MEDICAL COVERAGE POLICY	
SERVICE:	**Step Therapy Policy – Commercial plans**
Policy Number:	**306**
Effective Date:	**1/1/2024**
Last Review:	**12/13/2023**
Next Review:	**12/13/2024**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Step Therapy Policy – Commercial plans

PRIOR AUTHORIZATION: See specific policy for appropriate drug or device

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

This policy provides a list of drugs and devices that require step therapy. Step therapy is when a trial of a preferred therapeutic alternative is required prior to coverage of a non-preferred drug or device for a specific indication. Baylor Scott & White Health Plan medical policies as specified in the table below will be applied first. Thereafter, the step therapy requirement(s) in this supplemental policy should be applied.

Baylor Scott & White Health Plan, and its wholly owned subsidiaries (together, "Plan") considers the use of medications with a non-preferred status medically necessary when used consistent with the member's coverage document and based on the following criteria:

1) The member must have failure of an adequate trial of or clinically significant intolerance or contraindication to preferred drugs in the same class that can also be used for the requested indication
   a) Exception: Non-preferred drugs requested due to failure of an adequate trial of biosimilars of preferred products do not meet medical necessity.
   b) Regulatory notes for plans subject to Texas Department of Insurance requirements:
      i) Per Texas Mandate HB1584 and Texas Insurance Code (TIC) sec, 1369.213, step therapy will not be required for a non-preferred drug when use is:
         (1) consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition;
         (2) supported by peer-reviewed, evidence-based literature; and
         (3) approved by the United States Food and Drug Administration
2) The member meets additional clinical coverage criteria per Plan policy as specified in the table below.

Class	Preferred	Non-Preferred	BSWHP policy
Bevacizumab – for oncology indications only	Mvasi Zirabev	Avastin (J9035) Alymsys Other bevacizumab biosimilars	BSWHP policy 219 Cancer Chemotherapy / Therapy Guidelines
Botulinum Toxins	Botox Dysport	Myobloc Xeomin	BSWHP policy 215 Medications Covered Under Medical Insurance Policy
Injectable lipid lowering therapy	Praluent (obtained through pharmacy benefit) Repatha (obtained through pharmacy benefit)	Leqvio	BSWHP policy 215 Medications Covered Under Medical Insurance Policy
Long-acting G-CSF	Udenyca Neulasta	Fulphila Fylnetra Nyvepria Stimufend Ziextenzo Other long-acting G-CSF	BSWHP policy 215 Medications Covered Under Medical Insurance Policy OR BSWHP policy 219 Cancer Chemotherapy / Therapy Guidelines
Short-acting G-CSF	Zarxio	Granix Neupogen Nivestym Releuko Other short-acting GCSF	BSWHP policy 215 Medications Covered Under Medical Insurance Policy OR BSWHP policy 219 Cancer Chemotherapy / Therapy Guidelines
Rituximab	Ruxience Truxima	Riabni Rituxan Rituxan Hycela Other rituximab containing agents	BSWHP policy 215 Medications Covered Under Medical Insurance Policy OR

			BSWHP policy 219 Cancer Chemotherapy / Therapy Guidelines
Trastuzumab	Kanjinti Ontruzant	Herceptin Herceptin Hylecta Herzuma Ogivri Trazimera Other trastuzumab biosimilars	BSWHP policy 219 Cancer Chemotherapy / Therapy Guidelines
VEGF inhibitors – for ophthalmic indications only	Cimerli Compounded Avastin	Beovu Byooviz Eylea Lucentis Susvimo Vabysmo	BSWHP policy 215 Medications Covered Under Medical Insurance

POLICY HISTORY:

Status	Date	Action
New	12/13/2023	New policy – previously under medical policy 215 Medications Covered Under Medical Insurance Policy and 219 Cancer Chemotherapy/Therapy Guidelines

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs.