	**For Asthma** - **Step 1**: combination of medium/high-dose inhaled corticosteroids **AND Step 2**: a long-acting inhaled beta2-agonist **For Idiopathic urticaria- Step 1:** second-generation non-sedating H1 antihistamine **AND Step 2: ONE** from the following classes: leukotiene receptor antagonists, first generation H1 antihistamine or histamine H2-receptor antagonist **For nasal polyps - Step 1:** oral systemic corticosteroids OR intranasal corticosteroids	**1/1/2022**
J2356	TEZSPIRE	Tezepelumab-ekko	**For Severe Asthma: Step 1:** high-dose inhaled corticosteroid (ICS) plus and inhaled long-acting beta-2 agonist (LABA) **For Eosinophilic asthma or steroid-dependent asthma: Step 1:** Dupixent* (dupilumab)	**7/1/2022**
Anti-Infective Agents				
J3490	PREVYMIS*	Letermovir	**Step 1: One of the following -** GVHD requiring greater than **or** equal to 1mg/kg/day use of prednisone (or equivalent), **or** lymphocyte depleting therapy (antithymocyte globulin [ATG], antithymocyte globulin equine [ATGAM], alemtuzumab, fludarabine) **Step 2:** rationale for not using the oral formulation	**1/1/2022**
Endocrine Agents				
J2502	SIGNIFOR LAR*	Pasireotide pamoate	**For Acromegaly - Step 1:** Short-acting octreotide OR lanreotide subcutaneous depot*	**1/1/2022**
J1930	SOMATULINE DEPOT*	Lanreotide acetate	**Step 1:** Short-acting octreotide	**1/1/2022**
J2353	SANDOSTATIN LAR DEPOT*	Octreotide acetate, microspheres	**For Chemotherapy induced diarrhea – Step 1:** loperamide **AND Step 2:** Short-acting octreotide **For AIDS-related diarrhea – Step 1:** loperamide and diphenoxylate (Lomotil) **AND Step 2:** Short-acting octreotide	**1/1/2022**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J3490	TESTOPEL*	Testosterone (pellet)	**Step 1:** Generic topical testosterone 1% or generic topical testosterone 1.62% pump **and** generic testosterone cypionate	**1/1/2022**
J3145	AVEED*	Testosterone undecanoate	**Step 1:** Generic topical testosterone 1% or generic topical testosterone 1.62% pump **and** generic testosterone cypionate	**1/1/2022**
Hereditary Angioedema Agents				
J0597	BERINERT*	C1 esterase inhibitor	**Step 1:** generic icatibant*	**1/1/2022**
J0596	RUCONEST*	C1 esterase inhibitor, recombinant	**Step 1:** generic icatibant*	**1/1/2022**
J1290	KALBITOR*	Ecallantide	**Step 1:** generic icatibant*	**1/1/2022**
J0598	CINRYZE*	C1 esterase inhibitor	**For HAE with normal C1-INH or HAE Type III: Step 1:** HAEGARDA*	**1/1/2022**
IL-5 Inhibitors				
J2786	CINQAIR*	Reslizumab	**For eosinophilic asthma - Step 1:** oral glucocorticoids **or Step 2:** medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	**1/1/2022**
J0517	FASENRA*	Benralizumab	**For eosinophilic asthma - Step 1:** oral glucocorticoids **or Step 2:** medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist)	**1/1/2022**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J2181	NUCALA*	Mepolizumab	**For eosinophilic asthma - Step 1:** oral glucocorticoids **or Step 2:** medium to high-dose inhaled corticosteroid plus an additional asthma controller (e.g., long-acting inhaled beta2-agonist, leukotriene receptor antagonist) **For EGPA - Step 1:** relapse requiring an increase in glucocorticoid dose, initiation or increase in other immunosuppressive therapy, or hospitalization in previous two years while receiving at least 7.5mg/day prednisone (or equivalent) **OR Step2:** glucocorticoid in combination