Drug and Biologic Coverage Policy

Effective Date..... 11/1/2021
Next Review Date..... 11/1/2022
Coverage Policy Number 1403

Oncology Medications

Table of Contents

Related Coverage Resources

Interferon Therapy – (1315)
Lanreotide for Non-Oncology indications – (9005)
Pharmacy Prior Authorization – (1407)
Rituximab for Non-Oncology Indications – (5108)
Scar Revision – (0328)
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans - (1803)
Tocilizumab Intravenous – (M0004)
Treatment of Gender Dysphoria – (0266)
Vascular Endothelial Growth Factor (VEGF) Inhibitors for Ocular Use – (1206)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This coverage policy addresses medications used for the primary treatment of cancer. This coverage policy also addresses select anticancer medications used for non-oncology related symptoms.

I. Primary Treatment of Cancer
II. Uses Not Associated with Cancer

Coverage Policy

I. Primary Treatment of Cancer

Oncology Medications are considered medically necessary when **BOTH** of the following criteria are met:

a. For **ONE** of the below indications or uses:
   i. Use is an approved drug or biologic indication by the Food and Drug Administration (FDA).

ii. Use is a category 1, 2A, or 2B recommendation by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) or its derivative information product, The NCCN Drugs & Biologics Compendium (NCCN Compendium®).
iii. Use is an accepted off-label pediatric oncology use and ALL of the following
    1. The drug is FDA approved for at least one indication
    2. The drug has not been contraindicated or not recommended by the FDA for the off-label use
    3. Supported by one of the following:
        A. Compendia recognized by federal Centers for Medicare and Medicare Services (CMS) as part of an anticancer chemotherapeutic regimen (AHFS, Clinical Pharmacology, DrugDex, etc.)
        B. Results of at least two different controlled clinical studies published in peer reviewed English-language, biomedical journal(s) analyzed as supporting the off label use where consideration is given to quality of evidence, validity of the data, efficacy, and safety of the drug in specific patient populations and how well the study was designed to assess the intervention, including analysis of baseline patient characteristics, patient withdrawals, and meaningful clinical outcome
        C. Established as standard of care as analyzed in (ii) from clinical practice guidelines from professional or medical specialty societies, national government supported evidence assessments or guidelines

b. Coverage for Oncology Medications varies across plans. Refer to the customer's benefit plan document for coverage details. Refer to the following tables for pharmacy and medical benefit preferred products coverage criteria for primary treatment of cancer.

Where coverage requires the use of preferred products eligible for pharmacy benefit coverage, the following criteria apply:

Drug/Biologic	Standard Drug List Performance Drug List	Value Drug List Advantage Drug List	Legacy Drug List Plan	Cigna Total Savings	**Individual and Family Plans**
Bosulif (bosutinib tablets)	**Effective 1/1/2022:** **BOTH** of the following: **1.** Individiual meets Primary Treatment of Cancer criteria in Section I **2. ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets **ONE** of the following (A, B, C, or D): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib* or Sprycel *Note: Prior use of brand Gleevec also counts. B. Individual is currently receiving therapy with Bosulif C. Individual has intermediate- to high-risk disease AND **ONE** of the following (i or ii or iii): i. Individual has a history of a serious, chronic lung disease (for example, pulmonary arterial hypertension, interstitial pneumonitis) or has had or is at risk of pleural effusion ii. Individual is at risk of bleeding (for example, thrombocytopenia, taking a medication that inhibits platelet function or anticoagulants) iii. Individual has a prolonged QT interval or is at risk of developing QT interval prolongation D. Individual has a mutation in which imatinib or Sprycel should not be used				

Drug/Biologic	Standard Drug List Performance Drug List	Value Drug List Advantage Drug List	Legacy Drug List Plan	Cigna Total Savings	**Individual and Family Plans**
Cyclophosphamide tablets	Unable to use cyclophosphamide capsules				Cyclophosphamide tablets are covered
Gleevec® (imatinib)	Documented intolerance to generic imatinib.				
Iclusig (ponatinib tablets)	**Effective 1/1/2022:** **BOTH** of the following: **1.** Individiual meets Primary Treatment of Cancer criteria in Section I **2.** **ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets ONE of the following (A, B, C, D, or E): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib* or Sprycel *Note: Prior use of Gleevec also counts. B. Individual is currently receiving therapy with Iclusig C. Individual has the *T315I* mutation D. Individual meets **BOTH** of the following (i and ii): i. Individual has intermediate- to high-risk disease ii. Individual has a history of serious, chronic lung disease (for example, pulmonary arterial hypertension and interstitial pneumonitis) or has had or is at risk of pleural effusion E. Individual has a mutation in which imatinib or Sprycel should not be used				
Infugem™ (gemcitabine)	Documented intolerance to one generic formulation of Gemzar.				
Kisqali® (ribociclib)	**For Employer Group Benefit Plans Only.** **EITHER** of the following are met: • Individual has previously been started on, or is currently receiving ribociclib (Kisqali) • Individual has a documented trial for abemaciclib (Verzenio) or palbociclib (Ibrance)				Kisqali is covered when medical necessity coverage criteria in Section Ia and Ib are met.
Kisqali® Femara® Co-Pack (ribociclib tablets; letrozole tablets)	**For Employer Group Benefit Plans Only.** **EITHER** of the following are met: • Individual has previously been started on, or is currently receiving ribociclib tablets; letrozole tablets (Kisqali Femara Co-Pack) • Individual has documented trials for abemaciclib (Verzenio) or palbociclib (Ibrance) in combination with an aromatase inhibitor (for example, anastrozole, letrozole)				Kisqali Femara Co-Pack is covered when medical necessity coverage criteria in Section Ia and Ib are met.
Nilandron® (nilutamide)	**BOTH** of the following are met: • Documented intolerance to one generic formulation of Nilandron • Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for bicalutamide or flutamide				
Orgovyx (relugolix)	**ONE** of the following: • Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for ONE of the following*: Lupron Depot, Trelstar, Firmagon, or Eligard • According to the prescriber, the individual is at risk of cardiovascular disease • Individual is using for intermittent androgen deprivation therapy • Individual is currently receiving therapy with Orgovyx *May require prior authorization				

