Maximum Dosage and Frequency (for Louisiana Only)

Policy Number: CSLA2022D0034AB~~A~~
Effective Date: ~~March~~ ~~November~~ ~~1, 2022~~TBA

➲ Instructions for Use

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This policy does not appear more restrictive than the state.
Please submit to the state for review and approval
Cedric Cloud, PAM LA C&S
9.2.22

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®)
- atezolizumab (Tecentriq®)
- avelumab (Bavencio®)
- Bevacizumab (Avastin®)
- Bevacizumab-awwb (Mvasi™)
- Bevacizumab-bvzr (Zirabev™)
- bevacizumab-maly (Alymsys®)
- Brolucizumab-dbll (Beovu®)
- cemiplimab-rwlc (Libtayo®)
- Certolizumab pegol (Cimzia®)
- Denosumab (Prolia® & Xgeva®)
- durvalumab (Imfinzi®)
- Eculizumab (Soliris®)
- Emicizumab-kxwh (Hemlibra®)
- Golimumab (Simponi Aria®)
- Infliximab (Remicade®)
- Infliximab-axxq (Avsola™)
- Infliximab-dyyb (Inflectra®)
- Infliximab-abda (Renflexis®)
- ipilimumab (Yervoy®)
- Nivolumab (Opdivo®)
- Omalizumab (Xolair®)
- Patisiran (Onpattro®)

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- Pegaptanib sodium (Macugen®)
- Pegfilgrastim (Neulasta®)
- Pegfilgrastim-apgf (Nyvepria™)
- Pegfilgrastim-cbqv (Udenyca™)
- Pegfilgrastim-jmdb (Fulphila™)
- Pegfilgrastim-bmez (Ziextenzo™)
- pembrolizumab (Keytruda®)
- ranibizumab (Lucentis®)
- Ravulizumab-cwvz (Ultomiris®)
- Rituximab (Rituxan®)
- Rituximab-pvvr (Ruxience®)
- Rituximab-abbs (Truxima®)
- rituximab-arrx (Riabni™)
- 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 (140~~28~~ kg) and body surface area (2.7159 meters^2) in the U.S. (adult male, 30 to 39 years, Fryar, 2021~~16~~).[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~~28~~ kg or body surface area > 2.7159 meters^2.

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	bevacizumab		15 mg/kg	J9035	~~192~~ 240 HCPCS units (10 mg per unit)
Mvasi	bevacizumab-awwb		15 mg/kg	Q5107	~~192~~ 240 HCPCS units (10 mg per unit)
Zirabev	bevacizumab-bvzr		15 mg/kg	Q5118	~~192~~ 240 HCPCS units (10 mg per unit)
Aveed	testosterone undecanoate		750 mg	J3145	750 HCPCs units

Medication Name		Diagnosis	Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
					(1 mg per unit)
Cimzia	certolizumab pegol		400 mg	J0717	400 HCPCS units (1 mg per 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
Entyvio	vedolizumab		300 mg	J3380	300 HCPCS units (1 mg per unit)
Hemlibra	emicizumab-kxwh		6mg/kg	J7170	1,680~~536~~ HCPCs units (0.5 mg per unit)
Herceptin	trastuzumab		8 mg/kg	J9355	~~103~~ 126 HCPCS units (10 mg per unit)
Herzuma	trastuzumab-pkrb		8 mg/kg	Q5113	~~103~~ 126 HCPCS units (10 mg per unit)
Kanjinti	trastuzumab-anns		8 mg/kg	Q5117	~~103~~ 126 HCPCS units (10 mg per unit)
Ogivri	trastuzumab-dkst		8 mg/kg	Q5114	~~103~~ 126 HCPCS units (10 mg per unit)
Ontruzant	trastuzumab-dttb		8 mg/kg	Q5112	~~103~~ 126 HCPCS units (10 mg per unit)
Trazimera	trastuzumab-qyyp		8 mg/kg	Q5116	~~103~~ 126 HCPCS units (10 mg per unit)
Ilumya	tildrakizumab-asmn		100 mg	J3245	100 HMCPCs units (1 mg per unit)
Neulasta	pegfilgrastim		6 mg	J2506	12 HCPCS unit (0.5 mg per unit)

