Maximum Dosage and Frequency (for Louisiana Only)

Policy Number: ~~CSLA2024D0034AI~~CSLA2024D0034AJ
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➲ Instructions for Use

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Application

This Medical Benefit Drug Policy only applies to the state of Louisiana.

Coverage Rationale

This policy provides information about the maximum dosage per administration and dosing frequency for certain medications administered by a medical professional. Most medications have a maximum dosage and frequency based upon body surface area or patient weight or a set maximal dosage and frequency independent of patient body size.

Drug Products

- abatacept (Orencia®)
- abobotulinumtoxinA (Dysport®)
- aflibercept (Eylea®)
- atezolizumab (Tecentriq®)
- avelumab (Bavencio®)
- benralizumab (Fasenra®)
- bevacizumab (Avastin®)
- bevacizumab-adcd (Vegzelma®)
- bevacizumab-awwb (Mvasi™)
- bevacizumab-bvzr (Zirabev®)
- bevacizumab-maly (Alymsys®)
- brolucizumab-dbll (Beovu®)
- canakinumab (Ilaris®)
- cemiplimab-rwlc (Libtayo®)
- certolizumab pegol (Cimzia®)
- daxibotulinumtoxina-lanm (Daxxify®)
- denosumab (Prolia® & Xgeva®)
- durvalumab (Imfinzi®)
- eculizumab (Soliris®)
- edaravone (Radicava®)
- efgartigimod alfa-fcab (Vyvgart®)
- efgartigimod alfa and hyaluronidase-qvfc (Vyvgart® Hytrulo)
- eflapegrastim-xnst (Rolvedon™)
- emicizumab-kxwh (Hemlibra®)
- eptinezumab-jjmr (Vyepti®)
- faricimab-svoa (Vabysmo™)
- golimumab (Simponi Aria®)
- inclisiran (Leqvio®)
- incobotulinumtoxinA (Xeomin®)
- infliximab (Remicade®)
- infliximab-axxq (Avsola™)
- infliximab-dyyb (Inflectra®)
- infliximab-abda (Renflexis®)
- ipilimumab (Yervoy®)
- mepolizumab (Nucala®)
- mirikizumab-mrkz (Omvoh™)
- nivolumab (Opdivo®)
- ocrelizumab (Ocrevus®)
- omalizumab (Xolair®)
- onabotulinumtoxinA (Botox®)
- patisiran (Onpattro®)
- pegcetacoplan (Syfovre™)
- pegfilgrastim (Neulasta®)
- pegfilgrastim-apgf (Nyvepria™)
- pegfilgrastim-cbqv (Udenyca®)
- pegfilgrastim-fpgk (Stimufend®)
- pegfilgrastim-jmdb (Fulphila™)
- pegfilgrastim-pbbk (Fylnetra®)
- pegfilgrastim-bmez (Ziextenzo®)
- pegloticase (Krystexxa®)
- pembrolizumab (Keytruda®)
- ranibizumab (Lucentis®)
- ranibizumab-nuna (Byooviz™)
- ranibizumab-eqrn (Cimerli™)
- ravulizumab-cwvz (Ultomiris®)
- reslizumab (Cinqair®)
- rimabotulinumtoxinB (Myobloc®)
- risankizumab-rzaa (Skyrizi®)
- rituximab (Rituxan®)
- rituximab-pvvr (Ruxience™)
- rituximab-abbs (Truxima®)
- rituximab-arrx (Riabni™)
- rituximab and hyaluronidase (Rituxan Hycela®)
- rozanolixizumab-noli (Rystiggo®)
- spesolimab-sbzo (Spevigo®)

- testosterone cypionate (Depo-Testosterone®)
- testosterone enanthate
- testosterone pellets (Testopel®)
- testosterone undecanoate (Aveed®)
- tezepelumab-ekko (Tezspire®)
- tildrakizumab-asmn (Ilumya™)
- tocilizumab (Actemra®)
- tofersen (Qalsody®)
- trastuzumab (Herceptin®)
- trastuzumab-anns (Kanjinti™)
- trastuzumab-dkst (Ogivri™)
- trastuzumab-dttb (Ontruzant®)
- trastuzumab-pkrb (Herzuma®)
- trastuzumab-qyyp (Trazimera™)
- ustekinumab (Stelara®)
- vedolizumab (Entyvio®)
- vutrisiran (Amvuttra™)
- zoledronic acid (zoledronic acid, Reclast®)

The use of medications included in this policy when given within the maximum dosage and/or frequency based upon body surface area or patient weight or a set of maximal dosage and/or frequency independent of patient body size are proven when used according to labeled indications or when otherwise supported by published clinical evidence.

The medications included in this policy when given beyond maximum dosages and/or frequency based upon body surface area or patient weight or a set maximal dosage independent of patient body size are not supported by package labeling or published clinical evidence and are unproven.

This policy creates an upper dose limit based on the clinical evidence and the 95th percentile for adult body weight (140 kg) and body surface area (2.71 meters^2) in the U.S. (adult male, 30 to 39 years, Fryar, 2021).[59] In some cases, the maximum allowed units and/or vials may exceed the upper-level limit as defined within this policy due to an individual patient body weight > 140 kg or body surface area > 2.71 meters^2.

Maximum Allowed Quantities by HCPCS Units

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Actemra	tocilizumab	800 mg	J3262	800 HCPCs units (1 mg per unit)
Avastin	bevacizumab	15 mg/kg	J9035	240 HCPCS units (10 mg per unit)
Vegzelma	bevacizumab-adcd	15 mg/kg	Q5129	240 HCPCS units (10 mg per unit)
Mvasi	bevacizumab-awwb	15 mg/kg	Q5107	240 HCPCS units (10 mg per unit)
Zirabev	bevacizumab-bvzr	15 mg/kg	Q5118	240 HCPCS units (10 mg per unit)
Alymsys	bevacizumab-maly	15 mg/kg	Q5126	240 HCPCS units (10 mg per unit)
Aveed	testosterone undecanoate	750 mg	J3145	750 HCPCs units (1 mg per unit)
Botox	onabotulinumtoxinA	600 units	J0585	600 HCPCS units (1 unit per HCPCS unit)
Cimzia	certolizumab pegol	400 mg	J0717	400 HCPCS units (1 mg per unit)
Cinqair	reslizumab	3 mg/kg	J2786	500 HCPCS units (1 mg per unit)
Daxxify	daxibotulinumtoxinA-lanm	250 units	J0589	250 HCPCS units (1 unit per HCPCS unit)
N/A	testosterone enanthate	400 mg	J3121	400 HCPCs units (1 mg per unit)
Depo-Testosterone	testosterone cypionate	400 mg	J1071	400 HCPCs units (1 mg per unit
Dysport	abobotulinumtoxinA	1,500 units	J0586	300 HCPCS units (5 units per HCPCS unit)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Entyvio	vedolizumab	300 mg	J3380	300 HCPCS units (1 mg per unit)
Fasenra	benralizumab	30 mg	J0517	30 HCPCS units (1 mg per unit)
Hemlibra	emicizumab-kxwh	6 mg/kg	J7170	1,680 HCPCs units (0.5 mg per unit)
Herceptin	trastuzumab	8 mg/kg	J9355	126 HCPCS units (10 mg per unit)
Herzuma	trastuzumab-pkrb	8 mg/kg	Q5113	126 HCPCS units (10 mg per unit)
Kanjinti	trastuzumab-anns	8 mg/kg	Q5117	126 HCPCS units (10 mg per unit)
Ogivri	trastuzumab-dkst	8 mg/kg	Q5114	126 HCPCS units (10 mg per unit)
Ontruzant	trastuzumab-dttb	8 mg/kg	Q5112	126 HCPCS units (10 mg per unit)
Trazimera	trastuzumab-qyyp	8 mg/kg	Q5116	126 HCPCS units (10 mg per unit)
Ilaris	canakinumab	300 mg	J0638	300 HCPCS units (1 mg per unit)
Ilumya	tildrakizumab-asmn	100 mg	J3245	100 HCPCs units (1 mg per unit)
Leqvio	inclisiran	284 mg	J1306	284 HCPCs units (1 mg per unit)
Myobloc	rimabotulinumtoxinB	30,000 units	J0587	300 HCPCS units (100 units per HCPCS unit)
Neulasta	pegfilgrastim	6 mg	J2506	12 HCPCS unit (0.5 mg per unit)
Nyvepria	pegfilgrastim-apgf	6 mg	Q5122	12 HCPCS units (0.5 mg per unit)
Fulphila	pegfilgrastim-jmdb	6 mg	Q5108	12 HCPCS units (0.5 mg per unit)
Fylnetra	pegfilgrastim-pbbk	6 mg	Q5130	12 HCPCS units (0.5 mg per unit)
Stimufend	pegfilgrastim-fpgk	6 mg	Q5127	12 HCPCS units (0.5 mg per unit)
Udenyca	pegfilgrastim-cbqv	6 mg	Q5111	12 HCPCS units (0.5 mg per unit)
Ziextenzo	pegfilgrastim-bmez	6 mg	Q5120	12 HCPCS units (0.5 mg per unit)
Rolvedon	eflapegrastim-xnst	13.2 mg	J1449	132 HCPCS units (0.1 mg per unit)
Krystexxa	pegloticase	8 mg	J2507	8 HCPCS units (1 mg per unit)
Nucala	mepolizumab	300 mg	J2182	300 HCPCS units (1 mg per unit)
Ocrevus	ocrelizumab	600 mg	J2350	600 HCPCS units (1 mg per unit)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Omvoh	mirikizumab-mrkz	300 mg	J2267	300 HCPCS units (1 mg per unit)
Opdivo	nivolumab	480 mg	J9299	480 HCPCS units (1 mg per unit)
Orencia	abatacept	1,000 mg	J0129	100 HCPCs units (10 mg per unit)
Reclast	zoledronic acid	5 mg	J3489	5 HCPCS units (1 mg per unit)
Zoledronic Acid	zoledronic acid	5 mg	J3489	5 HCPCS units (1 mg per unit)
Avsola	infliximab-axxq	10 mg/kg	Q5121	150 HCPCS units (10 mg per unit)
Inflectra	infliximab-dyyb	10 mg/kg	Q5103	150 HCPCS units (10 mg per unit)
Remicade	infliximab	10 mg/kg	J1745	150 HCPCS units (10 mg per unit)
Renflexis	infliximab-abda	10 mg/kg	Q5104	150 HCPCS units (10 mg per unit)
Onpattro	patisiran	30 mg	J0222	300 HCPCS units (0.1 mg per unit)
Amvuttra	vutrisiran	25 mg	J0225	25 HCPCS units (1 mg per unit)
Prolia	denosumab	60 mg	J0897	60 HCPCS units (1 mg per unit)
Xgeva	denosumab	120 mg	J0897	120 HCPCS units (1 mg per unit)
Qalsody	tofersen	100 mg	J1304	100 HCPCS units (1 mg per unit)
Radicava	edaravone	60 mg	J1301	60 HCPCS units (1 mg per unit)
Rituxan	rituximab	500 mg/m2	J9312	150 HCPCS units (10 mg per unit)
Ruxience	rituximab-pvvr	500 mg/m2	Q5119	150 HCPCS units (10 mg per unit)
Truxima	rituximab-abbs	500 mg/m2	Q5115	150 HCPCS units (10 mg per unit)
Riabni	rituximab-arrx	500 mg/m2	Q5123	150 HCPCS units (10 mg per unit)
Rituxan Hycela	rituximab and hyaluronidase	1,600 mg	J9311	160 HCPCs units (10 mg per unit)
Rystiggo	rozanolixizumab-noli	840 mg	J9333	840 HCPCs units (1 mg per unit)
Simponi Aria	golimumab	2 mg/kg	J1602	300 HCPCs units (1 mg per unit)
Soliris	eculizumab	1,200 mg	J1300	120 HCPCS units (10 mg per unit)
Spevigo	spesolimab-sbzo	900 mg	J1747	900 HCPCS units (1 mg per unit)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Stelara	ustekinumab	90 mg	J3357	90 HCPCS units (1 mg per unit)
		520 mg	J3358	520 HCPCS units (1 mg per unit)
Testopel	testosterone pellet	450 mg	S0189	6 HCPCS units (75 mg per unit)
Tezspire	tezepelumab-ekko	210 mg	J2356	210 HCPCS units (1 mg per unit)
Ultomiris	ravulizumab-cwvz	3,600 mg	J1303	360 HCPCS units (10 mg per unit)
Vyepti	eptinezumab-jjmr	300 mg	J3032	300 HCPCS units (1 mg per unit)
Vyvgart	efgartigimod alfa-fcab	1,200 mg	J9332	600 HCPCS units (2 mg per unit)
Vyvgart Hytrulo	efgartigimod alfa, hyaluronidase-qvfc	1,008 mg/11,200 units (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase)	J9334	504 HCPCS units (2 mg per unit)
Xeomin	incobotulinumtoxinA	600 units	J0588	600 HCPCS units 1 unit per HCPCS unit
Xolair	omalizumab	600 mg	J2357	120 HCPCS units (5 mg per unit)
Bavencio	avelumab	800 mg	J9023	80 HCPCS units (10 mg per unit)
Imfinzi	durvalumab	1,500 mg	J9173	150 HCPCS units (10 mg per unit)
Keytruda	pembrolizumab	400 mg	J9271	400 HCPCS units (1 mg per unit)
Libtayo	cemiplimab-rwlc	350 mg	J9119	350 HCPCS units (1 mg per unit)
Tecentriq	atezolizumab	1,680 mg	J9022	168 HCPCS units (10 mg per unit)
Yervoy	ipilimumab	10 mg/kg	J9228	1400 HCPCS units (1 mg per unit)
Skyrizi	risankizumab-rzaa	~~600~~ 1200 mg	J2327	126~~0~~0 HCPCS units (1 mg per unit)

Maximum Allowed Quantities for National Drug Code (NDC) Billing

The allowed quantities in this section are calculated based upon both the maximum dosage information supplied within this policy as well as the process by which NDC claims are billed. This list may not be inclusive of all available NDCs for each drug product and is subject to change. Absence of a specific NDC does not mean that it is not subject to the following maximum allowed.

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Actemra	tocilizumab	20 mg/mL vials	50242-0135-01 50242-0136-01 50242-0137-01	40 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Avastin	bevacizumab	100 mg/4 mL vials	50242-0060-01 50242-0060-10	12 mL
		400 mg/16 mL vials	50242-0061-01 50242-0061-10	96 mL
Vegzelma	bevacizumab-adcd	100 mg/4 mL vials	32228-0011-01 32228-0011-02	12 mL
		400 mg/16 mL vials	32228-0011-03 32228-0011-04	96 mL
Mvasi	bevacizumab-awwb	100 mg/4mL vials	55513-0206-01	12 mL
		400 mg/16 mL vials	55513-0207-01	96 mL
Zirabev	bevacizumab-bvzr	100 mg/4mL vials	00069-0315-01	12 mL
		400 mg/16 mL vials	00069-0342-01	96 mL
Alymsys	bevacizumab-maly	100 mg/4 mL vials	70121-1754-01 70121-1754-07	12 mL
		400 mg/16 mL vials	70121-1755-01 70121-1755-07	96 mL
Aveed	testosterone undecanoate	750 mg/3 mL	67979-0511-43	3 mL
Botox	onabotulinumtoxinA	100 unit vials	00023-1145-01	6 vials
		200 unit vials	00023-3921-02	3 vials
Cimzia	certolizumab pegol	2 x 200mg kit	50474-0700-62	2 vials
		2 x 200 mg/ml prefilled syringe (PFS) kit	50474-0710-79	2 mL
		6 x 200 mg/ml PFS kit	50474-0710-81	2 mL
Cinqair	reslizumab	100 mg/10 mL vials	59310-0610-31	50 mL
Daxxify	daxibotulinumtoxina-lanm	50 unit vials	72960-111-01	5 vials
		100 unit vials	72960-112-01	3 vials
N/A	testosterone enanthate	200 mg/mL	00143-9750-01 00574-0821-05 00591-3221-26	2 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Depo-Testosterone	testosterone cypionate	200 mg/mL	00009-0085-10 00009-0086-01 00009-0086-10 00009-0347-02 00009-0417-01 00009-0417-02 00009-0520-01 00009-0520-10 00143-9659-01 00143-9726-01 00409-6557-01 00409-6562-01 00409-6562-02 00409-6562-20 00409-6562-22 00517-1830-01 00574-0820-01 00574-0820-10 00574-0827-01 00574-0827-10 00591-4128-79 50090-0330-00 52536-0625-01 52536-0625-10 62756-0015-40 62756-0016-40 62756-0017-40 63874-1061-01 64980-0467-99 69097-0536-37 69097-0537-31 69097-0537-37 69097-0802-32 69097-0802-37 76420-0650-01 76519-1210-00	2 mL
Dysport	abobotulinumtoxinA	500 unit vials	15054-0500-01 15054-0500-02	3 vials
		300 unit vials	15054-0530-06	5 vials
Entyvio	vedolizumab	300 mg vial	64764-0300-20	1 vial
Fasenra	benralizumab	30 mg/mL pre-filled pen	00310-1830-30	1 mL
		30 mg/mL PFS	00310-1730-30	1 mL
		10 mg/0.5 mL PFS	00310-1745-01	0.5 mL
Hemlibra	emicizumab-kxwh	30 mg/mL	50242-0920-01	1 mL
		105 mg/0.7 mL	50242-0922-01	0.7 mL
		150 mg/mL	50242-0923-01	6 mL
		60 mg/0.4 mL	50242-0921-01	0.4 mL
Herceptin	trastuzumab	150 mg vial	50242-0132-01 50242-0132-10	8 vials

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Herzuma	trastuzumab-pkrb	420 mg vial	63459-0305-47 63459-0307-41	3 vials
		150 mg vial	63459-0303-43	3 vials
Kanjinti	trastuzumab-anns	420 mg vial	55513-0132-01	3 vials
		150 mg vial	55513-0141-01	3 vials
Ogivri	trastuzumab-dkst	420 mg vial	67457-0847-44 67457-0845-50	3 vials
		150 mg vial	67457-0991-15	3 vials
Omvoh	mirikizumab-mrkz	300 mg/15 mL vial	00002-7575-01	1 vial
Ontruzant	trastuzumab-dttb	150 mg vial	00006-5033-02	3 vials
		420 mg vial	00006-5034-01 00006-5034-02	3 vials
Trazimera	trastuzumab-qyyp	420 mg vial	00069-0305-01 00069-0306-01	3 vials
Ilaris	canakinumab	150 mg/mL vials	00078-0734-61	2 mL
Ilumya	tildrakizumab-asmn	100 mg/mL PFS	47335-0177-95	1 mL
Leqvio	inclisiran	284 mg/1.5 mL PFS	00078-1000-60	1.5 mL
Myobloc	rimabotulinumtoxinB	2,500 Units/0.5 mL vials	10454-0710-10	12 vials
		5,000 Units/mL vials	10454-0711-10	6 vials
		10,000 Units/2 mL vials	10454-0712-10	3 vials
Neulasta	pegfilgrastim	6 mg/0.6 mL PFS	55513-0190-01	0.6 mL
		6 mg/0.6 mL PFS with on-body Injector	55513-0192-01	0.6 mL
Nyvepria	pegfilgrastim-apgf	6 mg/0.6 mL PFS	00069-0324-01	0.6 mL
Fulphila	pegfilgrastim-jmdb	6 mg/0.6 mL PFS	67457-0833-06	0.6 mL
Fylnetra	pegfilgrastim-pbbk	6mg/0.6 mL PFS	70121-1627-01	0.6 mL
Stimufend	pegfilgrastim-fpgk	6mg/0.6 mL PFS	65219-0371-10	0.6 mL
Udenyca	pegfilgrastim-cbqv	6 mg/0.6 mL PFS	70114-0101-01	0.6 mL
Ziextenzo	pegfilgrastim-bmez	6 mg/0.6 mL PFS	61314-0866-01	0.6 mL
Rolvedon	eflapegrastim-xnst	13.2 mg/0.6 mL PFS	76961-0101-01	0.6 mL
Krystexxa	pegloticase	8 mg/mL vials	75987-0080-10	1 mL
Nucala	mepolizumab	100 mg vials	00173-0881-01	3 vials
		40 mg/0.4mL PFS	00173-0904-42	0.4 mL
		100 mg/mL PFS	00173-0892-01	3 mL
		100 mg/mL PFS	00173-0892-42	3 mL
Ocrevus	ocrelizumab	300 mg/10 mL vial	50242-0150-01	20 mL
Opdivo	nivolumab	100 mg/10 mL vials	00003-3774-12	40 mL
		120mg/12 mL vials	00003-3756-14	48 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
		240 mg/24 mL vials	00003-3734-13	48 mL
		40 mg/4 mL vials	00003-3772-11	8 mL
Onpattro	patisiran	10 mg/5 mL vials	71336-1000-01	15 mL
Amvuttra	vutrisiran	25 mg/0.5 mL PFS	71336-1003-01	0.5 mL
Orencia	abatacept	250 mg vials	00003-2187-10 00003-2187-13	4 vials
Remicade	infliximab	100 mg vials	57894-0030-01	14 vials
Avsola	infliximab-axxq	100 mg vials	55513-0670-01	14 vials
Renflexis	infliximab-abda	100 mg vials	00006-4305-01 00006-4305-02	14 vials
Inflectra	infliximab-dyyb	100 mg vials	00069-0809-01	14 vials
Rituxan	rituximab	100 mg/10 mL vials	50242-0051-10 50242-0051-21	40 mL
		500 mg/50 mL vials	50242-0053-06	150 mL
Ruxience	rituximab-pvvr	100 mg/10 mL vials	00069-0238-01	40 mL
		500 mg/50 mL vials	00069-0249-01	150 mL
Truxima	rituximab-abbs	100 mg/10 mL vials	63459-0103-10	40 mL
		500 mg/50 mL vials	63459-0104-50	150 mL
Riabni	rituximab-arrx	100 mg/10 mL vials	55513-0224-01	40 mL
		500 mg/50 mL vials	55513-0326-01	150 mL
Rituxan Hycela	rituximab and hyaluronidase	1,400-23, 400 mg/11.7 mL	50242-0108-01	1 vial
		1,600-26, 800 mg/13.4 mL	50242-0109-01	1 vial
Rystiggo	rozanolixizu-mab-noli	280 mg/2 mL vials	50474-0980-79	6 mL
		420 mg/3 mL vials	50474-0981-83	3 mL
		560 mg/4 mL vials	50474-0982-84	4 mL
		840 mg/6 mL vials	50474-0983-86	6 mL
Simponi Aria	golimumab	50 mg/4 mL	57894-0350-01	24 mL
Soliris	eculizumab	300 mg/30 mL vials	25682-0001-01	120 mL
Spevigo	spesolimab-sbzo	450 mg/7.5 mL vials	00597-0035-10	15 mL
		150 mg/mL PFS	00597-0620-20	2 mL
Stelara	ustekinumab	45 mg/0.5 mL PFS	57894-0060-03	0.5 mL
		45 mg/0.5 mL vials	57894-0060-02	0.5 mL
		90 mg/1 mL PFS	57894-0061-03	1 mL
		130 mg/26 mL vials	57894-0054-27	104 mL
Testopel	testosterone pellet	75 mg pellet	66887-0004-01 66887-0004-10 66887-0004-20	6 pellets
Tezspire	tezepelumab-ekko	210 mg/1.91 mL pre-filled pen	55513-0123-01	1.91 mL
		210 mg/1.91 mL PFS	55513-0112-01	1.91 mL
Ultomiris	ravulizumab-cwvz	300 mg/3 mL vials	25682-0025-01	9 mL
		1,100 mg/11 mL vials	25682-0028-01	44 mL
Vyepti	eptinezumab-jjmr	100 mg/mL vials	67386-0130-51	3 mL
Vyvgart	efgartigimod alfa-fcab	400 mg/20 mL vials	73475-3041-05	60 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Vyvgart Hytrulo	efgartigimod alfa and hyaluronidase-qvfc	1,008 mg, 11,200 units hyaluronidase / 5.6 mL	73475-3102-03	5.6 mL
Xolair	omalizumab	150 mg vials	50242-0040-62	4 vials
		150 mg/mL PFS	50242-0215-01	4 mL
		75 mg/0.5 mL PFS	50242-0214-01	0.5 mL
		75 mg/0.5 mL PFS	50242-0214-03	0.5 mL
		150 mg/mL PFS	50242-0215-03	4 mL
		300 mg/2 mL PFS	50242-0227-01	4 mL
		75 mg/0.5 mL autoinjector	50242-0214-55	0.5 mL
		150 mg/mL autoinjector	50242-0215-55	4 mL
		300 mg/2 mL autoinjector	50242-0227-55	4 mL
Prolia	denosumab	60 mg/1 mL PFS	55513-0710-01	1 mL
Xgeva	denosumab	120 mg/1.7 mL vials	55513-0730-01	1.7 mL
Qalsody	tofersen	100 mg/15 mL vials	64406-0109-01	15 mL
Radicava	edaravone	30 mg/100 mL bags	70510-2171-01 70510-2171-02	200 mL
Reclast	zoledronic acid	4 mg/5 mL vials	00409-4215-01 00409-4215-05 16714-0815-01 16729-0242-31 23155-0170-31 25021-0801-66 43598-0330-11 51991-0065-98 54288-0100-01 55111-0685-07 55150-0266-05 63323-0961-98 67457-0390-54 68001-0366-22 68001-0366-25	5 mL
		4 mg/100 mL vials	70860-0210-51	100 mL
		4 mg/100 mL infusion	00409-4229-01 23155-0186-31 25021-0826-67 25021-0826-82	100 mL
		5 mg/100 mL vials	00078-0435-61 25021-0830-82 43598-0331-11 51991-0064-98 55111-0688-52 63323-0966-00 67457-0619-10	100 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
		5 mg/100 mL infusion	00409-4228-01 25021-0830-82 67457-0794-10 70860-0802-82	100 mL
Bavencio	avelumab	200 mg/10mL vials	44087-3535-01	40 mL
Imfinzi	durvalumab	120 mg/2.4 mL vials	00310-4500-12	9.6 mL
		500 mg/10 mL vials	00310-4611-50	30 mL
Keytruda	pembrolizumab	50 mg vials	00006-3029-01 00006-3029-02	8 vials
		100 mg/4 mL vials	00006-3026-01 00006-3026-02 00006-3026-04	16 mL
Libtayo	cemiplimab-rwlc	350 mg/7 mL vials	61755-0008-01	7 mL
Tecentriq	atezolizumab	840 mg/14 mL vials	50242-0918-01	28 mL
		1200 mg/20 mL vials	50242-0917-01	40 mL
Yervoy	ipilimumab	50 mg/10 mL vials	00003-2327-11	30 mL
		200 mg/40 mL vials	00003-2328-22	280 mL
Skyrizi	risankizumab	600 mg/10 mL vials	00074-5015-01	10 mL
Xeomin	incobotulinumtoxinA	50 unit vials	00259-1605-01	12 vials
		100 unit vials	00259-1610-01	6 vials
		200 unit vials	00259-1620-01	3 vials

Maximum Allowed Frequencies

The allowed frequencies in this section are based upon the FDA approved prescribing information for the applicable medications. For indications covered by UnitedHealthcare without FDA approved dosing, the frequencies are derived from available clinical evidence. This list may not be inclusive of all medications listed and is subject to change.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Actemra	tocilizumab	Giant cell arteritis, PJIA, rheumatoid arthritis	Administered once every 4 weeks.
		SJIA	Administered once every 2 weeks.
		Cytokine release syndrome, chimeric antigen receptor T-cell induced, severe or life threatening disease	Administer once, then if no improvement in signs and symptoms, may give up to 3 additional doses at least 8 hours apart.
Alymsys	bevacizumab-maly	Oncology	Administered once every 2 weeks.
Amvuttra	vutrisiran	Polyneuropathy from hATTR amyloidosis	Administered once every 3 months.
Avastin	bevacizumab	Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome	The recommended dose is 1.25 mg (0.05 mL) near-monthly into affected eyes during the first 12 months, with fewer injections needed in subsequent years. Maximum of 12 doses per year per eye.
		Diabetic macular edema	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Avastin	bevacizumab	Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)	
		Neovascular age-related macular degeneration	
		Neovascular glaucoma	
		Neovascularization of the iris (rubeosis iridis)	
		Proliferative diabetic retinopathy	
		Type I retinopathy of prematurity	
		Oncology	Administered once every 2 weeks.
Aveed	testosterone undecanoate		The recommended dose is 750 mg initially, followed by 750 mg after 4 weeks, then 750 mg every 10 weeks thereafter.
Bavencio	avelumab	Oncology	Administered once every 2 weeks.
Beovu	brolucizumab	Neovascular age-related macular degeneration	The recommended dose is 6 mg (0.05 mL) into affected eye(s) once monthly (approximately every 25 to 31 days) for the first 3 doses, then 6 mg every 8 to 12 weeks thereafter. Maximum of 12 doses per year per eye.
		Diabetic macular edema	The recommended dose is 6 mg (0.05 mL) into affected eye(s) every six weeks (approximately every 39 to 45 days) for the first 5 doses, then 6 mg every 8 to 12 weeks thereafter. Maximum of 12 doses per year per eye.
Botox	onabotulinumtoxinA		Administered no more frequent than every 12 weeks.
Byooviz	ranibizumab-nuna	Neovascular age-related macular degeneration	The recommended dose is 0.5 mg (0.05 ML) administered by intravitreal injection once a month (approximately 28 days). Patients may be treated with 3 monthly doses followed by less frequent dosing. Patients may also be treated with one dose every 3 months after 4 monthly doses. Maximum of 12 doses per year per eye.
		Macular edema following retinal vein occlusion (RVO)	The recommended dose is 0.5 mg (0.05 ML) administered by intravitreal injection once a month (approximately 28 days). Maximum of 12 doses per year per eye.
		Myopic choroidal neovascularization (mCNV)	The recommended dose is 0.5 mg (0.05 ML) administered by intravitreal injection once a month (approximately 28 days) for up to 3 months. Patients may be retreated if needed. Maximum of 12 doses per year per eye.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Cimerli	ranibizumab- eqrn	Myopic choroidal neovascularization (mCNV)	The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days) for up to 3 months. May be retreated if necessary. Maximum of 12 doses per year per eye.
		Diabetic macular edema (DME)	The recommended dose is 0.3 mg to affected eye(s) once a month (approximately every 28 days). Maximum of 12 doses per year per eye.
		Diabetic retinopathy (DR)	
		Macular edema following retinal vein occlusion (RVO)	The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days). Maximum of 12 doses per year per eye.
		Neovascular (wet) age-related macular degeneration (AMD)	The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days). Treatment may be reduced to 3 once monthly doses, followed by an average of 4 to 5 injections over the subsequent 9 months. Maximum of 12 doses per year per eye.
Cimzia	certolizumab pegol	Crohn's disease	Administered initially, and at weeks 2, 4, then every 4 weeks thereafter.
		Ankylosing spondylitis, axial spondyloarthritis, plaque psoriasis (BW ≤ 90 kg), psoriatic arthritis, rheumatoid arthritis	Administered initially, and at weeks 2, 4, then every other week or every 4 weeks thereafter.
		Plaque psoriasis (BW > 90kg)	Administered every other week.
Cinqair	reslizumab	Asthma	Administered once every 4 weeks.
Daxxify	daxibotulinumtoxinA-lanm		Administered no more frequent than every 12 weeks.
N/A	testosterone enanthate		For replacement therapy, the suggested dosage is 50 mg to 400 mg every 2 to 4 weeks, not to exceed 400 mg per 14 days.
Depo-testosterone	testosterone cypionate		For replacement in the hypogonadal male, the suggested dosage is 50 mg to 400 mg every 2 to 4 weeks, not to exceed 400 mg per 14 days.
Dysport	abobotulinumtoxinA		Administered no more frequent than every 12 weeks.
Entyvio	vedolizumab	Crohn's disease, ulcerative colitis	Administered at 0, 2, and 6 weeks, then every 8 weeks thereafter.
Eylea	aflibercept	Diabetic macular edema	The recommended dose is 2 mg (0.05 mL) into affected eye(s) every 4 weeks (approximately every 28 days, monthly) for the first 20 weeks (5 months), then 2 mg every 8 weeks (2 months). Maximum of 12 doses per year per eye.
		Diabetic retinopathy	
		Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)	The recommended dose is 2 mg (0.05 mL) once every 4 weeks. Maximum of 12 doses per year per eye.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		Neovascular age-related macular degeneration	The recommended dose is 2 mg (0.05 mL) into affected eye(s) every 4 weeks (approximately every 28 days, monthly) for the first 12 weeks (3 months), followed by 2 mg once every 8 weeks (2 months). Maximum of 12 doses per year per eye.
Fasenra	benralizumab	Asthma	Administered once every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter.
Fulphila	pegfilgrastim-jmdb	Oncology	Administered once every 2 weeks.
Fylnetra	pegfilgrastim-pbbk	Oncology	Administered once every 2 weeks.
Hemlibra	emicizumab-kxwh	Hemophilia A	3 mg/kg once weekly for the first 4 weeks, followed by maintenance dose of: • 1.5 mg/kg once every week; or • 3 mg/kg once every 2 weeks; or • 6 mg/kg once every 4 weeks
Herceptin	trastuzumab	Oncology	Administered once every week.
Herzuma	trastuzumab-pkrb	Oncology	Administered once every week.
Ilaris	canakinumab	Cryopyrin-associated periodic syndromes (CAPS)	Administered once every 8 weeks.
		Tumor necrosis factor receptor associated periodic syndrome (TRAPS), hyperimmunoglobulin D syndrome/mevalonate kinase deficiency (HIDS/MKD), familial Mediterranean fever (FMF), Still's disease	Administered once every 4 weeks.
		Gout flares	Administered once every 12 weeks.
Ilumya	tildrakizumab-asmn	Plaque psoriasis	Administered at weeks 0, 4, and every 12 weeks thereafter.
Imfinzi	durvalumab	Oncology	Administered once every 2 weeks.
Remicade Avsola Inflectra Renflexis	infliximab infliximab-axxq infliximab-dyyb infliximab-abda	Ankylosing spondylitis	Administered at 0, 2, and 6 weeks, then every 6 weeks thereafter.
		Crohn's disease, noninfectious uveitis, plaque psoriasis, psoriatic arthritis, ulcerative colitis	Administered at 0, 2, and 6 weeks, then every 8 weeks thereafter.
		Sarcoidosis	Administered at week 0 and 2, then once every 4 to 6 weeks thereafter.
		Rheumatoid arthritis	Administered at 0, 2, and 6 weeks, then every 8 weeks thereafter; maintenance treatment may be increased to as often as every 4 weeks.
Kanjinti	trastuzumab-anns	Oncology	Administered once every week.
Keytruda	pembrolizumab	Oncology	Administered once every 3 weeks.
Krystexxa	pegloticase	Chronic gout	Administered once every 2 weeks.
Leqvio	inclisiran	Hyperlipidemia	Administered initially and 3 months later, then every 6 months thereafter.
Libtayo	cemiplimab-rwlc	Oncology	Administered once every 3 weeks.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Lucentis	ranibizumab	Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome	The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days) for up to 3 months. May be retreated if necessary. Maximum of 12 doses per year per eye.
		Diabetic macular edema	The recommended dose is 0.3 mg to affected eye(s) once a month (approximately every 28 days). Maximum of 12 doses per year per eye.
		Diabetic retinopathy	
Lucentis	ranibizumab	Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)	The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days). Maximum of 12 doses per year per eye.
		Neovascular age-related macular degeneration	The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days). Treatment may be reduced to 3 once monthly doses, followed by an average of 4 to 5 injections over the subsequent 9 months. Maximum of 12 doses per year per eye.
Mvasi	bevacizumab-awwb	Oncology	Administered once every 2 weeks.
Myobloc	rimabotulinumtoxinB		Administered no more frequent than every 12 weeks.
Neulasta	pegfilgrastim	Oncology	Administered once every 2 weeks.
Nucala	mepolizumab	Asthma	Administered once every 4 weeks.
Nyvepria	pegfilgrastim-apgf	Oncology	Administered once every 2 weeks.
Ocrevus	ocrelizumab	Multiple sclerosis (MS)	Administered intravenously initially and 2 weeks later, then every 6 months thereafter.
Ogivri	trastuzumab-dkst	Oncology	Administered once every week.
Omvoh	mirikizumab-mrkz	Ulcerative colitis	Administered intravenously initially at Week 0, Week 4, and Week 8, then administered subcutaneously at Week 12 and every 4 weeks thereafter.
Onpattro	patisiran	Polyneuropathy from hATTR amyloidosis	Administered once every 3 weeks.
Ontruzant	trastuzumab-dttb	Oncology	Administered once every week.
Orencia	Abatacept	JIA, psoriatic arthritis, rheumatoid arthritis	Administered intravenously at 0, 2, and 4 weeks, then once every 4 weeks thereafter. Administered subcutaneously once weekly.
Orencia	abatacept	Graft-versus-host disease (GVHD) prophylaxis	Administered on day before transplantation, followed by a dose on day 5, 14, and 28 after transplant.
Prolia	denosumab	Osteoporosis	Administered once every 6 months.
Qalsody	tofersen	Amyotrophic lateral sclerosis	Administered every 14 days for 3 doses, followed by 100 mg every 28 days.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Radicava	edaravone	Amyotrophic lateral sclerosis	Initial treatment cycle administered with daily dosing for 14 days, followed by a 14-day drug-free period. Subsequent treatment cycles administered with daily dosing for 10 days out of 14-day periods, followed by 14-day drug-free periods.
Rolvedon	eflapegrastim-xnst	Oncology	Administered once every 2 weeks.
Rystiggo	rozanolixizumab-noli	Myasthenia gravis	Administered once every week for 6 weeks. Subsequent treatment cycles administered based on clinical evaluation.
Simponi Aria	golimumab	Ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis, rheumatoid arthritis	Administered at 0, 4, then every 8 weeks thereafter.
Skyrizi	risankizumab-rzaa	Crohn's disease, ulcerative colitis	Administered intravenously (IV) initially at week 0, week 4, and week 8, then administered subcutaneously at week 12, and once every 8 weeks thereafter.
Soliris	eculizumab	aHUS, MG, NMOSD, PNH	Administered once weekly for 5 doses, then every 2 weeks thereafter.
Spevigo (IV)	spesolimab-sbzo (IV)	Generalized pustular psoriasis	Administered intravenously as a single 900 mg dose. If flare symptoms persist, may administer an additional intravenous 900 mg dose one week after the initial dose.
Spevigo (SC)	spesolimab-sbzo (SC)	Generalized pustular psoriasis	Administered subcutaneously as a loading dose of 600 mg (four 150 mg injections), followed by 300 mg (two 150 mg injections) subcutaneously 4 weeks later and every 4 weeks thereafter. 4 weeks after treatment with intravenous Spevigo for generalized pustular psoriasis flare, subcutaneous Spevigo is initiated or reinitiated at a dose of 300 mg (two 150 mg injections) administered every 4 weeks. A loading dose is not required following treatment of a generalized pustular psoriasis flare with intravenous Spevigo.
Stelara	ustekinumab	Psoriasis, psoriatic arthritis	Administered subcutaneously - initially and 4 weeks later, then every 12 weeks thereafter.
Stelara	ustekinumab	Crohn's disease, ulcerative colitis	Administered intravenously (IV) initially one time, then subcutaneously 8 weeks after the initial IV dose, then once every 8 weeks thereafter.
Stimufend	pegfilgrastim-fpgk	Oncology	Administered once every 2 weeks.
Syfovre	pegcetacoplan	Geographic atrophy (GA) secondary to age-related macular degeneration (AMD)	The recommended dose is 15 mg administered to each affected eye once every 25 to 60 days.
Tecentriq	atezolizumab	Oncology	Administered once every 2 weeks.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Testopel	testosterone pellet		The dosage guideline for the testosterone pellets for replacement therapy in androgen-deficient males is 150 mg to 450 mg subcutaneously every 3 to 6 months. The usual dosage is as follows: implant two 75 mg pellets for each 25 mg testosterone propionate required weekly. Thus, when a patient requires injections of 75 mg per week, it is usually necessary to implant 450 mg (6 pellets). With injections of 50mg per week, implantation of 300 mg (4 pellets) may suffice for approximately three months.
Tezspire	tezepelumab-ekko	Asthma	Administered once every 4 weeks.
Trazimera	trastuzumab-qyyp	Oncology	Administered once every week.
Udenyca	pegfilgrastim-cbqv	Oncology	Administered once every 2 weeks.
Ultomiris	ravulizumab-cwvz	aHUS, PNH	Administered initially, week 2, then once every 4 or 8 weeks thereafter, depending on body weight.
		MG, NMOSD	Administered initially, week 2, then once every 8 weeks thereafter.
Vabysmo	faricimab	Neovascular age-related macular degeneration	The recommended dose is 6 mg by intravitreal injection every 4 weeks for the first 4 doses, followed by one of the following three regimens: 1) weeks 28 and 44; 2) weeks 24, 36, and 48; or 3) weeks 20, 28, 36 and 44. Although most patients require dosing every 8 weeks, some patients may need dosing every 4 weeks. Maximum of 12 doses per year per eye.
		Diabetic macular edema	The recommended dose is one of the following regimens: 1) 6 mg administered by intravitreal injection every 4 weeks for at least 4 doses, followed by extensions of up to 4 week interval increments or reductions of up to 8 week interval increments based on response; or 2) 6 mg administered every 4 weeks for the first 6 doses, followed by 6 mg dose via intravitreal injections at intervals of every 8 weeks over the next 28 weeks. Although most patients require dosing every 8 weeks, some patients may need dosing every 4 weeks. Maximum of 12 doses per year per eye.
Vegzelma	bevacizumab-adcd	Oncology	Administered once every 2 weeks.
Vyepti	eptinezumab-jjmr	Migraine	Administered once every 3 months.
Vyvgart	efgartigimod alfa-fcab	Myasthenia gravis	Administered once every week for 4 weeks. Subsequent treatment cycles administered based on clinical evaluation.
Vyvgart Hytrulo	efgartigimod alfa and hyaluronidase-qvfc	Myasthenia gravis	Administered once every week for 4 weeks. Subsequent treatment cycles administered based on clinical evaluation.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		Chronic inflammatory demyelinating polyneuropathy (CIDP)	Administered once weekly.
Xeomin	incobotulinumtoxinA		Administered no more frequent than every 12 weeks.
Xgeva	denosumab	Oncology	Administered once every 4 weeks.
		Hypercalcemia of malignancy	Administered every 4 weeks with additional doses on days 8 and 15 of the first month of therapy.
Xolair	omalizumab	Asthma	Administered once every 2 or 4 weeks, depending on body weight and serum total IgE levels.
		Chronic urticaria	Administered once every 4 weeks.
		Nasal polyps	Administered once every 2 or 4 weeks, depending on body weight and IgE levels.
		IgE-mediated food allergy	Administered once every 2 or 4 weeks, depending on body weight and serum total IgE levels.
Yervoy	ipilimumab	Oncology	Administered once every 3 weeks.
Ziextenzo	pegfilgrastim-bmez	Oncology	Administered once every 2 weeks.
Zirabev	bevacizumab-bvzr	Oncology	Administered once every 2 weeks.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
C9151	Injection, pegcetacoplan, 1 mg
J0129	Injection, abatacept, 10 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug self-administered
J0222	Injection, patisiran, 0.1 mg
J0225	Injection, vutrisiran, 1 mg
J0517	Injection, benralizumab, 1 mg
J0585	Injection, onabotulinumtoxinA, 1 unit
J0586	Injection, abobotulinumtoxinA, 5 units
J0587	Injection, rimabotulinumtoxinB, 100 units
J0588	Injection, incobotulinumtoxinA, 1 unit
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit
J0638	Injection, canakinumab, 1 mg
J0717	Injection, certolizumab pegol, 1 mg (Code may be used when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J0897	Injection, denosumab, 1 mg
J1071	Injection, testosterone cypionate, 1 mg
J1300	Injection, eculizumab, 10 mg

HCPCS Code	Description
J1301	Injection, edaravone, 1 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
J1304	Injection, tofersen, 1 mg
J1306	Injection, inclisiran, 1 mg
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J1602	Injection, golimumab, 1 mg, for intravenous use
J1745	Injection, infliximab, excludes biosimilar, 10 mg
J1747	Injection, spesolimab-sbzo, 1 mg
J2182	Injection, mepolizumab, 1 mg
J2267	Injection, mirikizumab-mrkz, 1 mg
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg
J2350	Injection, ocrelizumab, 1 mg
J2356	Injection, tezepelumab-ekko, 1 mg
J2357	Injection, omalizumab, 5 mg
J2506	Injection, pegfilgrastim, 0.5 mg
J2507	Injection, pegloticase, 1 mg
J2786	Injection, reslizumab, 1 mg
J3032	Injection, eptinezumab-jjmr, 1 mg
J3121	Injection, testosterone enanthate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg
J3245	Injection, tildrakizumab, 1 mg
J3262	Injection, tocilizumab, 1 mg
J3357	Ustekinumab, for subcutaneous injection, 1mg
J3358	Ustekinumab, for intravenous injection, 1 mg
J3380	Injection, vedolizumab, intravenous, 1 mg
J3489	Injection, zoledronic acid, 1 mg
J7170	Injection, emicizumab-kxwh, 0.5 mg
J9022	Injection, atezolizumab, 10 mg
J9023	Injection, avelumab, 10 mg
J9035	Injection, bevacizumab, 10 mg
J9119	Injection, cemiplimab-rwlc, 1 mg
J9173	Injection, durvalumab, 10 mg
J9228	Injection, ipilimumab, 1 mg
J9271	Injection, pembrolizumab, 1 mg
J9299	Injection, nivolumab, 1 mg
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg
J9332	Injection, efgartigimod alfa-fcab, 2 mg
J9333	Injection, rozanolixizumab-noli, 1 mg
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg

HCPCS Code	Description
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (Fulphila), 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv, biosimilar, (Udenyca), 0.5 mg
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (Nyvepria), 0.5 mg
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg
Q5114	Injection, trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar, (Ruxience), 10 mg
Q5120	Injection, pegfilgrastim-bmez, biosimilar, (Ziextenzo), 0.5 mg
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg
Q5123	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg
Q5126	Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg
S0189	Testosterone pellet, 75 mg

National Drug Code	Description
50242-0135-01	Actemra 20 mg/mL vial
50242-0136-01	Actemra 200 mg/10 mL vial
50242-0137-01	Actemra 400 mg/20 mL vial
70121-1754-01	Alymsys 100 mg/4 mL vial
70121-1754-07	Alymsys 100 mg/4 mL vial
70121-1755-01	Alymsys 400 mg/16 mL vial
70121-1755-07	Alymsys 400 mg/16 mL vial
71336-1003-01	Amvuttra 25 mg/0.5 mL PFS
50242-0060-01 50242-0060-10	Avastin 100 mg/4 mL vial
50242-0061-01 50242-0061-10	Avastin 400 mg/16 mL vial
67979-0511-43	Aveed 750 mg/3 mL vial
55513-0670-01	Avsola 100 mg vial
44087-3535-01	Bavencio 200 mg/10 mL vial
00023-1145-01	Botox 100 units vial
00023-3921-02	Botox 200 units vial
50474-0700-62	Cimzia 2 x 200 mg kit
50474-0710-79	Cimzia 2 x 200 mg/ml prefilled syringe (PFS) kit
50474-0710-81	Cimzia 6 x 200 mg/ml PFS kit
59310-0610-31	Cinqair 100 mg/10 mL vial
72960-0111-01	Daxxify 50 unit vial
72960-0112-01	Daxxify 100 unit vial

National Drug Code	Description
00574-0821-05 00143-9750-01 00591-3221-26	Testosterone enanthate 200 mg/mL vial
00517-1830-01 52536-0625-10 52536-0625-01 64980-0467-99 69097-0802-32 69097-0802-37 00574-0827-01 76519-1210-00 00009-0086-01 00009-0417-01 00009-0520-01 69097-0536-37 69097-0537-31 69097-0537-37 50090-0330-00 00409-6562-02 00409-6562-22 00143-9659-01 62756-0017-40 62756-0016-40 00409-6557-01 00409-6562-01 00409-6562-20 76420-0650-01 00591-4128-79 00009-0085-10 00009-0086-10 00574-0827-10 00009-0520-10 00009-0347-02 62756-0015-40 00143-9726-01 00009-0417-02 63874-1061-01 00574-0820-01 00574-0820-10	Depo-Testosterone (testosterone cypionate) 200 mg/mL vial
15054-0500-01 15054-0500-02	Dysport 500 units vial
15054-0530-06	Dysport 300 units vial
64764-0300-20	Entyvio 300 mg vial
00310-1830-30	Fasenra 30 mg/mL pre-filled pen
00310-1730-30	Fasenra 30 mg/mL PFS
00310-1745-01	Fasenra 10 mg/ 0.5 mL PFS
67457-0833-06	Fulphila 6 mg/0.6 mL PFS
70121-1627-01	Fylnetra 6 mg/0.6 mL PFS
50242-0922-01	Hemlibra 105 mg/0.7 L

National Drug Code	Description
50242-0923-01	Hemlibra 150 mg/mL
50242-0920-01	Hemlibra 30 mg/mL
50242-0921-01	Hemlibra 60 mg/0.4 mL
50242-0132-01 50242-0132-10	Herceptin 150 mg vial
63459-0303-43	Herzuma 150 mg vial
63459-0305-47	Herzuma 420 mg vial
00078-0734-61	Ilaris 150mg/mL vial
47335-0177-95	Ilumya 100mg/mL PFS
00310-4500-12	Imfinzi 120 mg/2.4 mL vial
00310-4611-50	Imfinzi 500 mg/10 mL vial
00069-0809-01	Inflectra 100 mg vial
55513-0141-01	Kanjinti 150 mg vial
55513-0132-01	Kanjinti 420 mg vial
00006-3029-01 00006-3029-02	Keytruda 50 mg vial
00006-3026-01 00006-3026-02 00006-3026-04	Keytruda 100 mg/4 mL vial
75987-0080-10	Krystexxa 8 mg/mL vial
00078-1000-60	Leqvio 284 mg/1.5 mL PFS
61755-0008-01	Libtayo 350 mg/7 mL vial
55513-0206-01	Mvasi 100 mg/4 mL vial
55513-0207-01	Mvasi 400 mg/16 mL vial
10454-0710-10	Myobloc 2,500 units/0.5 mL vial
10454-0711-10	Myobloc 5,000 units/mL vial
10454-0712-10	Myobloc 10,000 units/2 mL vial
55513-0190-01	Neulasta 6 mg/0.6 mL PFS
55513-0192-01	Neulasta 6 mg/0.6 mL PFS with on-body injector
00173-0881-01	Nucala 100 mg vials
00173-0904-42	Nucala 40 mg/0.4 mL PFS
00173-0892-01	Nucala 100 mg/mL PFS
00173-0892-42	Nucala 100 mg/mL PFS
00069-0324-01	Nyvepria 6 mg/0.6 mL PFS
50242-0150-01	Ocrevus 300 mg/10 mL vial
67457-0991-15	Ogivri 150 mg vial
67457-0847-44 67457-0845-50	Ogivri 420 mg vial
00002-7575-01	Omvoh 300mg/15mL vial
71336-1000-01	Onpattro 10 mg/5 mL vial
00006-5033-02	Ontruzant 150 mg vial
00003-3774-12	Opdivo 100 mg/10 ml vial
00003-3756-14	Opdivo 120 mg/12 mL vials
00003-3734-13	Opdivo 240 mg/24 ml vial

National Drug Code	Description
00003-3772-11	Opdivo 40 mg/4 mL vial
00003-2187-10 00003-2187-13	Orencia 250 mg vial
55513-0710-01	Prolia 60 mg/1 mL PFS
64406-0109-01	Qalsody 100 mg/15 mL vial
70510-2171-01 70510-2171-02	Radicava 30 mg/100 mL bag
00078-0435-61	Reclast 5 mg/100 mL solution in vial
35356-0351-01	Reclast 5 mg/100 mL solution in vial
57894-0030-01	Remicade 100 mg vial
00006-4305-01 00006-4305-02	Renflexis 100 mg vial
55513-0224-01	Riabni 100 mg/10 mL vial
55513-0326-01	Riabni 500 mg/50 mL vial
50242-0051-10 50242-0051-21	Rituxan 100 mg/10 mL vial
50242-0053-06	Rituxan 500 mg/50 mL vial
50242-0108-01	Rituxan Hycela 1,400-23, 400 mg/11.7 mL vial
50242-0109-01	Rituxan Hycela 1,600-26, 800 mg/13.4 mL vial
76961-0101-01	Rolvedon 13.2 mg/0.6 mL PFS
00069-0238-01	Ruxience 100 mg/10 mL vial
00069-0249-01	Ruxience 500 mg/50 mL vial
50474-0980-79	Rystiggo 280 mg/2 mL vial
50474-0981-83	Rystiggo 420 mg/3 mL vial
50474-0982-84	Rystiggo 560 mg/4 mL vial
50474-0983-86	Rystiggo 840 mg/6 mL vial
57894-0350-01	Simponi Aria 50 mg/4 mL vial
00074-5015-01	Skyrizi 600 mg/10 mL vials
25682-0001-01	Soliris 300 mg/30 mL vial
00597-0035-10	Spevigo 450 mg/7.5 mL vial
00597-0620-20	Spevigo 150 mg/mL PFS
57894-0054-27	Stelara 130 mg/26 mL vial
57894-0060-03	Stelara 45 mg/0.5 mL PFS
57894-0060-02	Stelara 45 mg/0.5 mL vial
57894-0061-03	Stelara 90 mg/1 mL PFS
65219-0371-10	Stimufend 6 mg/0. 6mL PFS
50242-0918-01	Tecentriq 840 mg/14 mL vial
50242-0917-01	Tecentriq 1200 mg/20 mL vial
66887-0004-01 66887-0004-10 66887-0004-20	Testopel 75 mg pellet
55513-0123-01	Tezspire 210 mg/1.91 mL pre-filled pen
55513-0112-01	Tezspire 210 mg/1.91 mL PFS
00069-0305-01 00069-0306-01	Trazimera 420 mg vial