Drug/Biologic	Standard Drug List Performance Drug List	Value Drug List Advantage Drug List	Legacy Drug List Plan	Cigna Total Savings	**Individual and Family Plans**
Pemazyre (Pemigatinib)	**Effective 12/1/2021:** **BOTH** of the following **1.** Individiual meets Primary Treatment of Cancer criteria in Section I **2.** ONLY for Cholangiocarcinoma with fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. Individual meets one of the following (A or B) A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for Truseltiq B. Individual has already been started on therapy with Pemazyre				
Pomalyst® (pomalidomide)	Non-Preferred Brand	Non-Preferred Brand	Non-Preferred Brand	**ANY** of the following are met: • Individual has been started on Pomalyst • For treatment of Multiple Myeloma AND the individual has tried Revlimid • For treatment of Kaposi Sarcoma, Central Nervous System Lymphoma, or Systemic Light Chain Amyloidosis	Pomalyst (brand) is covered when above medical necessity coverage criteria in Section Ia and Ib are met.
Sutent (Sunitinib)	Documented intolerance to generic sunitinib.				**Effective 1/1/2022:** Documented intolerance to generic sunitinib.
Tarceva® (erlotinib)	**For Employer Group Benefit Plans Only.** Documented intolerance to generic erlotinib.				Tarceva (brand) is covered when above medical necessity coverage criteria in Section Ia and Ib are met.
Targretin® (bexarotene)	Documented intolerance to generic bexarotene.				

Drug/Biologic	Standard Drug List Performance Drug List	Value Drug List Advantage Drug List	Legacy Drug List Plan	Cigna Total Savings	**Individual and Family Plans**
Tasgina (nilotinib capsules)	**Effective 1/1/2022:** **BOTH** of the following: **1.** Individiual meets Primary Treatment of Cancer criteria in Section I **2.** **ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets **ONE** of the following (A, B, C, or D) A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib* or Sprycel *Note: Prior use of Gleevec also counts. B. Individual is currently receiving therapy with Tasigna C. Individual has intermediate- to high-risk disease AND **ONE** of the following (i or ii): **i.** Individual has a history of serious, chronic lung disease (for example, pulmonary arterial hypertension, interstitial pneumonitis) or has had or is at risk of pleural effusion **ii.** Individual is at risk of bleeding (for example, thrombocytopenia, taking a medication that inhibits platelet function or anticoagulants) D. Individual has a mutation in which imatinib or Sprycel should not be used				
Temodar® (temozolomide)	Documented intolerance to generic temozolomide.				
Tykerb® (lapatinib)	Documented intolerance to generic lapatinib.				
Xeloda® (capecitabine)	Documented intolerance to generic capecitabine.				
Xtandi® (enzalutamide)	**BOTH** of the following: **1.** Individiual meets Primary Treatment of Cancer criteria in Section I **2.** **ONLY for castration-recurrent metastatic prostate cancer**. Individual meets **BOTH** of the following (A and B): A. **ONE** of the following: i. Individual has previously been started on, or is currently receiving enzalutamide (Xtandi) ii. Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate (for example: unable to use prednisone) for abiraterone (Zytiga®). B. Xtandi will not be concomitantly administered with Zytiga.				
Yonsa® (abiraterone)	Documented intolerance to the generic formulation of Zytiga (abiraterone).				
Zytiga® (abiraterone)	Documented intolerance to the generic formulation of Zytiga (abiraterone).				

Where coverage requires the use of preferred products eligible for medical benefit coverage, the following criteria apply:

Drug/Biologic	Employer Group Plans	Individual and Family Plans
Avastin® (bevacizumab)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving bevacizumab (Avastin) • Individual has documented trials for Mvasi (bevacizumab-awwb) AND Zirabev (bevacizumab-bvzr)	

Drug/Biologic	Employer Group Plans	Individual and Family Plans
Fusilev® (levoleucovorin) **Khapzory**™ (levoleucovorin)	Unable to obtain leucovorin injection due to a documented drug shortage (Food and Drug Administration [FDA] Drug Shortage database or American Society of Health-Systems Pharmacists [ASHP] Drug Shortage list).	
Herceptin® (trastuzumab)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving trastuzumab (Herceptin) • Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)	
Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving trastuzumab and hyaluronidase-oysk (Herceptin Hylecta) • Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)	
Herzuma® (trastuzumab-pkrb)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving trastuzumab-pkrb (Herzuma) • Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)	
Ogivri (trastuzumab-dkst)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving trastuzumab-dkst (Ogivri) • Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)	
Ontruzant® (trastuzumab-dttb)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving trastuzumab-dttb (Ontruzant) • Individual has documented trials for Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)	
Rituxan® (rituximab)	**ANY** of the following are met: • Individual has previously been started on, or is currently receiving rituximab (Rituxan) • Individual has documented trials for ALL of the following: Riabni (rituximab-arrx) AND Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs)	
Rituxan Hycela™ (rituximab and hyaluronidase human)	**EITHER** of the following are met: • Individual has previously been started on, or is currently receiving rituximab and hyaluronidase (Rituxan Hycela) • Treatment is for a malignancy and **BOTH** of the following: o The individual has received at least one dose of intravenous rituximab o Individual has documented trials for ALL of the following: Riabni (rituximab-arrx) AND Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs)	
Sandostatin LAR Depot (octreotide injectable suspension)	**ONE** of the following are met: 1. Individual has documented trial of Somatuline Depot (lanreotide) injection 2. Individual with meningioma 3. Individual with thymoma/thymic carcinoma 4. Individual has previously been started on, or is currently receiving Sandostatin LAR Depot	