Medication Name		Diagnosis	Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
Nyvepria	pegfilgrastim-apgf		6 mg	Q5122	12 HCPCS units (0.5mg per unit)
Fulphila	pegfilgrastim-jmdb		6 mg	Q5108	12 HCPCS units (0.5mg per unit)
Udenyca	pegfilgrastim-cbqv		6 mg	Q5111	12 HCPCS units (0.5mg per unit)
Ziextenzo	pegfilgrastim-bmez		6 mg	Q5120	12 HCPCS units (0.5mg per unit)
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		5 mg	J3489	5 HCPCS units (1 mg per unit)
Zoledronic Acid	zoledronic acid	Osteoporosis/ Paget's disease	5 mg	J3489	5 HCPCS units (1 mg per unit)
		Oncology/ Hypercalcemia	4 mg	J3489	5 HCPCS units (1 mg per unit)
~~Zometa~~	~~zoledronic acid~~		~~4 mg~~	~~J3489~~	~~5 HCPCS units (1 mg per unit)~~
Avsola	infliximab-axxq		10 mg/kg	Q5121	150~~28~~ HCPCS units (10 mg per unit)
Inflectra	infliximab-dyyb		10 mg/kg	Q5103	150~~28~~ HCPCS units (10 mg per unit)
Remicade	infliximab		10 mg/kg	J1745	150~~28~~ HCPCS units (10 mg per unit)
Renflexis	infliximab-abda		10 mg/kg	Q5104	150~~28~~ HCPCS units (10 mg per unit)

Medication Name		Diagnosis	Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
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	rituximab		500mg/m^2~~1,~~2925 ~~mg~~	J9312	~~123~~ 1530 HCPCS units (10 mg per unit)
Ruxience	rituximab-pvvr		500mg/m^2~~1,~~2925 ~~mg~~	Q5119	~~123~~ 1530 HCPCS units (10 mg per unit)
Truxima	rituximab-abbs		500mg/m^2~~1,~~2925 ~~mg~~	Q5115	~~123~~ 1530 HCPCS units (10 mg per unit)
Riabni	rituximab-arrx		500mg/m^2~~1,~~295 ~~mg~~	Q5123	150 HCPCS units (10 mg per unit)
Rituxan Hycela	rituximab and hyaluronidase		1,600 mg	J9311	160 HCPCs units (10 mg per unit)
Simponi Aria	golimumab		2 mg/kg	J1602	300 HCPCs units (1 mg per unit)
Soliris	eculizumab	PNH	900 mg	J1300	90 HCPCS units (10 mg per unit)
		aHUS	1200 mg	J1300	120 HCPCS units (10 mg per unit)
		MG	1200 mg	J1300	120 HCPCS units (10 mg per unit)
Stelara	ustekinumab		90 mg	J3357	90 HCPCS units (1 mg per unit)

Medication Name		Diagnosis	Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic				
		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)
Xolair	omalizumab	Chronic Urticaria	300 mg	J2357	60 HCPCS units (5 mg per unit)
Xolair	~~Omalizumab~~omalizumab	Nasal Polyps	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)

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 vials	50242-0135-01 50242-0136-01 50242-0137-01	40 mL
			162 mg / 0.9 mL pre-filled syringe 162 mg / 0.9 mL pre-filled syringe autoinjector	50242-0138-01 50242-0143-01	0.9 mL
Avastin	bevacizumab		100 mg/4mL vials	50242-0060-01 50242-0060-10	~~77~~ 12 mL
			400 mg/16 mL vials	50242-0061-01 50242-0061-10	~~77~~ 96 mL
Mvasi	bevacizumab-awwb		100 mg/4mL vials	55513-0206-01	12~~77~~ mL
			400 mg/16 mL vials	55513-0207-01	96~~77~~ mL
Zirabev	bevacizumab-bvzr		100 mg/4mL vials	00069-0315-01	12~~77~~ mL
			400 mg/16 mL vials	00069-0342-01	96~~77~~ mL
Alymsys	bevacizumab-maly		100mg/4mL vials	70121-1754-01 70121-1754-07	12 mL
			400mg/16mL vials	70121-1755-01 70121-1755-07	96 mL
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 200 mg/ml prefilled syringe (PFS) kit	50474-0710-79	2 mL
			6 x 200 mg/ml PFS kit	50474-0710-81	2 mL
N/A	testosterone enanthate		200 mg/mL	00143-9750-01 00574-0821-05 00591-3221-26	2 mL

