

# Maximum Dosage and Frequency (for Pennsylvania Only)

**Policy Number:** CSPA2026D0034AS  
**Effective Date:** May 1, 2026

[➔ Instructions for Use](#)

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### Related Policies

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- [Rituximab \(Riabni®, Rituxan®, Ruxience®, & Truxima®\) \(for Pennsylvania Only\)](#)
- [RNA-Targeted Therapies \(Amvuttra® and Onpattro®\)](#)

## Application

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

## 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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• abatacept (Orencia®)</li> <li>• abobotulinumtoxinA (Dysport®)</li> <li>• aflibercept (Eylea®)</li> <li>• aflibercept (Eylea® HD)</li> <li>• aflibercept-ayyh (Pavblu™)</li> <li>• atezolizumab (Tecentriq®)</li> <li>• avelumab (Bavencio®)</li> <li>• axatilimab-csfr (Niktimvo™)</li> <li>• benralizumab (Fasenra®)</li> <li>• bevacizumab (Avastin®)</li> <li>• bevacizumab-adcd (Vegzelma®)</li> <li>• bevacizumab-awwb (Mvasi™)</li> <li>• bevacizumab-bvzr (Zirabev™)</li> <li>• bevacizumab-maly (Alymsys®)</li> <li>• brotucizumab-dbll (Beovu®)</li> <li>• canakinumab (Ilaris®)</li> <li>• cemiplimab-rwlc (Libtayo®)</li> <li>• certolizumab pegol (Cimzia®)</li> <li>• crovalimab-akkz (PiaSky™)</li> <li>• daxibotulinumtoxinA-lanm (Daxxify®)</li> <li>• denosumab (Prolia® &amp; Xgeva®)</li> </ul> | <ul style="list-style-type: none"> <li>• denosumab-bbdz (Jubbonti® &amp; Wyost®)</li> <li>• denosumab-bmwo (Stoboclo® &amp; Osenvelt®)</li> <li>• denosumab-bnht (Bomynta® &amp; Conexence®)</li> <li>• denosumab-nxxp (Bildyos® &amp; Bilprevda®)</li> <li>• durvalumab (Imfinzi®)</li> <li>• eculizumab (Soliris®)</li> <li>• eculizumab-aagh (Epysqli®)</li> <li>• eculizumab-aeeb (Bkemv™)</li> <li>• edaravone (Radicava®)</li> <li>• efgartigimod alfa-fcab (Vyvgart®)</li> <li>• efgartigimod alfa and hyaluronidase-qvfc (Vyvgart® Hytrulo)</li> <li>• eflapegrastim-xnst (Rolvedon™)</li> <li>• emicizumab-kxwh (Hemlibra®)</li> <li>• eptinezumab-jjmr (Vyepti®)</li> <li>• faricimab-svoa (Vabysmo™)</li> </ul> | <ul style="list-style-type: none"> <li>• golimumab (Simponi Aria®)</li> <li>• guselkumab (Tremfya®)</li> <li>• inclisiran (Leqvio®)</li> <li>• incobotulinumtoxinA (Xeomin®)</li> <li>• infliximab (Remicade®)</li> <li>• infliximab-axxq (Avsola™)</li> <li>• infliximab-dyyb (Inflectra®)</li> <li>• infliximab-abda (Renflexis®)</li> <li>• ipilimumab (Yervoy®)</li> <li>• mepolizumab (Nucala®)</li> <li>• mirikizumab-mrkz (OmvoH™)</li> <li>• nivolumab (Opdivo®)</li> <li>• ocrelizumab (Ocrevus®)</li> <li>• omalizumab (Xolair®)</li> <li>• onabotulinumtoxinA (Botox®)</li> <li>• patisiran (Onpattro®)</li> <li>• pegcetacoplan (Syfovre™)</li> <li>• pegfilgrastim (Neulasta®)</li> <li>• pegfilgrastim-appgf (Nyvepria™)</li> <li>• pegfilgrastim-cbqv (Udenyca™)</li> <li>• pegfilgrastim-fpgk (Stimufend®)</li> </ul> |
|---|--|---|

- pegfilgrastim-jmdb (Fulphila™)
- pegfilgrastim-pbbk (Fynetra®)
- pegfilgrastim-bmez (Ziextenzo™)
- pegloticase (Krystexxa®)
- pembrolizumab (Keytruda®)
- ranibizumab (Lucentis®)
- ranibizumab (Susvimo™)
- 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®)
- tocilizumab-aazg (Tyenne®)
- tocilizumab-bavi (Tofidence™)
- tofersen (Qalsody™)
- trastuzumab (Herceptin®)
- trastuzumab-anns (Kanjinti™)
- trastuzumab-dkst (Ogivri™)
- trastuzumab-dttb (Ontruzant™)
- trastuzumab-pkrb (Herzuma®)
- trastuzumab-qyyp (Trazimera™)
- ustekinumab (Stelara®)
- ustekinumab-aauz (Otulfi™)
- ustekinumab-aekn (Selarsdi)
- ustekinumab-kfce (Yesintek™)
- ustekinumab-srlf (Imuldosa)
- ustekinumab-stba (Steqeyma®)
- ustekinumab-ttwe (Pyzchiva®)
- vedolizumab (Entyvio®)
- vutrisiran (Amvuttra™)
- 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 [e.g., well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials, the National Comprehensive Cancer Network (NCCN) guidelines].

The use of 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.

Continued use of a medication or dosages used beyond labeled indication or other published clinical evidence [e.g., well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials, NCCN guidelines] is considered not medically necessary.

This policy creates an upper dose limit based on the clinical evidence and the 95<sup>th</sup> percentile for adult body weight (140 kg) and body surface area (2.71 meters<sup>2</sup>) in the U.S. (adult male, 30 to 39 years, Fryar, 2021).<sup>59</sup> 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<sup>2</sup>.