II. Uses Not Associated with Cancer

Use of certain Oncology Medications for treatment or symptoms not associated with cancer may require medical necessity determination; see medical necessity criteria, if any, under the specific medication listing:

Drug/Biologic	Uses Not Associated with Cancer Criteria
Bleomycin (bleomycin sulfate)	Treatment for symptomatic recalcitrant verruca vulgaris (unresponsive to all other treatments). *For scar revision, please refer to Scar Revision – (0328)*
Cyclophosphamide tablets	Unable to use cyclophosphamide capsules
Fluorouracil	*For scar revision, please refer to Scar Revision – (0328)*
Jakafi® (ruxolitinib)	**Effective thru 12/1/2021:** **BOTH** of the following are met: • Treatment for graft-versus-host disease (GVHD) • Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for one systemic corticosteroid.

Initial authorization is up to 12 months unless otherwise stated.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Oncology Medications for uses that are an NCCN category 3 recommendation (unless the use is approved by the FDA) are not covered because they are considered not medically necessary.

Oncology Medications are considered experimental, investigational or unproven for ANY other use.

Note: Receipt of sample product does not satisfy any criteria requirements for coverage

FDA Approved Indications

FDA Approved Indication

Drugs
Drugs@FDA.
http://www.accessdata.fda.gov/scripts/cder/drugsatfda/

Biologics
Licensed Biological Products with Supporting Documents.
http://www.fda.gov/BiologicsBloodVaccines/ucm133705.htm

General Background

Professional Societies/Organizations

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®)
[available with free subscription]
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

The NCCN Drugs & Biologics Compendium (NCCN Compendium®)
[available with paid subscription]
http://www.nccn.org/professionals/drug_compendium/content/contents.asp

The National Comprehensive Cancer Network® (NCCN®) is an organization of cancer centers, developing treatment guidelines for most cancers. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) present evidenced-based recommendations for the diagnosis and treatment of cancer and cancer care supportive therapies. NCCN provides the following definitions for their categories of recommendations:

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate;
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate;
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate;
- Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

For the 'uniform NCCN consensus' defined in Category 1 and Category 2A, a majority Panel vote of at least 85% is required. For the 'NCCN consensus' defined in Category 2B, a Panel vote of at least 50% (but less than 85%) is required. Lastly, for recommendations where there is strong Panel disagreement regardless of the quality of the evidence, NCCN requires a vote from at least three Panel Members (representing at least three different Member Institutions) to include and designate a recommendation as Category 3. The large majority of the recommendations put forth in the Guidelines are Category 2A. Where categories are not specified within the Guidelines, the default designation for the recommendation is Category 2A. (NCCN, 2020)

The NCCN Drugs & Biologics Compendium (NCCN Compendium®) includes FDA Approved Indications of cancer and cancer support medications and recommended non-FDA approved uses based upon the recommendations contained within the NCCN Guidelines.

Chronic Myeloid Leukemia (CML)

Tyrosine kinase inhibitor (TKI) have various indications for patients with chronic myeloid leukemia (CML).[1-6] Selected agents have additional agents, which are not detailed.

- **Bosulif** is indicated for: 1) newly diagnosed adults with Philadelphia chromosome-positive (Ph+) CML in chronic phase; and 2) chronic phase, accelerated phase or blast phase Ph+ CML with resistance or intolerance to prior therapy.
- **Imatinib** is indicated for: 1) newly diagnosed adult and pediatric patients with Ph+ CML in chronic phase and 2) Ph+ CML in blast crisis, accelerated phase, and chronic phase after interferon therapy.
- **Iclusig** is indicated for: 1) adults with chronic phase CML with resistance or intolerance to at least two prior TKIs, 2) adults with T315I-positive CML (chronic phase, accelerated phase, or blast phase), and 3) adults with accelerated phase or blast phase CML for whom no other TKI therapy is indicated.
- **Sprycel** is indicated for: 1) newly diagnosed adults with Ph+ CML in chronic phase, 2) Ph+ CML (adults) in chronic phase, accelerated phase, or blast phase with resistance or intolerance to prior therapy including imatinib, and 3) Ph+ CML in chronic phase in pediatric patients ≥ 1 year of age.
- **Tasigna** is indicated for: 1) newly diagnosed adult and pediatric patients (≥ 1 year of age) with Ph+ CML in chronic phase, 2) chronic phase and accelerated phase Ph+ CML in adults with resistance to or intolerance to prior therapy with imatinib, and 3) pediatric patients ≥ 1 year of age with Ph+ CML in chronic phase resistance or intolerance to prior TKI therapy.

GUIDELINES

The National Comprehensive Cancer Network (NCCN) CML guidelines (version 3.2021 – January 13, 2021) make many recommendations regarding TKI inhibitors. Therapy choice may be toxicity driven. For example, imatinib may be preferred for older patients with comorbidities (e.g., cardiovascular disease).[7]

- For patients with CP CML with a low-risk score, the primary treatment recommended includes a first-generation TKI (Gleevec or generic imatinib 400 mg QD [category 1]), or a second-generation TKI (Bosulif 400 mg QD [category 1], Sprycel 100 mg QD [category 1], or Tasigna 300 mg BID [category 1]).
- For patients with CP CML with an intermediate- or high-risk score, a second-generation TKI is preferred (Bosulif 400 mg QD [category 1], Sprycel 100 mg QD [category 1], or Tasigna 300 mg BID [category 1]).