with an immunosuppressant such as cyclophosphamide, azathioprine, methotrexate or mycophenolate mofetil) **For Hyperesosinophilic Syndrome (HES) - Step 1: one** of the following: chronic or episodic oral corticosteroids, immunosuppressive therapy or, cytotoxic therapy **For Adjunct Therapy for Chronic Rhinosinusitis with Nasal Polyp (CRSwNP): Step 1:** oral systemic corticosteroids, **Step 2:** three-month trial of intranasal corticosteroids (e.g., fluticasone) or documented intolerance/contraindication to ALL intranasal corticosteroids	**1/1/2022**
			Migraine Agents	
J3032	VYEPTI*	Eptinezumab-jjmr	**Step 1: One of the following categories-** Anticonvulsants (i.e, divalproex, valproate, topiramate), Beta-blockers (i.e., metoprolol, propranolol, timolol), Antidepressants (i.e., amitriptyline, venlafaxine) **AND Step 2:** TWO preferred CGRP agents (AIMOVIG*, EMGALITY*, Ajovy* or Qulipta*)	**1/1/2022** **10/1/2022 Policy updated to include Ajovy and Qulipta)**
			Neurologic Agents	
J0202	LEMTRADA*	Alemtuzumab	**Step 1:** OCREVUS **AND Step 2: One of the following**: Interferon-Beta 1a, Interferon-Beta 1b, Generic Dimethyl Fumarate, Copaxone, Tysabri, Aubagio, Gilenya, Vumerity, Zeposia, OR Mayzent	**1/1/2022**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J1300	SOLIRIS*	Eculizumab	**For gMG – Step 1:** TWO immunosuppressive therapies (ie. azathioprine, mycophenolate mofetil, cyclosporine and tacrolimus, corticosteroids) **OR** ONE immunosuppressive therapy of either IVIg* or plasma exchange **AND Step 2**: Ultomiris* **For NMOSD: Step 1:** a preferred rituximab product (RUXIENCE*, TRUXIMA*) **AND Step 2**: either satralizumab (Ensprinyng*) or Inebilizumab (Uplizna*)	**1/1/2022** **10/1/2022: Policy updated to include Ultomiris for gMG**
J1303	Ultomiris*	Ravulizumab-cwvz	**For gMG – Step 1:** Failed treatment for at least a year with ONE of the following: A. At least TWO immunosuppressive therapies (ie. azathioprine, mycophenolate mofetil, cyclosporine and tacrolimus, corticosteroids) **OR** B. ONE immunosuppressive therapy of either IVIg* or plasma exchange	**10/1/2022**
J1823	UPLIZNA*	Inebilizumab-cdon	**For NMOSD: Step 1:** a preferred rituximab product (RUXIENCE*, TRUXIMA*)	**1/1/2022**
J2323	TYSABRI*	Natalizumab	**For Multiple Sclerosis - Step 1: ONE of the following:** Interferon-Beta 1a, Interferon-Beta 1b, Generic Dimethyl Fumarate, Copaxone, Aubagio, Gilenya, Zeposia, Mayzent OR OCREVUS **For moderate to severe Crohn's Disease – Step 1: documented trial and failure, intolerance or contraindication to a** preferred infliximab product (RENFLEXIS*, INFLECTRA*) and/or adalimumab (Humira*) indicated for Crohn's.	**1/1/2022** **10/1/2022: Policy language re-worded without change to pre-requisite therapy for moderate to severe Crohn's Disease**
Oncology Agents				
J9999	ALYMSYS*	Bevacizumab-maly	**Step 1:** ZIRABEV*, MVASI*	**10/1/2022**
J9035	AVASTIN*	Bevacizumab	**Step 1:** ZIRABEV*, MVASI*	**1/1/2022**
J9355	HERCEPTIN*	Trastuzumab	**Step 1:** KANJINTI*, OGIVRI*	**1/1/2022**
Q5112	ONTRUZANT*	Trastuzumab-dttb	**Step 1:** KANJINTI*, OGIVRI*	**1/1/2022**
J9356	HERCEPTIN* HYLECTA	Trastuzumab-hyaluronidase-oysk	**Step 1:** KANJINTI*, OGIVRI*	**1/1/2022**
Q5113	HERZUMA*	Trastuzumab-pkrb	**Step 1:** KANJINTI*, OGIVRI*	**1/1/2022**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
Q5116	TRAZIMERA*	Trastuzumab-qyyp	**Step 1:** KANJINTI*, OGIVRI*	**1/1/2022**
J9332	VYVGART*	Efgartigimod alfa - fcab	**For Generalized Myasthenia Gravis (gMG): Step 1:** at least two immunosuppressive agents (such as azathioprine, methotrexate, cyclosporine, mycophenolate, corticosteroids) or an intolerance or contraindication to these therapies	**7/1/2022**
Ophthalmic Agents				
J0179	BEOVU*	Brolucizumab-dbll	**For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema or Diabetic retinopathy: Step 1:** Bevacizumab (For Ophthalmology Use) **And Step 2:** Eylea (Aflibercept)	**1/1/2022** **10/1/2022 updated to include treatment for Diabetic macular edema or Diabetic retinopathy**
J7351	DURYSTA*	Bimatoprost	Two ophthalmic products from TWO different pharmacological classes, one of which is an ophthalmic prostaglandin **Step 1 Drugs: Ophthalmic prostaglandins:** bimatoprost, latanoprost, travoprost, LUMIGAN, VYZULTA XELPROS **Step 2 Drugs: Ophthalmic beta-adrenergic blocking agents:** betaxolol, BETIMOL, carteolol, levobunolol, timolol maleate **Ophthalmic intraocular pressure lowering agents, other:** ALPHAGAN P, apraclonidine, brimonidine tartrate, brinzolamide, dorolamide, methazolamide, PHOSPHOLINE IODIDE, pilocarpine hcl, RHOPRESSA, SIMBRINZA	**1/1/2022**
J0178	EYLEA	Aflibercept	**For Neovascular (wet) age-related macular degeneration (AMD) Step 1:** Bevacizumab (For Ophthalmology Use)	**1/1/2022 - 8/14/2022** **8/15/2022: Retired Step Therapy & Prior Authorization criteria for Eylea**
J2778	LUCENTIS*	Ranibizumab	**For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema, Diabetic retinopathy, or Macular edema following retinal vein occlusion: Step 1:** Bevacizumab (For Ophthalmology Use) **And Step 2:** Eylea (Aflibercept) **And Step 3:** Byooviz (Ranibizumab-nuna) **For Myopic Choroidal Neovascularization (mCNV): Step 1:** Byooviz (Ranibizumab-nuna)	**1/1/2022 - 8/14/2022** **8/15/2022:** **Policy update: add Byooviz (Ranibizumab-nuna) prerequisite**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J2779	SUSVIMO*	Ranibizumab	**For Neovascular (wet) age-related macular degeneration (AMD) Step 1:** Bevacizumab (For Ophthalmology Use) **AND** **Step 2:** Eylea (Aflibercept) **AND Step 3**: at least two intravitreal injections of Lucentis* (ranibizumab) or Byooviz (Ranibizumab-nuna)	**8/15/2022 Policy update: add Susvimo* (Ranibizumab)**
C9097 J3590	VABYSMO*	Faricimab	**For Neovascular (wet) age-related macular degeneration (AMD), Diabetic macular edema or Diabetic retinopathy: Step 1:** Bevacizumab (For Ophthalmology Use) **And Step 2:** Eylea (Aflibercept)	**8/15/2022 Policy update: add Vabysmo* (Faricimab)**
Rare Disease Agents				
J0224	OXLUMO*	Lumasiran sodium	**Step 1:** Pyridoxine	**1/1/2022**
J0791	ADAKVEO*	Crizanlizumab-tmca	**Step 1:** Hydroxyurea	**1/1/2022**
Rituximab				
J9312	RITUXAN*	Rituximab	**For Oncology use - Step 1:** a preferred rituximab product (RUXIENCE*, TRUXIMA*) **For Rheumatology use - Step 1:** Enbrel*, Humira, or preferred infliximab product (RENFLEXIS*, INFLECTRA*)	**1/1/2022**
J9311	RITUXAN HYCELA*	Rituximab/hyaluronidase, human recombinant	**For Oncology use - Step 1:** a preferred rituximab product (RUXIENCE*, TRUXIMA*)	**1/1/2022**
Q5123	RIABNI*	Rituximab-arrx	**For Oncology use - Step 1:** a preferred rituximab product (RUXIENCE*, TRUXIMA*) **For Rheumatology use - Step 1:** Enbrel*, Humira*, or a preferred infliximab product (RENFLEXIS*, INFLECTRA*)	**1/1/2022**