## 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)
Tofidence	tocilizumab-bavi	800 mg	Q5133	800 HCPCS units (1 mg per unit)
Tyenne	tocilizumab-aazg	800 mg	Q5135	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)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
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)
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)
Dysport	abobotulinumtoxinA	1,500 units	J0586	300 HCPCS units (5 units per HCPCS unit)
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)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Fulphila	pegfilgrastim-jmdb	6 mg	Q5108	12 HCPCS units (0.5 mg per unit)
Fylnetra	pegfilgrastim-pbbk	6 mg	Q5130	12 HCPCS units (0.5mg per unit)
Stimufend	pegfilgrastim-fpgk	6 mg	Q5127	12 HCPCS units (0.5mg 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 (0.1mg per unit)
Krystexxa	pegloticase	8 mg	J2507	8 HCPCS units (1mg per unit)
Niktimvo	axatilimab-csfr	35 mg	J9038	350 HCPCS units (0.1mg 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)
Omvoh	mirikizumab-mrkz	900 mg	J2267	900 HCPCS units (1 mg 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)
PiaSky	crovalimab-akkz	1500 mg	J1307	150 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)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Jubbonti	denosumab-bbdz	60 mg	Q5136	60 HCPCS units (1 mg per unit)
Wyost	denosumab-bbdz	120 mg	Q5136	120 HCPCS units (1 mg per unit)
Stoboclo	denosumab-bmwo	60 mg	Q5157	60 HCPCS units (1 mg per unit)
Osenvelt	denosumab-bmwo	120 mg	Q5157	120 HCPCS units (1 mg per unit)
Conexence	denosumab-bnht	60 mg	Q5158	60 HCPCS units (1 mg per unit)
Bomynta	denosumab-bnht	120 mg	Q5158	120 HCPCS units (1 mg per unit)
Bildyos	denosumab-nxxp	60 mg	Q5162	60 HCPCS units (1 mg per unit)
Bilprevda	denosumab-nxxp	120 mg	Q5162	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	500mg/m <sup>2</sup>	J9312	150 HCPCS units (10 mg per unit)
		1355 mg	J9312	150 HCPCS units (10 mg per unit)
Ruxience	rituximab-pvvr	500mg/m <sup>2</sup>	Q5119	150 HCPCS units (10 mg per unit)
		1355 mg	J9312	150 HCPCS units (10 mg per unit)
Truxima	rituximab-abbs	500mg/m <sup>2</sup>	Q5115	150 HCPCS units (10 mg per unit)
		1355 mg	J9312	150 HCPCS units (10 mg per unit)
Riabni	rituximab-arrx	500mg/m <sup>2</sup>	Q5123	150 HCPCS units (10 mg per unit)
		1355 mg	J9312	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	80 mg/m <sup>2</sup>	J1602	300 HCPCS units (1 mg per unit)
		2 mg/kg	J1602	300 HCPCS units (1 mg per unit)
Bkemv	eculizumab-aeeb	1200 mg	Q5152	600 HCPCS units (2 mg per unit)
Epysqli	eculizumab-aagh	1200 mg	Q5151	600 HCPCS units (2 mg per unit)
Soliris	eculizumab	1200 mg	J1299	600 HCPCS units (2 mg per unit)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Spevigo	spesolimab-sbzo	900 mg	J1747	900 HCPCS units (1 mg per unit)
Imuldosa	ustekinumab-srlf	90 mg	Q9999	90 HCPCS units (1 mg per unit)
		520 mg	Q5098	520 HCPCS units (1 mg per unit)
Otulfi	ustekinumab-aaaz	90 mg	Q9999	90 HCPCS units (1 mg per unit)
		520 mg	Q9999	520 HCPCS units (1 mg per unit)
Pyzchiva	ustekinumab-ttwe	90 mg	Q9996	90 HCPCS units (1 mg per unit)
		520 mg	Q9997	520 HCPCS units (1 mg per unit)
Selarsdi	ustekinumab-aekn	90 mg	Q9998	90 HCPCS units (1 mg per unit)
		520 mg	Q9998	520 HCPCS units (1 mg per unit)
Stelara	ustekinumab	90 mg	J3357	90 HCPCS units (1 mg per unit)
		520 mg	J3358	520 HCPCS units (1 mg per unit)
Steqeyma	ustekinumab-stba	90 mg	Q5099	90 HCPCS units (1 mg per unit)
		520 mg	Q5099	520 HCPCS units (1 mg per unit)
Yesintek	ustekinumab-kfce	90 mg	Q5100	90 HCPCS units (1 mg per unit)
		520 mg	Q5100	520 HCPCS units (1 mg per unit)
Testopel	testosterone pellet	450 mg	J1073	6 HCPCS units (75 mg per unit)
Tezspire	tezepelumab-ekko	210 mg	J2356	210 HCPCS units (1mg per unit)
Tremfya	guselkumab	200 mg	J1628	200 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	1200 mg	J9332	600 HCPCS units (2mg per unit)
Vyvgart Hytrulo	efgartigimod alfa and hyaluronidase-qvfc	1,008 mg/11,200 units (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase)	J9334	504 HCPCS units (2mg per unit)

Medication Name		Maximum Dosage Per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
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	1200 mg	J2327	1200 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
Tofidence	tocilizumab-bavi	20 mg/mL vials	64406-0022-01 64406-0023-01 64406-0024-01	40 mL
Tyenne	tocilizumab-aazg	20 mg/mL vials	65219-0590-04 65219-0592-10 65219-0594-20	40 mL
Avastin	bevacizumab	100 mg/4mL 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