A first-generation TKI (Gleevec or generic imatinib 400 mg QD) is an alternative (category 2A). Sprycel, Tasigna, and Bosulif are associated with quicker, deeper and higher rates of major molecular response, as well as less disease progression, compared with imatinib. Therefore, these agents are preferred in patients at intermediate or high risk. This is particularly preferred for young women whose goal is to achieve deep and rapid molecular response and possible medication discontinuation of TKIs for purposes of family planning.

- Iclusig is an option for patients with the T315I mutation and/or CP CML with resistance or intolerance to at least two prior TKIs or for patients with accelerated or blast phase CML for whom no other TKI is indicated. Iclusig has several serious toxicities (e.g., arterial occlusion).
- Regarding safety profiles, imatinib may be preferred for older patients with toxicities, such as cardiovascular disease. Tasigna or Bosulif may be preferred for patients with a history of lung disease or at risk of developing pleural effusions. Sprycel may be associated with significant but reversible inhibition of platelet aggregation that may contribute to bleeding in some patients, especially if a patient also has thrombocytopenia. Tasigna prolongs the QT interval and has a Boxed Warning in its prescribing information regarding this risk.

Coding/Billing Information

Oncology Medication Listing

Covered when medically necessary:

Oncology Medication	Benefit Type:
Abemaciclib (Verzenio™)	Pharmacy
Abiraterone (Zytiga®)	Pharmacy
Abiraterone (Yonsa®)	Pharmacy
Acalabrutinib (Calquence®)	Pharmacy
Afatinib (Gilotrif™)	Pharmacy
Alectinib (Alecensa®)	Pharmacy
Alpelisib (Piqray®)	Pharmacy
Amivantamab-vmjw (Rybrevant) *Note: if coverage of Rybrevant as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Anakinra (Kineret®)	Pharmacy
Apalutamide (Erleada™)	Pharmacy
Asparaginase Erwinia chrysanthemi (Erwinaze®) *Note: if coverage of Erwinaze as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Asparaginase erwinia-rywn (Rylaze) *Note: if coverage of Rylaze as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Axitinib (Inlyta®)	Pharmacy
Avapritinib (Ayvakit™)	Pharmacy
Azacitidine (Onureg®)	Pharmacy
Belzutifan (Welireg)	Pharmacy
Bexarotene (Targretin®)	Pharmacy
Binimetinib (Mektovi®)	Pharmacy
Bosutinib (Bosulif®)	Pharmacy
Brigatinib (Alunbrig™)	Pharmacy
Cabozantinib (Cabometyx™)	Pharmacy
Cabozantinib (Cometriq™)	Pharmacy
Capecitabine (Xeloda®)	Pharmacy
Capmatinib (Tabrecta™)	Pharmacy
Ceritinib (Zykadia™)	Pharmacy
Cobimetinib (Cotellic)	Pharmacy

Oncology Medication	Benefit Type:
Crizotinib (Xalkori®)	Pharmacy
Dacomitinib (Vizimpro®)	Pharmacy
Dabrafenib (Tafinlar®)	Pharmacy
Darolutamide (Nubeqa®)	Pharmacy
Dasatinib (Sprycel®)	Pharmacy
Decitabine and cedazuridine (Inqovi®)	Pharmacy
Degarelix (Firmagon®)*	Pharmacy
Dostarlimab-gxly (Jemperli) *Note: if coverage of Jemperli as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Duvelisib (Copiktra™)	Pharmacy
Enasidenib (Idhifa®)	Pharmacy
Encorafenib (Braftovi™)	Pharmacy
Entrectnib (Rozlytrek™)	Pharmacy
Enzalutamide (Xtandi®)	Pharmacy
Erdafitinib (Balversa™)	Pharmacy
Erlotinib (Tarceva®)	Pharmacy
Everolimus (Afinitor®, Afinitor® Disperz)	Pharmacy
Fam-trastuzumab deruxtecan-nxki (Enhertu®) *Note: if coverage of Enhertu as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Fedratinib dihydrochloride (Inrebic®)	Pharmacy
Gefitinib (Iressa®)	Pharmacy
Gilteritinib (Xospata®)	Pharmacy
Glasdegib maleate (Daurismo™)	Pharmacy
Goserelin (Zoladex®)*	Pharmacy
Ibrutinib (Imbruvica®)	Pharmacy
Idelalisib (Zydelig®)	Pharmacy
Imatinib (Gleevec®)	Pharmacy
Infigratinib (Truseltiq)	Pharmacy
Ipilimumab (Yervoy®) *Note: if coverage of Yervoy as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Ivosidenib (Tibsovo®)	Pharmacy
Interferon gamma-1b (Actimmune®)	Pharmacy
Ixazomib (Ninlaro®)	Pharmacy
Lapatinib (Tykerb®)	Pharmacy
Larotrectinib sulfate (Vitrakvi®)	Pharmacy
Lenalidomide (Revlimid®)	Pharmacy
Lenvatinib (Lenvima™)	Pharmacy
Letrozole; ribociclib (Kisqali® Femara® Co-Pack)	Pharmacy
Leuprolide (Lupron Depot®, Eligard®)* *Note: if coverage of Leuprolide as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Loncastuximab tesirine-lpyl (Zynlonta) *Note: if coverage of Zynlonta as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Lorlatinib (Lorbrena®)	Pharmacy
Margetuximab-cmkb (Margenza) *Note: if coverage of Margenza as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Midostaurin (Rydapt®)	Pharmacy

