

Maximum Dosage and Frequency (for Louisiana Only)

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 [Instructions for Use](#)

Table of Contents	Page
Application.....	1
Coverage Rationale.....	1
Applicable Codes.....	14
Clinical Evidence.....	21
References.....	21
Policy History/Revision Information.....	23
Instructions for Use.....	23

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®)
- aflibercept (Eylea®)
- Bevacizumab (Avastin®)
- Bevacizumab-awwb (Mvasi™)
- Bevacizumab-bvzr (Zirabev™)
- brolocizumab-dbl1 (Beovu®)
- Certolizumab pegol (Cimzia®)
- Denosumab (Prolia® & Xgeva®)
- Eculizumab (Soliris®)
- Emicizumab-kxwh (Hemlibra®)
- Golimumab (Simponi Aria®)
- Infliximab (Remicade®)
- Infliximab-axxq (Axsol®)
- Infliximab-dyyb (Inflectra®)
- Infliximab-abda (Renflexis®)
- Nivolumab (Opdivo®)
- Omalizumab (Xolair®)
- Patisiran (Onpattro®)
- pegaptanib sodium (Macugen®)
- Pegfilgrastim (Neulasta®)
- Pegfilgrastim-apgf (Nyevepria™)
- Pegfilgrastim-cbqv (Udenyca™)
- Pegfilgrastim-jmdb (Fulphila™)
- Pegfilgrastim-bmez (Ziextenzo™)
- ranibizumab (Lucentis®)
- Ravulizumab-cwvz (Ultomiris®)
- Rituximab (Rituxan®)
- Rituximab-pvvr (Ruxience™)
- Rituximab-abbs (Truxima®)
- Rituximab and hyaluronidase (Rituxan Hycela®)
- Testosterone cypionate (Depo-Testosterone®)
- Testosterone enanthate
- Testosterone pellets (Testopel®)
- Testosterone undecanoate (Aveed®)
- Tildrakizumab-asmn (Ilumya™)
- Tocilizumab (Actemra®)
- Trastuzumab (Herceptin®)

- Trastuzumab-anns (Kanjinti™)
- Trastuzumab-dkst (Ogivri™)
- Trastuzumab-dttb (Ontruzant™)
- Trastuzumab-pkrb (Herzuma®)
- Trastuzumab-qyyp (Trazimera™)
- Ustekinumab (Stelara®)
- Vedolizumab (Entyvio®)
- Zoledronic acid (zoledronic acid, Reclast® and Zometa®)

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 (128 kg) and body surface area (2.59 meters²) in the U.S. (adult male, 30 to 39 years, Fryar, 2016). 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 > 128 kg or body surface area > 2.59 meters².

Maximum Allowed Quantities by HCPCS Units

Medication Name		Diagnosis	Maximum Dosage per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
Actemra	tocilizumab		800 mg	J3262	800 HCPCS units (1 mg per unit)
Avastin Mvasi Zirabev	bevacizumab		15 mg/kg	J9035	192 HCPCS units (10 mg per unit)
	bevacizumab-awwb			Q5107	192 HCPCS units (10 mg per unit)
	bevacizumab-bvzr			Q5118	192 HCPCS units (10 mg per unit)
Aveed	testosterone undecanoate		750mg	J3145	750 HCPCS units (1 mg per unit)
Cimzia	certolizumab pegol		400 mg	J0717	400 HCPCS units (1 mg per unit)
NA	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)
Entyvio	vedolizumab		300 mg	J3380	300 HCPCS units (1 mg per unit)
Hemlibra	emicizumab-kxwh		6 mg/kg	J7170	1,536 HCPCS units (0.5 mg per unit)
Herceptin Herzuma Kanjinti Ogivri Ontruzant	trastuzumab trastuzumab-pkrb trastuzumab-anns		8 mg/kg	J9355	103 HCPCS units (10 mg per unit)
				Q5113	
				Q5117	
				Q5114	
				Q5112	