Medication Name		Diagnosis	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
Entyvio	vedolizumab		300 mg vial	64764-0300-20	1 vial
Hemlibra	emicizumab-kxwh		30 mg/mL	50242-0920-01	~~768 mg~~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~~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

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
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
			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
Ilumya	tildrakizumab-asmn		100 mg/mL PFS	~~47335-0177-96~~ 47335-0177-95 ~~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 vials	00003-3774-12	40 mL
			120mg/12 mL vials	00003-3756-14	48 mL
			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
Orencia	abatacept		250 mg vials	00003-2187-10 00003-2187-13	4 vials
Remicade	infliximab		100 mg vials	57894-0030-01	14~~3~~ vials
Avsola	infliximab-axxq		100 mg vials	55513-0670-01	14~~3~~ vials
Renflexis	infliximab-abda		100 mg vials	00006-4305-01 00006-4305-02	14~~3~~ vials
Inflectra	infliximab-dyyb		100 mg vials	00069-0809-01	14~~3~~ vials
Rituxan	rituximab		100 mg/10 mL vials	50242-0051-10 50242-0051-21	40 mL
			500 mg/50 mL vials	50242-0053-06	15~~3~~0 mL
Ruxience	rituximab-pvvr		100 mg/10 mL vials	00069-0238-01	40 mL
			500 mg/50 mL vials	00069-0249-01	15~~3~~0 mL
Truxima	rituximab-abbs		100 mg/10 mL vials	63459-0103-10	40 mL
			500 mg/50 mL vials	63459-0104-50	15~~3~~0 mL
Riabni	rituximab-arrx		100 mg/10 mL vials	55513-0224-01	40 mL
			500 mg/50 mL vials	55513-0326-01	150 mL
			1,400-23, 400 mg/11.7 mL	50242-0108-01	1 vial

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
Rituxan Hycela	rituximab and hyaluronidase		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 vials	25682-0001-01	90 mL
		aHUS	300 mg/30 mL vials	25682-0001-01	120 mL
		MG	300 mg/30 mL vials	25682-0001-01	120 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
		Crohn's Disease	130 mg/26 mL vials	57894-0054-27	104 mL
		Ulcerative Colitis	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
Ultomiris	ravulizumab-cwvz		300 mg/30 mL vials	25682-00252-01	3690 mL
			1,100 mg/11 mL vials	25682-0028-01	44 mL
Xolair	omalizumab	Asthma	150 mg vials	50242-0040-62	3 vials
			150 mg/1 mL PFS	50242-0215-01 50242-0215-86	2 mL
			75 mg/0.5 mL PFS	50242-0214-01	0.5 mL
		Chronic Urticaria	150 mg vials	50242-0040-8662	2 vials
			150 mg/1 mL PFS	50242-0215-01 50242-0215-86	2 mL
		Nasal Polyps	150 mg vials	50242-0040-62	4 vials
			150 mg/1 mL PFS	50242-0215-01	4 mL
			75 mg/ 0.5 mL PFS	50242-0214-01	0.5 mL
Prolia	denosumab	Osteoporosis	60 mg/1 mL PFS	55513-0710-01	1 mL
Xgeva	denosumab	Oncology	120 mg/1.7 mL vials	55513-0730-01	1.7 mL
Reclast ~~Zometa~~ Reclast ~~Zometa~~	zoledronic acid 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

Medication Name		Diagnosis	How Supplied	National Drug Code	Maximum Allowed
Brand	Generic				
			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
			5mg/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
			5 mg/100 mL infusion	00409-4228-01 25021-0830-82 67457-0794-10 70860-0802-82	100 mL
Bavencio	avelumab		200mg/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		350mg/7mL vials	61755-0008-01	7 mL
Tecentriq	atezolizumab		840mg/14mL vials	50242-0918-01	28 mL
			1200mg/20mL vials	50242-0917-01	40 mL
Yervoy	ipilimumab		50mg/10mL vials	00003-2327-11	30 mL
			200mg/40mL vials	00003-2328-22	280 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, 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.

Medication Name		Diagnosis	Maximum Frequency
Brand	**Generic**		
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	
		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 750mg initially, followed by 750mg after 4 weeks, then 750mg 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.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		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.
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.
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/ every 2 weeks thereafter.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		Plaque Psoriasis (BW > 90kg)	Administered every other week
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
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.
		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.
Fulphila	pegfilgrastim-jmdb	Oncology	Administered once every 2 weeks

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
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.
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 dDisease, 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.~~Administered at 0, 2, and 6 weeks, then every 8 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.
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	
		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.
Mvasi	bevacizumab-awwb	Oncology	Administered once every 2 weeks.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Neulasta	pegfilgrastim	Oncology	Administered once every 2 weeks
Nyvepria	pegfilgrastim-apgf	Oncology	Administered once every 2 weeks
Ogivri	trastuzumab-dkst	Oncology	Administered once every week.
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~~JIA~~	Administered intravenously at 0, 2, and 4 weeks, then once every 4 weeks thereafter. Administered subcutaneously once weekly.~~Administered at 0, 2, and 4 weeks, then once every 4 weeks thereafter~~
		Graft-versus-host disease (GVHD) prophylaxis~~Rheumatoid Arthritis~~	Administered on day before transplantation, followed by a dose on Day 5, 14, and 28 after transplant.~~Administered at 0, 2, and 4 weeks, then once every 4 weeks thereafter~~
Prolia	denosumab	Osteoporosis	Administered once every 6 months
Simponi Aria	golimumab	Ankylosing s~~S~~pondylitis, juvenile idiopathic arthritis, psoriatic arthritis, rheumatoid arthritis	Administered at 0, 4, then every 8 weeks thereafter
Soliris	eculizumab	~~PNH,~~ aHUS, MG, NMOSD, PNH	Administered once weekly for 5 doses, then every 2 weeks thereafter
Stelara	ustekinumab	Psoriasis, psoriatic arthritis	Administered subcutaneously - initially and 4 weeks later, then every 12 weeks thereafter

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Stelara	ustekinumab	Crohn's ddisease, ulcerative colitis	Administered intravenously (IV) initially one time, then subcutaneously 8 weeks after the initial IV dose, then once every 8 weeks thereafter
Tecentriq~~Stelara~~	atezolizumab~~ustekinumab~~	Oncology~~Ulcerative colitis~~	Administered once every 2 weeks.~~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 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 50 mg per week, implantation of 300 mg (4 pellets) may suffice for approximately three months.
Trazimera	trastuzumab-qyyp	Oncology	Administered once every week.
Udenyca	pegfilgrastim-cbqv	Oncology	Administered once every 2 weeks

Medication Name		Diagnosis	Maximum Frequency
Brand	**Generic**		
Ultomiris	ravulizumab-cwvz	aHUS, PNH	Administered initially, week 2, then once every 4 or 8 weeks thereafter, depending on body weight~~Administered initially, week 2, then once every 8 weeks thereafter~~
		MG~~aHUS~~	Administered initially, week 2, then once every 8 weeks thereafter.~~Administered initially, week 2, then once every 4 or 8 weeks thereafter, depending on body weight~~
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.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
		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.
Xgeva	denosumab	Oncology	Administered once every 4 weeks
		Hypercalcemia of Malignancy	Administer 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 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.
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
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
J2506	Injection, pegfilgrastim, 0.5 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, 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
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
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
50242-0138-01	Actemra 162 mg / 0.9 mL pre-filled syringe
50242-0143-01	Actemra 162 mg / 0.9 mL pre-filled syringe autoinjector
70121-1754-01	Alymsys 100mg/4mL vial
70121-1754-07	Alymsys 100mg/4mL vial
70121-1755-01	Alymsys 400mg/16mL vial
70121-1755-07	Alymsys 400mg/16mL 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
44087-3535-01	Bavencio 200mg/10mL vial

National Drug Code	Description
50474-0700-62	Cimzia 2 x 200mg kit
50474-0710-79	Cimzia 2 x 200mg/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 50090-0330-00 00409-6562-02 00409-6562-22 00143-9659-01 62756-0017-40 62756-0016-40 00409-6557-01	Depo-Testosterone (testosterone cypionate) 200 mg/mL vial