Oncology Medication	Benefit Type:
Mobocertinib succinate (Exkivity)	Pharmacy
Neratinib (Nerlynx®)	Pharmacy
Nilotinib (Tasigna®)	Pharmacy
Nilutamide (Nilandron®)	Pharmacy
Niraparib tosylate (Zejula™)	Pharmacy
Nivolumab (Opdivo®) *Note: if coverage of Opdivo as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Olaparib (Lynparza™)	Pharmacy
Osimertinib (Tagrisso™)	Pharmacy
Palbociclib (Ibrance®)	Pharmacy
Panobinostat (Farydak®)	Pharmacy
Pazopanib (Votrient®)	Pharmacy
Peginterferon alfa-2a (PegaSys®)	Pharmacy
Peginterferon alfa-2b (PegIntron®)	Pharmacy
Peginterferon alfa-2b (Sylatron™)	Pharmacy
Pemigatinib (Pemazyre™)	Pharmacy
Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo™) *Note: If coverage of Phesgo as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Pexidartinib (Turalio™)	Pharmacy
Pomalidomide (Pomalyst®)	Pharmacy
Ponatinib (Iclusig®)	Pharmacy
Pralsetinib (Gavreto™)	Pharmacy
Regorafenib (Stivarga®)	Pharmacy
Relugolix (Orgovyx™)	Pharmacy
Ribociclib (Kisqali®)	Pharmacy
Ripretinib (Qinlock™)	Pharmacy
Rucaparib (Rubraca™)	Pharmacy
Ruxolitinib (Jakafi®)	Pharmacy
Selinexor (Xpovio™)	Pharmacy
Selpercatinib (Retevmo™)	Pharmacy
Selumetinib (Koselugo)	Pharmacy
Sonidegib (Odomzo®)	Pharmacy
Sorafenib (Nexavar®)	Pharmacy
Sotorasib (Lumakras)	Pharmacy
Sunitinib (Sutent®)	Pharmacy
Talazoparib (Talzenna®)	Pharmacy
Tazemetostat (Tazverik™)	Pharmacy
Telotristat (Xermelo™)	Pharmacy
Temozolomide (Temodar®)	Pharmacy
Tepotinib (Tepmetko®)	Pharmacy
Thalidomide (Thalomid®)	Pharmacy
Tisotumab vedotin-tftv (Tivdak) *Note: if coverage of Tivdak as a medical benefit, refer to the* Medical Benefit table	Pharmacy
Tivozanib HCl (Fotivda)	Pharmacy
Topotecan (Hycamtin®)	Pharmacy
Trametinib (Mekinist™)	Pharmacy
Tretinoin (Vesanoid®)	Pharmacy
Trifluridine and tipiracil (Lonsurf®)	Pharmacy
Triptorelin pamoate (Trelstar®)	Pharmacy

Oncology Medication	Benefit Type:
Note: if coverage of Triptorelin pamoate as a medical benefit, refer to the Medical Benefit table	
Tucatinib (Tukysa™)	Pharmacy
Umbralisib tosylate (Ukoniq™)	Pharmacy
Vandetanib (Caprelsa®)	Pharmacy
Vemurafenib (Zelboraf®)	Pharmacy
Venetoclax (Venclexta™)	Pharmacy
Vismodegib (Erivedge™)	Pharmacy
Vorinostat (Zolinza®)	Pharmacy
Zanubrutinib (Brukinsa™)	Pharmacy

* *When covered by pharmacy benefit*

Note: These medications are covered under pharmacy benefit plans. Certain prescription drugs require an authorization for coverage to ensure that appropriate treatment regimens are followed. Medical drug coding and diagnosis codes, however, are generally not required for pharmacy claims submissions; therefore, coding information is not provided.

Covered when medically necessary:
Note:

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Oncology Medication	Benefit Type:	HCPCS Code:	Description
Ado-trastuzumab emtansine (Kadcyla®)	Medical	J9354	Injection, ado-trastuzumab emtansine, 1mg
Amivantamab-vmjw (Rybrevant) *Note: if coverage of Rybrevant as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	C9399 J3490 J3590 J9999	Unclassified drugs or biologicals Unclassified drugs Unclassified biologics Not otherwise classified, antineoplastic drugs
Aldeslelukin (Proleukin®)	Medical	J9015	Injection, aldesleukin, per single use vial
Arsenic trioxide (Trisenox®)	Medical	J9017	Injection, arsenic trioxide, 1 mg
Asparaginase Erwinia chrysanthemi (Erwinaze®) *Note: if coverage of Erwinaze as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	J9019	Injection, asparaginase (Erwinaze) 1,000 IU
Asparaginase erwinia-rywn (Rylaze) *Note: if coverage of Rylaze as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	C9399 J3490 J9999	Unclassified drugs or biologicals Unclassified drugs Not otherwise classified, antineoplastic drugs
Atezolizumab (Tecentriq®)	Medical	J9022	Injection, atezolizumab, 10 mg
Avelumab (Bavencio®)	Medical	J9023	Injection, avelumab, 10 mg
Azacitidine	Medical	J9025	Injection, azacitidine, 1 mg
Belantamab mafodotin-blmp (Blenrep™)	Medical	C9069 J9037	Injection, belantamab mafodontin-blmf, 0.5 mg (Code deleted 03/31/2021) Injection, belantamab mafodontin-blmf, 0.5 mg
Belinostat (Beleodaq®)	Medical	J9032	Injection, Belinostat, 10 mg
Bendamustine (Belrapzo)	Medical	J9036	Injection, bendamustine hydrochloride, (belrapzo/bendamustine), 1 mg
Bendamustine (Bendeka™)	Medical	J9034	Injection, bendamustine HCL (bendeka), 1 mg
Bendamustine (Treanda®)	Medical	J9033	Injection, bendamustine HCL (Treanda), 1 mg

Oncology Medication	Benefit Type:	HCPCS Code:	Description
Bevacizumab (Avastin®)	Medical	J9035	Injection, bevacizumab, 10 mg
Bevacizumab-awwb (Mvasi™)	Medical	Q5107	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg
Bevacizumab-bvzr (Zirabev™)	Medical	Q5118	Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10 mg
Bleomycin sulfate	Medical	J9040	Injection, bleomycin sulfate, 15 units
Blinatumomab (Blincyto®)	Medical	J9039	Injection, blinatumomab 1 microgram
Bortezomib (Velcade®)	Medical	J9041	Injection, bortezomib (velcade), 0.1 mg
Bortezomib	Medical	J9044	Injection, bortezomib, not otherwise specified, 0.1 mg
Brentuximab Vedotin (Adcetris®)	Medical	J9042	Injection, Brentuximab Vedotin, 1 mg
Cabazitaxel (Jevtana®)	Medical	J9043	Injection, cabazitaxel, 1 mg
Calaspargase pegol-mknl (Asparlas™)	Medical	J9118	Injection, calaspargase pegol-mknl, 10 units
Carboplatin	Medical	J9045	Injection, carboplatin, 50 mg
Carfilzomib (Kyprolis®)	Medical	J9047	Injection, carfilzomib, 1 mg
Cemiplimab-rwlc (Libtayo®)	Medical	J9119	Injection, cemiplimab-rwlc, 1 mg
Cetuximab (Erbitux®)	Medical	J9055	Injection, cetuximab, 10 mg
Cisplatin	Medical	J9060	Injection, cisplatin, powder or solution, 10 mg
Cladribine	Medical	J9065	Injection, cladribine, per 1 mg
Clofarabine (Clolar®)	Medical	J9027	Injection, clofarabine, 1 mg
Copanlisib (Aliqopa™)	Medical	J9057	Injection, copanlisib, 1 mg
Cytarabine liposome/PF (Depocyt®)	Medical	J9098	Injection, cytarabine liposome, 10 mg
Cytarabine/PF	Medical	J9100	Injection, cytarabine, 100 mg
Dacarbazine	Medical	J9130	Dacarbazine, 100 mg
Dactinomycin (Cosmegen®)	Medical	J9120	Injection, dactinomycin, 0.5 mg
Daratumumab (Darzalex™)	Medical	J9145	Injection, daratumumab, 10 mg
Daratumumab and hyaluronidase-fihj (Darzalex Faspro™)	Medical	C9062	Injection, daratumumab 10 mg and hyaluronidase-fihj (Code deleted 12/31/2020)
Daratumumab and hyaluronidase-fihj (Darzalex Faspro™)	Medical	J9144	Injection, daratumumab 10 mg and hyaluronidase-fihj
Daunorubicin HCl	Medical	J9150	Injection, daunorubicin, 10 mg
Daunorubicin and cytarabine (Vyxeos®)	Medical	J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
Decitabine (Dacogen®)	Medical	J0894	Injection, decitabine, 1 mg
Degarelix (Firmagon®)**	Medical	J9155	Injection, degarelix, 1 mg
Docetaxel (Taxotere®)	Medical	J9171	Injection, docetaxel, 1 mg
Dostarlimab-gxly (Jemperli) *Note: if coverage of Jemperli as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	C9399 J3490 J3590	Unclassified drugs or biologicals Unclassified drugs Unclassified biologics
Doxorubicin HCL	Medical	J9000	doxorubicin hydrochloride, 10 mg
Doxorubicin HCL PEG-Liposomal (Doxil®)	Medical	Q2050	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg
Durvalumab (Imfinzi®)	Medical	J9173	Injection, durvalumab, 10 mg
Elotuzumab (Empliciti®)	Medical	J9176	Injection, elotuzumab, 1 mg
Enfortumab vedotin-ejfv (Padcev™)	Medical	J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg
Epirubicin HCl (Ellence®)	Medical	J9178	Injection, epirubicin HCl, 2 mg
Eribulin mesylate (Halaven®)	Medical	J9179	Injection, eribulin mesylate, 0.1 mg

Oncology Medication	Benefit Type:	HCPCS Code:	Description
Etoposide phosphate (Etopophos®)	Medical	J9181	Injection, etoposide, 10 mg
Fam-trastuzumab deruxtecan-nxki (Enhertu®) *Note: if coverage of Enhertu as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg
Floxuridine	Medical	J9200	Injection, floxuridine, 500 mg
Fludarabine phosphate	Medical	J9185	Injection, fludarabine phosphate, 50 mg
Fluorouracil	Medical	J9190	Injection, fluorouracil, 500 mg
Fulvestrant (Faslodex®)	Medical	J9395	Injection, fulvestrant, 25 mg
Gemcitabine HCl	Medical	J9201	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg
Gemcitabine (Infugem™)	Medical	J9198	Injection, gemcitabine hydrochloride, (Infugem), 100 mg
Gemtuzumab ozogamicin (Mylotarg™)	Medical	J9203	Injection, gemtuzumab ozogamicin, 0.1 mg
Goserelin (Zoladex®)**	Medical	J9202	Goserelin acetate implant, per 3.6 mg
Histrelin (Vantas®)	Medical	J9225	Histrelin implant (Vantas), 50 mg
Idarubicin (Idamycin PFS®)	Medical	J9211	Injection, idarubicin hydrochloride, 5 mg
Ifosfamide (Ifex)	Medical	J9208	Injection, ifosfamide, 1 gram
Inotuzumab ozogamicin (Besponsa™)	Medical	J9229	Injection, inotuzumab ozogamicin, 0.1 mg
Interferon alfa-2b (Intron®A)	Medical	J9214	Injection, interferon alfa-2b, recombinant, 1 million units
Ipilimumab (Yervoy®) *Note: if coverage of Yervoy as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	J9228	Injection, ipilimumab, 1 mg
Irinotecan (Camptosar®)	Medical	J9206	Injection, irinotecan, 20 mg
Irinotecan liposome (Onivyde®)	Medical	J9205	Injection, irinotecan liposome, 1 mg
Isatuximab-irfc (Sarclisa®)	Medical	J9227	Injection, isatuximab-irfc, 10 mg
Ixabepilone (Ixempra®)	Medical	J9207	Injection, ixabepilone, 1 mg
Lanreotide (Somatuline Depot®)	Medical	J1930	Injection, lanreotide, 1 mg
Leuprolide (Lupron Depot®, Eligard®) *Note: if coverage of Leuprolide as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
Leuprolide (Lupron Depot®)	Medical	J9217	Leuprolide acetate (for depot suspension), 7.5 mg
Levoleucovorin (Fusilev®)	Medical	J0641	Injection, levoleucovorin, 0.5 mg
Levoleucovorin (Khapzory™)	Medical	J0642	Injection, levoleucovorin (khapzory), 0.5 mg
Loncastuximab tesirine-lpyl (Zynlonta) *Note: if coverage of loncastuximab-tesirine-lpyl as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	C9399 J3490 J3590	Unclassified drugs or biologicals Unclassified drugs Unclassified biologics
Lurbinectedin (Zepzelca™)	Medical	J9223	Injection, lurbinectedin, 0.1 mg
Margetuximab-cmkb (Margenza)	Medical	J9353	Injection, margetuximab-cmkb, 5 mg