Medication Name		Diagnosis	Maximum Dosage per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
Trazimera	trastuzumab-dkst trastuzumab-dttb trastuzumab-qyyp			Q5116	
Ilumya	tildrakizumab-asmn		100 mg	J3245	100 HCPCS units (1 mg per unit)
Neulasta	pegfilgrastim		6 mg	J2505	1 HCPCS unit (6 mg per unit)
Nyvepria	pegfilgrastim-apgf		6 mg	Q5122	12 HCPCS units (0.5mg per unit)
Fulphila Udenyca	pegfilgrastim-jmdb pegfilgrastim-cbqv		6 mg	Q5108	12 HCPCS units (0.5mg per unit)
				Q5111	
Ziextenzo	pegfilgrastim-bmez			TBD	
Opdivo	nivolumab		480 mg	J9299	480 HCPCS units (1 mg per unit)
Orencia	Abatacept		1000 mg	J0129	100 HCPCS units (10 mg per unit)
Reclast zoledronic acid Zometa	zoledronic acid		5 mg	J3489	5 HCPCS units (1 mg per unit)
			5 mg		
			4 mg		
			4 mg		
Remicade Avsola Renflexis Inflectra	Infliximab infliximab-axxq infliximab-abda infliximab-dyyb		10 mg/kg	J1745	128 HCPCS units (10 mg per unit)
				TBD	
				Q5103	
				Q5104	
Onpattro	patisiran		30 mg	J0222	300 HCPCS units (0.1 mg per unit)
Prolia	denosumab	Osteoporosis	60 mg	J0897	60 HCPCS units (1 mg per unit)
Xgeva	denosumab	Oncology	120 mg	J0897	120 HCPCS units (1 mg per unit)
Rituxan Ruxience Truxima	rituximab rituximab-abbs rituximab-pvvr		1,225 mg	J9312	123 HCPCS units (10 mg per unit)
				TBD	
				Q5115	
Rituxan Hycela	rituximab and hyaluronidase		1,600 mg	J9311	160 HCPCS units (10 mg per unit)
Simponi Aria	golimumab		2 mg/kg	J1602	<u>300256</u> HCPCS units (1 mg per unit)

Medication Name		Diagnosis	Maximum Dosage per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
Soliris	eculizumab	PNH	900 mg	J1300	90 HCPCS units (10 mg per unit)
		aHUS, MG, NMOSD	1200 mg	J1300	120 HCPCS units (10 mg per unit)
Stelara	ustekinumab		90 mg	J3357	90 HCPCS units (1 mg per unit)
		Crohn's Disease	520 mg	J3358	520 HCPCS units (1 mg per unit)
Testopel	testosterone pellet		450 mg	S0189	6 HCPCS units (75 mg per unit)
Ultomiris	ravulizumab-cwvz		3,600 mg	J1303	360 HCPCS units (10 mg per unit)
Xolair	omalizumab	Asthma	375 mg	J2357	90 HCPCS units (5 mg per unit)
		Chronic Urticaria	300 mg	J2357	60 HCPCS units (5 mg per unit)
		<u>Nasal Polyps</u>	<u>600 mg</u>	<u>J2357</u>	<u>120 HCPCS units (5 mg per unit)</u>

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		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
Actemra	Tocilizumab		20 mg/mL vial	50242-0135-01	40 mL
				50242-0136-01	
				50242-0137-01	
Avastin	bevacizumab		100 mg/4 mL vial	50242-0060-01	77 mL
				50242-0060-10	
			400 mg/16 mL vial	50242-0061-01	77 mL
				50242-0061-10	
Mvasi	bevacizumab-awwb		100 mg/4 mL vial	55513-0206-01	77 mL
			400 mg/16 mL vial	55513-0207-01	77 mL
Zirabev	bevacizumab-bvzr		100 mg/4 mL vial	00069-0315-01	77 mL
			400 mg/16 mL vial	00069-0342-01	77 mL