National Drug Code	Description
63459-0103-10	Truxima 100 mg/10 mL vial
63459-0104-50	Truxima 500 mg/50 mL vial
70114-0101-01	Udenyca 6 mg/0.6 mL PFS
25682-0025-01	Ultomiris 300 mg/3 mL vial
25682-0028-01	Ultomiris 1,100 mg/11 mL vial
32228-0011-01 32228-0011-02	Vegzelma 100 mg/4 mL vial
32228-0011-03 32228-0011-04	Vegzelma 400 mg/16 mL vial
67386-0130-51	Vyepti 100 mg/mL vial
73475-3041-05	Vyvgart 400 mg/20 mL vial
73475-3102-03	Vyvgart Hytrulo 1,008 mg, 11,200 units /5.6 mL vial
00259-1605-01	Xeomin 50 units vial
00259-1610-01	Xeomin 100 units vial
00259-1620-01	Xeomin 200 units vial
55513-0730-01	Xgeva 120 mg/1.7 mL vial
50242-0040-62	Xolair 150 mg vial
50242-0214-01	Xolair 75 mg/0.5 mL PFS
50242-0215-01	Xolair 150 mg/mL PFS
50242-0214-03	Xolair 75 mg/0.5 mL PFS
50242-0215-03	Xolair 150 mg/mL PFS
50242-0227-01	Xolair 300 mg/mL PFS
50242-0214-55	Xolair 75 mg/0.5 mL autoinjector
50242-0215-55	Xolair 150 mg/mL autoinjector
50242-0227-55	Xolair 300 mg/mL autoinjector
00003-2327-11	Yervoy 50 mg/10 mL vials
00003-2328-22	Yervoy 200 mg/40 mL vials
61314-0866-01	Ziextenzo 6 mg/0.6 mL PFS
00069-0315-01	Zirabev 100 mg/4 mL vial
00069-0342-01	Zirabev 400 mg/16 mL vial
00409-4229-01 23155-0186-31 25021-0826-67 25021-0826-82	Zoledronic Acid 4 mg/100 mL infusion
70860-0210-51	Zoledronic Acid 4 mg/100 mL vial
00409-4215-01 00409-4215-05 16714-0815-01 16729-0242-31 23155-0170-31 25021-0801-66 43598-0330-11 51991-0065-98 54288-0100-01 55111-0685-07 55150-0266-05	Zoledronic Acid 4 mg/5 mL vial

National Drug Code	Description
63323-0961-98 67457-0390-54 68001-0366-22 68001-0366-25	
00409-4228-01 25021-0830-82 67457-0794-10 70860-0802-82	Zoledronic Acid 5 mg/100 mL infusion
00078-0435-61 25021-0830-82 43598-0331-11 51991-0064-98 55111-0688-52 63323-0966-00 67457-0619-10	Zoledronic Acid 5 mg/100 mL vial

Clinical Evidence

The aforementioned pharmaceuticals all have dosing parameters that support a maximum dosage per body weight or body surface area or a set maximal dosage independent of patient body size. These maximum doses are product-specific, and in some cases, disease state-specific and are defined in the U.S. Food and Drug Administration (FDA) approved product prescribing information and/or in national compendia and other peer reviewed resources. This policy creates an upper dose limit based on the clinical evidence and the 95th percentile for adult body weight (140 kg) and body surface area (2.71 meters^2) in the U.S. (adult male, 30 to 39 years, Fryar, 2021).[59]

Clinical evidence supports the use of the medications listed in this policy up to maximum dosages based upon body surface area or patient weight, when used according to labeled indications or when otherwise supported by published clinical evidence.

Clinical evidence does not support the use of the medications listed in this policy beyond maximum dosages based upon body surface area or patient weight. Use of these agents beyond such established maximum dosages adds significantly to risk of adverse events without conferring additional clinical benefit.

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Policy History/Revision Information

Date	Summary of Changes
TBD	Revised list of applicable drug products; added: abobotulinumtoxinA (Dysport®), daxibotulinumtoxinA-lanm (Daxxify®), incobotulinumtoxinA (Xeomin®), mirikizumab-mrkz (Omvoh®), onabotulinumtoxinA (Botox®), and rimabotulinumtoxinB (Myobloc®). Revised list of applicable drug products; updated: efgartigimod alfa and hyaluronidase-qvfc (Vyvgart® Hytrulo), risankizumab-rzaa (Skyrizi®). Revised list of NDCs with maximum allowed quantities; added: rozanolixizumab-noli (Rystiggo®). Updated References section to reflect the most current information.

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Archived Policy Versions

Effective Date	Policy Number	Policy Title
08/01/2024 – 10/31/2024	CSLA2024D0034AH	Maximum Dosage and Frequency (for Louisiana Only)
06/01/2024 – 07/31/2024	CSLA2024D0034AG	Maximum Dosage and Frequency (for Louisiana Only)
01/01/2024 – 05/31/2024	CSLA2024D0034AF	Maximum Dosage and Frequency (for Louisiana Only)
09/01/2023 – 12/31/2023	CSLA2023D0034AE	Maximum Dosage and Frequency (for Louisiana Only)
06/01/2023 – 08/31/2023	CSLA2023D0034AD	Maximum Dosage (for Louisiana Only)
04/01/2023 – 05/31/2023	CSLA2023D0034AC	Maximum Dosage (for Louisiana Only)
02/01/2023 – 03/31/2023	CSLA2023D0034AB	Maximum Dosage (for Louisiana Only)
03/01/2022 – 01/31/2023	CSLA2022D0034AA	Maximum Dosage (for Louisiana Only)
01/01/2022 – 02/28/2022	CSLA2021D0034Z	Maximum Dosage (for Louisiana Only)
06/01/2021 – 12/31/2021	CSLA2021D0034Y	Maximum Dosage (for Louisiana Only)
12/01/2020 – 05/31/2021	CSLA2020D0034X	Maximum Dosage (for Louisiana Only)
11/01/2020 – 11/30/2020	CSLA2020D0034W	Maximum Dosage (for Louisiana Only)
07/01/2019 – 10/31/2020	CSLA2019D0034V	Maximum Dosage (for Louisiana Only)
05/01/2019 – 06/30/2019	CS2019D0034U	Maximum Dosage
03/01/2019 – 04/30/2019	CS2019D0034T	Maximum Dosage
01/01/2019 – 02/28/2019	CS2019D0034S	Maximum Dosage
10/01/2018 – 12/31/2018	CS2018D0034R	Maximum Dosage
04/01/2018 – 09/30/2018	CS2018D0034Q	Maximum Dosage Policy
01/01/2018 – 03/31/2018	CS2018D0034P	Maximum Dosage Policy
11/01/2017 – 12/31/2017	CS2017D0034O	Maximum Dosage Policy
02/01/2017 – 10/31/2017	CS2017D0034N	Maximum Dosage Policy
01/01/2017 – 01/31/2017	2017D0034M	Maximum Dosage Policy