Q5115	TRUXIMA*	Rituximab-abbs	**Step 1:** Preferred infliximab product (RENFLEXIS*, INFLECTRA*)	**1/1/2022**
Q5119	RUXIENCE*	Rituximab-pvvr	**Step 1:** Preferred infliximab product (RENFLEXIS*, INFLECTRA*)	**1/1/2022**

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Therapeutic Immunomodulators				
J0638	ILARIS*	Canakinumab/pf	**For SJIA and Adult-Onset Still's Disease:** **Step 1:** One of the following conventional therapies (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) AND, **Step 2**: etanercept* And **Step 3**: adalimumab* **For Familial Mediterranean Fever (FMF) – Step 1:** Colchicine	**1/1/2022**
J0129	ORENCIA*	Abatacept/maltose	**For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	**1/1/2022**
J1745	REMICADE*	Infliximab	**For Ulcerative Colitis: Step 1:** failure, intolerance, or contraindication to the preferred infliximab products RENFLEXIS* and, INFLECTRA* **For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** failure, intolerance, or contraindication to the preferred infliximab products (RENFLEXIS*, and INFLECTRA*) **For moderate to severe Plaque Psoriasis – Step 1:** At least one conventional therapy (e.g., methotrexate tazarotene, topical corticosteroids, calcitriol) **AND Step 2:** failure, intolerance, or contraindication to the preferred infliximab products RENFLEXIS* and INFLECTRA* **For all other FDA-Approved indications – Step 1:** failure, intolerance, or contraindication to the preferred infliximab products RENFLEXIS*and INFLECTRA*	**1/1/2022**
Q5104	RENFLEXIS*	Infliximab-abda	**For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **For moderate to severe plaque psoriasis – Step 1:** At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol)	**1/1/2022**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
Q5121	AVSOLA*	Infliximab-axxq	**For Ulcerative Colitis: Step 1:** failure, intolerance, or contraindication to the preferred infliximab products RENFLEXIS*, INFLECTRA* **For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1**: At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** failure, intolerance, or contraindication to the preferred infliximab products RENFLEXIS*, INFLECTRA* **For moderate to severe Plaque Psoriasis – Step 1**: At least one conventional therapy (e.g., methotrexate tazarotene, topical corticosteroids, calcitriol) **AND Step 2:** failure, intolerance, or contraindication to the preferred infliximab products RENFLEXIS*, INFLECTRA*	**1/1/2022**
Q5103	INFLECTRA*	Infliximab-dyyb	**For Rheumatoid Arthritis and Psoriatic Arthritis Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **For moderate to severe plaque psoriasis – Step 1:** At least one conventional therapy (e.g., methotrexate, tazarotene, topical corticosteroids, calcitriol)	**1/1/2022**
J3245	ILUMYA*	Tildrakizumab-asmn	**For moderate to severe Plaque Psoriasis – Step 1:** At least one conventional therapy (e.g., methotrexate tazarotene, topical corticosteroids, calcitriol) **AND Step 2:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	**1/1/2022**
J3262	ACTEMRA*	Tocilizumab	**For Rheumatoid Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) **For Giant cell arteritis – Step 1:** At least one conventional therapy (e.g., systemic corticosteroid therapy)	**1/1/2022**
J3380	ENTYVIO*	Vedolizumab	**For Crohn's disease only – Step 1: a** preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	**1/1/2022** **7/1/2022 Step Therapy retired. Entyvio* is a preferred agent**