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
Aveed	testosterone undecanoate		750 mg/3 mL	67979-0511-43	3 mL
Cimzia	certolizumab pegol		2 x 200mg kit	50474-0700-62	2 vials
			2 x 200mg/ml prefilled syringe (PFS) kit	50474-0710-79	2 mL
			6 x 200 mg/ml PFS kit	50474-0710-81	2 mL
NA1	testosterone enanthate		200 mg/mL	00574-0821-05 00143-9750-01 00591-3221-26	2 mL
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 00409-6562-22 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-	2 mL

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
				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	
Entyvio	vedolizumab		300 mg vial	64764-0300-20	1 vial
Hemlibra	emicizumab-kxwh		30 mg/mL	50242-0920-01	768 mg
			105 mg/0.7 mL	50242-0922-01	
			150 mg/mL	50242-0923-01	
			60 mg/0.4 mL	50242-0921-01	
Herceptin	trastuzumab		150 mg vial	50242-0132-01 50242-0132-10	7 vials
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
Ontruzant	trastuzumab-dttb		150 mg vial	00006-5033-02	3 vials
			420mg vial	00006-5034-01	3 vials
				00006-5034-02	
Trazimera	trastuzumab-qyyp		420 mg vial	00069-0305-01	3 vials

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
				00069-0306-01	
Ilumya	tildrakizumab-asmn		100 mg/mL PFS	47335-0177-95 47335-0177-96 47335-0177-01 47335-0177-10	1 mL
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/0.6mL PFS	00069-0324-01	0.6 mL
Fulphila	pegfilgrastim-jmdb		6 mg/0.6mL PFS	67457-0833-06	0.6 mL
Udenyca	pegfilgrastim-cbqv		6 mg/0.6mL PFS	70114-0101-01	0.6 mL
Ziextenzo	pegfilgrastim-bmez		6 mg/0.6mL PFS	61314-0866-01	0.6 mL
Opdivo	nivolumab		100 mg/10 mL vial	00003-3774-12	40 mL
			240 mg/24 mL vial	00003-3734-13	48 mL
			40 mg/4 mL vial	00003-3772-11	8 mL
Onpattro	patisiran		10 mg/5 mL vial	71336-1000-01	15 mL
Orencia	abatacept		250 mg vial	00003-2187-10 00003-2187-13	4 vials
Remicade	infliximab		100 mg vial	57894-0030-01	13 vials
Avsola	infliximab-axxq		100 mg vial	55513-0670-01	13 vials
Renflexis	infliximab-abda		100 mg vial	00006-4305-01 00006-4305-02	13 vials
Inflectra	infliximab-dyyb		100 mg vial	00069-0809-01	13 vials
Rituxan	rituximab		100 mg/10 mL vial	50242-0051-10 50242-0051-21	40 mL
			500 mg/50 mL vial	50242-0053-06	130 mL

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
Ruxience	rituximab-pvvr		100 mg/10 mL vial	00069-0238-01	40 mL
			500 mg/50 mL vial	00069-0249-01	130 mL
Truxima	rituximab-abbs		100 mg/10 mL vial	63459-0103-10	40 mL
			500 mg/50 mL vial	63459-0104-50	130 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
Simponi Aria	golimumab		50 mg/4 mL	57894-0350-01	24 mL
Soliris	eculizumab	PNH	300 mg/30 mL vial	25682-0001-01	90 mL
		aHUS, MG	300 mg/30 mL vial	25682-0001-01	120 mL
Stelara	ustekinumab		45 mg/0.5 mL PFS	57894-0060-03	0.5 mL
			45 mg/0.5 mL vial	57894-0060-02	0.5 mL
			90 mg/1 mL PFS	57894-0061-03	1 mL
		Crohn's Disease	130 mg/26 mL vial	57894-0054-27	104 mL
		Ulcerative colitis	130 mg/26 mL vial	57894-0054-27	104 mL
Testopel	testosterone pellet		75 mg pellet	66887-0004-01 66887-0004-10 66887-0004-20	6 pellets
Ultomiris	ravulizumab-cwvz		300 mg/30 mL vial	25682-0022-01	360 mL
Xolair	omalizumab	Asthma	150 mg vial	50242-0040-62	<u>32</u> vials
			150 mg/ <u>1 mL</u> PFS	50242-0215-01 50242-0215-86	2 mL
			75 mg/ <u>0.5 mL</u> PFS	50242-0214-01	<u>0.51</u> mL
		Chronic Urticaria	150 mg vial	50242-0040-86	2 vials
			150 mg/ <u>1 mL</u> PFS	50242-0215-01 50242-0215-86	2 mL