National Drug Code	Description
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
67457-0833-06	Fulphila 6 mg/0.6 mL PFS
50242-0922-01	Hemlibra 105mg/0.7 L
50242-0923-01	Hemlibra 150mg/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

National Drug Code	Description
~~47335-0177-96~~ 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
61755-0008-01	Libtayo 350mg/7mL 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
67457-0991-15	Ogivri 150 mg vial
67457-0847-44 67457-0845-50	Ogivri 420 mg 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 120mg/12 mL vials

National Drug Code	Description
00003-3734-13	Opdivo 240 mg/24 ml vial
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
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
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
57894-0054-27	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

National Drug Code	Description
50242-0918-01	Tecentriq 840mg/14mL vial
50242-0917-01	Tecentriq 1200mg/20mL 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
25682-00252-01	Ultomiris 300 mg/30 mL vial
25682-0028-01	Ultomiris 1,100 mg/11 mL vial
55513-0730-01	Xgeva 120 mg/1.7 mL vial
50242-0215-01 ~~50242-0215-86~~	Xolair 150 mg PFS
~~50242-0040-86~~	~~Xolair 150 mg vial~~
50242-0214-01	Xolair 75 mg PFS
00003-2327-11	Yervoy 50mg/10mL vials
00003-2328-22	Yervoy 200mg/40mL 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

National Drug Code	Description
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 63323-0961-98 67457-0390-54 68001-0366-22 68001-0366-25	Zoledronic Acid 4 mg/5 mL vial
00409-4228-01 25021-0830-82 67457-0794-10 70860-0802-82	Zoledronic Acid 5 mg/100 mL infusion

National Drug Code	Description
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~~28~~ kg) and body surface area (2.71~~59~~ meters^2) in the U.S. (adult male, 30 to 39 years, Fryar, 2021~~16~~).[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~~

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Date	Summary of Changes
TBD	Annual review. Added Bavencio, Imfinzi, Keytruda, Libtayo, Tecentriq, Yervoy, and Riabni. Updated Ultomiris dosing information for myasthenia gravis indication. Updated maximum allowed dosages for weight-based surface area-based drugs using recent CDC reference data. Updated maximum quantities, frequencies, as appropriate. Updated references.

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03/01/2022	Coverage Rationale • Revised list of: Maximum Allowed Quantities by HCPCS Units Simponi Aria (golimumab) o Changed maximum allowed amount from "***256*** HCPCS units" to "***300*** S units" Xolair (omalizumab) o Added: • Diagnosis: Nasal polyps • Maximum Dosage Per Administration: 600 mg • HCPCS Code: J2357 • Maximum Allowed: 120 HCPCS units (5 mg per unit) Maximum Allowed Quantities for National Drug Code (NDC) Billing Xolair (omalizumab) *Asthma* o Revised values for: • NCD 50242-0040-62: Replaced *Maximum Allowed* amount of "***2*** vials" "***3*** vials" • NCD 50242-0214-01: – Changed *How Supplied* value from "75 mg PFS" to "75 mg/*0.5 mL* PFS – Changed maximum allowed amount from "***1*** mL" to "***0.5*** mL" • NCDs 50242-0215-01 and 50242-0215-86: Changed *How Supplied* va "150 mg PFS" with "150 mg/*1 mL* PFS" *Nasal Polyps* o Added: • NDC 50242-0040-62: – How Supplied: 150 mg vials – Maximum Allowed: 4 vials • NDC 50242-0214-01: – How Supplied: 75 mg/0.5 mL pre-filled syringe (PFS) – Maximum Allowed: 0.5 mL • NDC 50242-0215-01: – How Supplied: 150 mg/1 mL PFS – Maximum Allowed: 4 mL Maximum Allowed Frequencies Simponi Aria (golimumab) o Added maximum frequency for the diagnosis of **juvenile idiopathic** **itis** to allow administration at 0, 4, then every 8 weeks thereafter Xolair (omalizumab) o Added maximum frequency for the diagnosis of **nasal polyps** to allow nistration once every 2 or 4 weeks, depending on body weight and IgE levels

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Date	Summary of Changes
	Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version CSLA2021D0034Z

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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
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

Effective Date	Policy Number	Policy Title
01/01/2017 – 01/31/2017	2017D0034M	Maximum Dosage Policy