Oncology Medication	Benefit Type:	HCPCS Code:	Description
Note: if coverage of Margenza as a pharmacy benefit, refer to the Pharmacy Benefit table			
Mechlorethamine (Mustargen®)	Medical	J9230	Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg
Melphalan (Alkeran® Evomela®)	Medical	J9245	Injection, melphalan hydrochloride, 50 mg
Melphalan flufenamide (Pepaxto)	Medical	C9080 J9247	Injection, melphalan flufenamide hydrochloride, 1 mg (Code deleted 09/30/2021) Injection, melphalan flufenamide, 1 mg
Mitomycin	Medical	J9280	Injection, mitomycin, 5 mg
Mitomycin ureteral gel (Jelmyto)	Medical	J9281	Mitomycin pyelocalyceal instillation, 1 mg
Mitoxantrone HCl	Medical	J9293	Injection, mitoxantrone hydrochloride, per 5 mg
Mogamulizumab-kpkc (Poteligeo®)	Medical	J9204	Injection, mogamulizumab-kpkc, 1 mg
Moxetumomab pasudotox-tdfk (Lumoxiti™)	Medical	J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg
Naxitamab-gqgk (Danyelza®)	Medical	J9348	Injection, naxitamab-gqgk, 1 mg
Necitumumab (Portrazza™)	Medical	J9295	Injection, necitumumab, 1 mg
Nelarabine (Arranon®)	Medical	J9261	Injection, nelarabine, 50 mg
Nivolumab (Opdivo®) *Note: if coverage of Opdivo as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	J9299	Injection, nivolumab, 1 mg
Octreotide injectable suspension (Sandostatin LAR Depot)	Medical	J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg
Obinutuzumab (Gazyva®)	Medical	J9301	Injection, obinutuzumab, 10 mg
Ofatumumab (Arzerra®)	Medical	J9302	Injection, ofatumumab, 10 mg
Omacetaxine mepesuccinate (Synribo®)	Medical	J9262	Injection, omacetaxine mepesuccinate, 0.01 mg
Oxaliplatin	Medical	J9263	Injection, oxaliplatin, 0.5 mg
Paclitaxel	Medical	J9267	Injection, paclitaxel, 1 mg
Paclitaxel protein-bound particles for injectable suspension, (Abraxane®)	Medical	J9264	Injection, paclitaxel protein-bound particles, 1 mg
Panitumumab (Vectibix®)	Medical	J9303	Injection, panitumumab, 10 mg
Pegaspargase (Oncaspar®)	Medical	J9266	Injection, pegaspargase, per single dose vial
Pembrolizumab (Keytruda®)	Medical	J9271	Injection, Pembrolizumab, 1 mg
Pemetrexed (Alimta®)	Medical	J9305	Inection, pemetrexed, 10 mg
Pentostatin (Nipent™)	Medical	J9268	Injection, pentostatin, 10 mg
Pertuzumab (Perjeta®)	Medical	J9306	Injection, pertuzumab, 1 mg
Pertuzumab, trastuzumab, and hyaluronidase-zzxf (Phesgo™) *Note: If coverage of Phesgo as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg
Polatuzumab vendotin (Polivy™)	Medical	J9309	Injection, polatuzumab vedotin-piiq, 1 mg
Pralatrexate (Folotyn®)	Medical	J9307	Injection, pralatrexate, 1 mg
Ramucirumab (Cyramza®)	Medical	J9308	Injection, ramucirumab, 5 mg
Rituximab (Rituxan®)	Medical	J9312	Injection, rituximab, 10 mg
Rituximab-abbs (Truxima®)	Medical	Q5115	Injection, rituximab-abbs, biosimilar, 10 mg
Rituximab-arrx (Riabni™)	Medical	Q5123	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg

Oncology Medication	Benefit Type:	HCPCS Code:	Description
Rituximab and hyaluronidase human (Rituxan Hycela™)	Medical	J9311	Injection, rituximab 10 mg and hyaluronidase
Rituximab-pvvr (Ruxience™)	Medical	Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg
Romidepsin	Medical	J9314 J9318	Injection, romidepsin, non-lyophilized (e.g. liquid), 0.1 mg (Code deleted 09/30/2021) Injection, romidepsin, non lyophilized 0.1mg
Romidepsin (Istodax®)	Medical	J9315 J9319	Injection, romidepsin, 1 mg (Code deleted 09/30/2021) Injection, romidepsin, lyophilized, 0.1 mg
Sacituzumab govitecan-hziy (Trodelvy™)	Medical	C9066 J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg (Code deleted 12/31/2020) Injection, sacituzumab govitecan-hziy, 2.5 mg
Siltuximab (Sylvant®)	Medical	J2860	Injection, siltuximab, 10 mg
Sipuleucel-T (Provenge®)	Medical	Q2043	Sipuleucel-t, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion
Streptozocin (Zanosar®)	Medical	J9320	Injection, streptozocin, 1 gram
Tagraxofusp-erzs (Elzonris®)	Medical	J9269	Injection, Tagraxofusp-erzs, 10 micrograms
Tafasitamab-cxix (Monjuvi)	Medical	C9070 J9349	Injection, tafasitamab-cxix, 2 mg (Code deleted 03/31/2021) Injection, tafasitamab-cxix, 2 mg
Talimogene (Imlygic®)	Medical	J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units
Temozolomide (Temodar®)	Medical	J9328	Injection, temozolomide, 1 mg
Temsirolimus (Torisel®)	Medical	J9330	Injection, temsirolimus, 1 mg
Teniposide	Medical	Q2017	Injection, teniposide, 50 mg
Thiotepa	Medical	J9340	Injection, thiotepa, 15 mg
Tisotumab vedotin-tftv (Tivdak) *Note: If coverage of Tivdak as a pharmacy benefit, refer to the* Pharmacy Benefit table	Medical	C9399 J3490 J3590	Unclassified drugs or biologicals Unclassified drugs Unclassified biologics
Tocilizumab (Actemra®)	Medical	J3262	Injection, tocilizumab, 1 mg
Topotecan (Hycamtin®)	Medical	J9351	Injection, topotecan, 0.1 mg
Trabectedin (Yondelis®)	Medical	J9352	Injection, trabectedin, 0.1 mg
Trastuzumab (Herceptin®)	Medical	J9355	Injection, trastuzumab, 10 mg
Trastuzumab-anns (Kanjinti)	Medical	Q5117	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg
Trastuzumab-dkst (Ogivri)	Medical	Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Trastuzumab-dttb (Ontruzant)	Medical	Q5112	Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg
Trastuzumab-pkrb (Herzuma®)	Medical	Q5113	Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg
Trastuzumab-qyyp (Trazimera™)	Medical	Q5116	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg
Trastuzumab and Hyaluronidase-oysk (Herceptin Hylecta ™)	Medical	J9356	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk
Triptorelin pamoate (Trelstar®) *Note: if coverage of Triptorelin pamoate as a pharmacy benefit,*	Medical	J3315	Injection, triptorelin pamoate, 3.75 mg

Oncology Medication	Benefit Type:	HCPCS Code:	Description
refer to the Pharmacy Benefit table			
Vinblastine HCl	Medical	J9360	Injection, vinblastine sulfate, 1 mg
Vincristine (Vincasar PFS®)	Medical	J9370	Vincristine sulfate, 1 mg
vincristine sulfate LIPOSOME injection (Marqibo®)	Medical	J9371	Injection, vincristine sulfate liposome, 1mg
Vinorelbine (Navelbine®)	Medical	J9390	Injection, vinorelbine tartrate, 10 mg
Ziv-aflibercept (Zaltrap®)	Medical	J9400	Injection, Ziv-aflibercept, 1 mg

*** When covered by medical benefit, pre-certification is not required*

References

1. Basch E, Loblaw DA, Oliver TK, et al. Systemic therapy in men with metastatic castration-resistant prostate cancer: American Society of Clinical Oncology and Cancer Care Ontario Clinical Practice Guideline. J Clin Oncol. 2014;32(30):3436-48. Accessed June 11, 2018.
2. Cookson MS, Roth BJ, Dahm P, et al. American Urological Association (AUA) Guideline: Castration-Resistant Prostate Cancer. Updated 2018. Available from: http://www.auanet.org/education/guidelines/castration-resistant-prostate-cancer.cfm.
3. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology. 2020(a); Available at: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp.
4. National Comprehensive Cancer Network (NCCN). NCCN Drugs & Biologics Compendium. 2020(b); Available at: http://www.nccn.org/professionals/drug_compendium/content/contents.asp.
5. National Comprehensive Cancer Network Clinical Practice Guideline: Breast Cancer (v.4.2018). http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Updated February 8, 2019a. Accessed February 11, 2019.
6. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Chronic Myeloid Leukemia v4.2018; [available with free subscription] https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf. Updated December 20, 2017(c). Accessed June 11, 2018.
7. National Comprehensive Cancer Network Clinical Practice Guideline: Soft Tissue Sarcoma (v.2.2019). https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Updated February 4, 2019b. Accessed February 26, 2019.
8. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/.
9. U.S. Food and Drug Administration. FDA News Release (Update): FDA grants accelerated approval to new treatment for advanced soft tissue sarcoma: January 24, 2019. U.S. Department of Health & Human Services: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm525878.htm. Accessed February 26, 2019.
10. U.S. Food and Drug Administration. Licensed Biological Products with Supporting Documents. U.S. Department of Health & Human Services: http://www.fda.gov/BiologicsBloodVaccines/ucm133705.htm.
11. Virgo KS, Basch E, Loblaw A, et al. Second-Line Hormonal Therapy for Men with Chemotherapy-Naïve, Castsration-Resistant Prostate Cancer: American Society of Clinical Oncology Provisional Clinical Opinion.J Clin Oncol. 2017:35(17):1952-64.