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
		<u>Nasal Polyps</u>	<u>150 mg vials</u>	<u>50242-0040-62</u>	<u>4 vials</u>
			<u>150 mg/1 mL PFS</u>	<u>50242-0215-01</u>	<u>4 mL</u>
			<u>75 mg/ 0.5 mL PFS</u>	<u>50242-0214-01</u>	<u>0.5 mL</u>
Prolia	denosumab	Osteoporosis	60 mg/1 mL PFS	55513-0710-01	1 mL
Xgeva	denosumab	Oncology	120 mg/1.7 mL vial	55513-0730-01	1.7 mL
Reclast Zometa	zoledronic acid		4 mg/5 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 63323-0961-98 67457-0390-54 68001-0366-22 68001-0366-25	5 mL
			4 mg/100 mL vial	70860-0210-51	100 mL
			4 mg/100 mL infusion	00409-4229-01 23155-0186-31 25021-0826-67 25021-0826-82	100 mL

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
			5 mg/100 mL vial	00078-0435-61 25021-0830-82 43598-0331-11 51991-0064-98 55111-0688-52 63323-0966-00 67457-0619-10	100 mL
			5 mg/100 mL infusion	00409-4228-01 25021-0830-82 67457-0794-10 70860-0802-82	100 mL

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	PJIA	Administered once every 4 weeks
		Rheumatoid Arthritis	
		SJIA	Administered once every 2 weeks
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	
		Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)	
		Neovascular age-related macular degeneration	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		Neovascular glaucoma	
		Neovascularization of the iris (rubeosis iridis)	
		Proliferative diabetic retinopathy	
		Type I retinopathy of prematurity	
Aveed	testosterone undecanoate		The recommended dose is 750mg initially, followed by 750mg after 4 weeks, then 750mg every 10 weeks thereafter
Beovu	brolocizumab	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.
Cimzia	certolizumab pegol	Crohn's Disease	Administered initially, and at weeks 2, 4, then every 4 weeks thereafter
		Ankylosing Spondylitis	Administered initially, and at weeks 2, 4, then every other/every 2 weeks thereafter
		Axial Spondyloarthritis	
		Plaque Psoriasis (BW ≤ 90kg)	
		Psoriatic Arthritis	
		Rheumatoid Arthritis	Administered every other week
		Plaque Psoriasis (BW > 90kg)	
NA	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
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	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		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.
		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.
Entyvio	vedolizumab	Crohn's Disease	Administered at 0, 2, and 6 weeks, then every 8 weeks thereafter
		Ulcerative Colitis	
Fulphila	pegfilgrastim-jmdb	Oncology	Administered once every 2 weeks.
Hemlibra	emicizumab-kxwh		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
Ilumya	tildrakizumab-asmn	Plaque Psoriasis	Administered at weeks 0, 4, and every 12 weeks thereafter
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	Administered at 0, 2, and 6 weeks, then every 8 weeks thereafter
		Noninfectious uveitis	
		Plaque Psoriasis	
		Psoriatic Arthritis	
		Sarcoidosis	
		Ulcerative Colitis	
		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
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	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		Diabetic retinopathy	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.
		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.
Macugen	pegaptanib	Diabetic macular edema	The recommended dose is 0.3 mg to affected eye(s) near-monthly during the first 12 months, with fewer injections needed in subsequent years. Maximum of 12 doses per year per eye.
		Neovascular age-related macular degeneration	The recommended dose is 0.3 mg to affected eye(s) once every 6 weeks. Maximum of 12 doses per year per eye.
