Medicare Part B Step-Therapy Drugs Program

Step therapy is a type of prior authorization for medications treating specific conditions. The step therapy process begins with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions.

Step Therapy Process:

- Is only required for new start of the therapy or administration of Part B drugs for enrollees that are not actively receiving the affected medication within the past 365 days.
- Step therapy exception can be requested for the non-preferred therapies.

Healthcare providers can conveniently obtain the preferred drug therapy from pharmacies that are able to ship the medication directly to your office. Please visit https://astivahealth.com/en-us/pharmacy for a directory of network pharmacies. For Elixir Specialty Mail Order Pharmacy, E-Prescribe to NCPDP 36-79252. Or via fax 877-309-0687 or phone 877-437-9012. Mailing Address is: 7835 Freedom Ave. NW, North Canton, OH 44720

Hyaluronic Acid Polymers

Non-Preferred Products Step Therapy Criteria

The Non-Preferred products may be covered when any of the criteria listed below are satisfied:

- Trial and failure of one of the following: Durolane, Gelsyn-3, and Synvisc/Synvisc-One, resulting in minimal clinical response to therapy; or
- History of intolerance or adverse event(s) to any of the following: Durolane, Gelsyn-3, and Synvisc/Synvisc-One; or
- Continuation of prior therapy within the past 365 days.

	Preferred Product(s)	Non-Preferred Product(s)	
Viscosupplements	Durolane Gelsyn-3 Synvisc, Synvisc-One	Euflexxa Gel-One Genvisc 850 Hyalgan Hymovis Monovisc	Orthovisc Supartz, Supartz Fx Synojoynt Triluron TriVisc Visco-3

Gonadotropin Releasing Hormone Analogs for Oncology

Non-Preferred Products Step Therapy Criteria

The Non-Preferred products may be covered when any of the criteria listed below are satisfied:

- Trial and failure of leuprolide acetate, per 7.5mg or
- History of intolerance or adverse event(s) to leuprolide acetate, per 7.5mg or
- Continuation of prior therapy within the past 365 days.

Gonadotropin Releasing Hormone Analogs	Preferred Product(s)	Non-Preferred Product(s)	
	Leupron Depot	Trelstar Zoladex	Eligard

Erythropoiesis-Stimulating Agents

Non-Preferred Products Step Therapy Criteria

The Non-Preferred products may be covered when any of the criteria listed below are satisfied:

- History of use of Retacrit resulting in minimal clinical response to therapy; or
- History of intolerance or adverse event(s) to Retacrit; or
- Continuation of prior therapy within the past 365 days.

Erythropoiesis-Stimulating Agents	Preferred Product(s)	Non-Preferred Product(s)	
	Retacrit	Epogen	Procrit