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HCPCS CODE	Non-Preferred Drug	Generic name	Prerequisite Drugs	Effective Date
J1602	SIMPONI ARIA*	Golimumab	**For Rheumatoid Arthritis and Psoriatic Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) **For ankylosing spondylitis – Step 1:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	**1/1/2022**
J3590	Skyrizi* (IV)	Risankizumab-rzaa	**For Crohn's disease – Step 1: a** preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or Entyvio* **For moderate to severe Plaque Psoriasis and Psoriatic Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*) ***Note:*** *Skyrizi Pen, Syringe and On-Body products are considered self-administered by CMS and therefore not covered under Part B.*	**9/1/2022**
J3358	STELARA* (IV)	Ustekinumab	**For Crohn's disease and Ulcerative colitis – Step 1: a** preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or Entyvio* ***Note:*** *Stelara products for SQ administration considered self-administered by CMS and therefore not covered under Part B.*	**1/1/2022** **7/1/2022 Policy Updated to include Entyvio* as a preferred agent**
J0717	Cimzia* (IV)	Certolizumab	**For Crohn's disease and ankylosing spondylitis s – Step 1: a** preferred infliximab biosimilar (RENFLEXIS*or INFLECTRA*) or Entyvio* **For Rheumatoid Arthritis, moderate to severe Plaque Psoriasis and Psoriatic Arthritis – Step 1:** At least one conventional therapy (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) **AND Step 2:** a preferred infliximab biosimilar (RENFLEXIS*, INFLECTRA*)	**12/1/2022** **Policy updated to include Cimzia (IV)**
Thrombocytopenia Medications				
J2796	NPLATE*	Romiplostim	**For Immune Thrombocytopenia (ITP) – Pharmacologic Step 1:** systemic corticosteroids **AND Step 2:** Immune globulin **AND Step 3:** a preferred rituximab product (RUXIENCE*, TRUXIMA*)	**8/15/2022**
Miscellaneous Therapeutics				

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J0879	Korsuva*	Difelikefalin	**For moderate to severe Pruritis associated with chronic kidney disease- Step1**: inadequate response to at least two weeks trial of an oral antihistamine or intolerance/contraindication to antihistamine therapy **AND Step 2:** inadequate response to at least two weeks trial of pregabalin or gabapentin, or intolerance/contraindication to both pregabalin and gabapentin	**10/1/2022**

Diabetic Durable Medical Equipment (DME)			
HCPCS CODE	**Preferred Products**	**Non-Preferred Product Criteria**	**Effective Date**
A4253	ONETOUCH BLOOD GLUCOSE TEST STRIPS – MANUFACURED BY LIFESCAN ACCU-CHEK BLOOD GLUCOSE TEST STRIPS - MANUFACTURED BY ROCHE	1. Patient is using and insulin pump that requires a meter that synchronizes with their pump. **OR** **2.** Physical or mental limitations that makes utilizing **BOTH** of the preferred products (manufactured by Roche and LifeScan) unsafe, inaccurate, or otherwise not feasible.	**1/1/2022**
E0607	ONETOUCH BLOOD GLUCOSE METERS – MANUFACURED BY LIFESCAN ACCU-CHEK BLOOD GLUCOSE METERS - MANUFACTURED BY ROCHE	1. Patient is using and insulin pump that requires a meter that synchronizes with their pump. **OR** **2.** Physical or mental limitations that makes utilizing **BOTH** of the preferred products (manufactured by Roche and LifeScan) unsafe, inaccurate, or otherwise not feasible.	**1/1/2022**

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