Neulasta	pegfilgrastim	Oncology	Administered once every 2 weeks.
Nyvepria	pegfilgrastim-apgf	Oncology	Administered once every 2 weeks.
Onpattro	patisiran	Polyneuropathy from hATTR amyloidosis	Administered once every 3 weeks
Orencia	abatacept	JIA	Administered at 0, 2, and 4 weeks, then once every 4 weeks thereafter
		Rheumatoid Arthritis	
		Psoriatic Arthritis	
Prolia	denosumab	Osteoporosis	Administered once every 6 months
Simponi Aria	golimumab	Ankylosing Spondylitis	Administered at 0, 4, then every 8 weeks thereafter
		<u>Juvenile Idiopathic Arthritis</u>	
		Psoriatic Arthritis	
		Rheumatoid Arthritis	
Soliris	eculizumab	PNH, aHUS, MG, NMOSD	Administered once weekly for 5 doses, then every 2 weeks thereafter
Stelara	ustekinumab	Psoriasis	Administered subcutaneously - initially and 4 weeks later, then every 12 weeks thereafter
		Psoriatic arthritis	
		Crohn's Disease	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		Ulcerative colitis	Administered intravenously (IV) initially one time, then subcutaneously 8 weeks after the initial IV dose, then once every 8 weeks thereafter
Testopel	testosterone pellet		The dosage guideline for the testosterone pellets for replacement therapy in androgen-deficient males is 150mg to 450mg subcutaneously every 3 to 6 months. The usual dosage is as follows: implant two 75mg pellets for each 25mg testosterone propionate required weekly. Thus when a patient requires injections of 75mg per week, it is usually necessary to implant 450mg (6 pellets). With injections of 50mg per week, implantation of 300mg (4 pellets) may suffice for approximately three months.
Udenyca	pegfilgrastim-cbqv	Oncology	Administered once every 2 weeks.
Ultomiris	ravulizumab-cwvz	PNH	Administered initially, week 2, then once every 8 weeks thereafter
		aHUS	Administered initially, week 2, then once every 4 or 8 weeks thereafter, depending on body weight
Xgeva	denosumab	Oncology	Administered once every 4 weeks
Xolair	omalizumab	Asthma	Administered once every 2 or 4 weeks, depending on body weight and <u>IgE</u> levels
		Chronic Urticaria	Administered once every 4 weeks
		<u>Nasal Polyps</u>	<u>Administered once every 2 or 4 weeks, depending on body weight and IgE levels.</u>
Ziextenzo	pegfilgrastim-bmez	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
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
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
J1303	Injection, ravulizumab-cwvz, 10 mg
J1602	Injection, golimumab, 1 mg, for intravenous use
J1745	Injection, infliximab, excludes biosimilar, 10 mg
J2357	Injection, omalizumab, 5 mg
J2505	Injection, pegfilgrastim, 6 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, 1mg
J3380	Injection, vedolizumab, 1 mg
J3489	Injection, zoledronic acid, 1 mg
J7170	Injection, emicizumab-kxwh, 0.5 mg
J9035	Injection, bevacizumab, 10 mg
J9299	Injection, nivolumab, 1 mg
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg
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
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (Fulphila), 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv, biosimilar, (Udenyca), 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
S0189	Testosterone pellet, 75 mg

National Drug Code	Description
50242-0135-01	Actemra 20 mg/mL vial

National Drug Code	Description
50242-0136-01	Actemra 200 mg/10 mL vial
50242-0137-01	Actemra 400 mg/20 mL vial
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
50474-0700-62	Cimzia 2 x 200mg 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
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	Depo-Testosterone (testosterone cypionate) 200 mg/mL vial

National Drug Code	Description
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	
64764-0300-20	Entyvio 300 mg vial
50242-0920-01	Hemlibra 30 mg/mL
50242-0922-01	Hemlibra 105 mg/0.7 mL
50242-0923-01	Hemlibra 150 mg/mL
50242-0921-01	Hemlibra 60 mg/0.4 mL
67457-0833-06	Fulphila 6 mg/0.6mL PFS
50242-0132-01	Herceptin 150 mg vial

National Drug Code	Description
50242-0132-10	
63459-0305-47	Herzuma 420 mg vial
63459-0303-43	Herzuma 150 mg vial
47335-0177-96 47335-0177-95	Ilumya 100 mg/mL PFS
00069-0809-01	Inflectra 100 mg vial
55513-0132-01	Kanjinti 420 mg vial
55513-0141-01	Kanjinti 150 mg vial
55513-0206-01	Mvasi 100 mg/4 mL vial
55513-0207-01	Mvasi 400 mg/16 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
00069-0324-01	Nyvepria 6 mg/0.6 mL PFS
67457-0847-44 67457-0845-50	Ogivri 420 mg vial
67457-0991-15	Ogivri 150 mg vial
00006-5033-02	Ontruzant 150 mg vial
00003-3774-12	Opdivo 100 mg/10 mL vial
00003-3734-13	Opdivo 240 mg/24 mL vial
00003-3772-11	Opdivo 40 mg/4 mL vial
71336-1000-01	Onpattro 10 mg/5 mL vial
00003-2187-10 00003-2187-13	Orencia 250 mg vial
55513-0710-01	Prolia 60 mg/1 mL PFS
00078-0435-61	Reclast 5 mg/100 mL vial
35356-0351-01	Reclast 5 mg/100 mL vial
57894-0030-01	Remicade 100 mg vial
00006-4305-01	Renflexis 100 mg vial

National Drug Code	Description
00006-4305-02	
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
00069-0238-01	Ruxience 100 mg/10 mL vial
00069-0249-01	Ruxience 500 mg/50 mL vial
57894-0350-01	Simponi Aria 50 mg/4 mL vial
25682-0001-01	Soliris 300 mg/30 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
57894-0054-27	Stelara 130 mg/26 mL vial
66887-0004-01 66887-0004-10 66887-0004-20	Testopel 75 mg pellet
00069-0305-01 00069-0306-01	Trazimera 420 mg vial
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
25682-0022-01	Ultomiris 300 mg/30 mL vial
55513-0730-01	Xgeva 120 mg/1.7 mL vial
50242-0040-86	Xolair 150 mg vial
50242-0214-01	Xolair 75 mg PFS
50242-0215-01 50242-0215-86	Xolair 150 mg PFS

National Drug Code	Description
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
00409-4215-01	Zoledronic Acid 4 mg/5 mL vial
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	
70860-0210-51	Zoledronic Acid 4 mg/100 mL vial
00409-4229-01	Zoledronic Acid 4 mg/100 mL infusion
23155-0186-31	
25021-0826-67	
25021-0826-82	
00078-0435-61	Zoledronic Acid 5 mg/100 mL vial
25021-0830-82	
43598-0331-11	
51991-0064-98	
55111-0688-52	
63323-0966-00	

National Drug Code	Description
67457-0619-10	
00409-4228-01	Zoledronic Acid 5 mg/100 mL infusion
25021-0830-82	
67457-0794-10	
70860-0802-82	

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 (128 kg) and body surface area (2.59 meters²) in the U.S. (adult male, 30 to 39 years, Fryar, 2016).

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
<u>xx/01/2021</u>	<u>Updated Simponi Aria maximum allowed amount and added maximum frequency for juvenile idiopathic arthritis indication. Updated Xolair maximum allowed amount for asthma and chronic urticaria and added Xolair for nasal polyps to policy. Updated references.</u>

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.