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
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
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	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
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	2 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Depo-Testosterone	testosterone cypionate	200 mg/mL	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
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	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
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
Niktimvo	axatilimab-csfr	9 mg/0.18 mL vials	50881-0034-12	4 vials
		22 mg/ 0.44 mL vials	50881-0023-11	2 vials
		50 mg/ 1 mL vials	50881-0012-10	1 vial
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
Fylneta	pegfilgrastim-pbbk	6mg/0.6mL PFS	70121-1627-01	0.6 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Stimufend	pegfilgrastim-fpgk	6mg/0.6mL PFS	65219-0371-10	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
Rolvedon	eflapeggrastim-xnst	13.2 mg/0.6mL 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
		40mg/0.4mL PFS	00173-0904-42	0.4 mL
		100mg/mL PFS	00173-0892-01	3 mL
		100mg/mL PFS	00173-0892-42	3 mL
Ocrevus	ocrelizumab	300mg/10mL 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
		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	4 vials
			00003-2187-13	
PiaSky	crovalimab-akkz	340 mg/2 mL vials	50242-0115-01	5 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	14 vials
			00006-4305-02	
Inflectra	infliximab-dyyb	100 mg vials	00069-0809-01	14 vials
Rituxan	rituximab	100 mg/10 mL vials	50242-0051-10	40 mL
			50242-0051-21	
Ruxience	rituximab-pvvr	500 mg/50 mL vials	50242-0053-06	150 mL
			00069-0238-01	
Truxima	rituximab-abbs	100 mg/10 mL vials	00069-0249-01	40 mL
			00069-0249-01	
Riabni	rituximab-abbs	500 mg/50 mL vials	63459-0103-10	40 mL
			63459-0104-50	
Rituxan Hycela	rituximab and hyaluronidase	100 mg/10 mL vials	55513-0224-01	40 mL
			55513-0326-01	
Rystiggo	rozanolixizumab-noli	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
		280 mg/2 mL vials	50474-0980-79	6 mL
		420 mg/3 mL vials	50474-0981-83	3 mL
Simpsoni Aria	golimumab	50 mg/4 mL	50474-0982-84	4 mL
			50474-0983-86	
Bkemv	eculizumab-aagh	300 mg/30 mL vials	57894-0350-01	24 mL
Epysqli	eculizumab-aeab	300 mg/30 mL vials	55513-0180-01	120 mL
Soliris	eculizumab	300 mg/30 mL vials	51759-0208-13	120 mL
			25682-0001-01	120 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Spevigo	spesolimab-sbzo	450 mg/7.5 mL vials	00597-0035-10	15 mL
		150 mg/mL PFS	00597-0620-20	2 mL
Imuldosa	ustekinumab-srlf	45 mg/0.5 mL PFS	51407-0929-11 69448-0017-63	0.5 mL
		90 mg/1 mL PFS	51407-0930-11 69448-0018-63	1 mL
		130 mg/26 mL vials	51407-0931-11 69448-0019-26	104 mL
Otulfi	ustekinumab-aaaz	45 mg/0.5 mL PFS	65219-0824-01	0.5 mL
		90 mg/1 mL PFS	65219-0826-26	1 mL
		130 mg/26 mL vials	65219-0828-05	104 mL
Pyzchiva	ustekinumab-ttwe	45 mg/0.5 mL PFS	61314-0651-01	0.5 mL
		90 mg/1 mL PFS	61314-0652-01	1 mL
		130 mg/26 mL vials	61314-0654-94	104 mL
Selarsdi	ustekinumab-aeqn	45 mg/0.5 mL PFS	51759-0505-32	0.5 mL
		90 mg/1 mL PFS	51759-0607-32	1 mL
		130 mg/26 mL vials	51759-0708-13	104 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
Steqeyma	ustekinumab-stba	45 mg/0.5 mL PFS	72606-0027-01	0.5 mL
		90 mg/1 mL PFS	72606-0028-01	1 mL
		130 mg/26 mL vials	72606-0029-01	104 mL
Yesintek	ustekinumab-kfee	45 mg/0.5 mL PFS	83257-0023-41	0.5 mL
		45 mg/0.5 mL vials	83257-0024-11	0.5 mL
		90 mg/1 mL PFS	83257-0025-41	1 mL
		130 mg/26 mL vials	83257-0026-11	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
Tremfya	guselkumab	200 mg/20 mL vials	57894-0650-02	20 mL
Ultomiris	ravulizumab-cwvz	300 mg/3 mL vials	25682-0025-01	36 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
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
		300 mg/2 mL PFS	50242-0227-01	4 mL
		150 mg vial/mL PFS	50242-0215-01	4 mL
		75 mg/0.5 mL PFS	50242-0214-01	0.5 mL

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Xolair	omalizumab	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 auto-injector	50242-227-55	4 mL
		150 mg/mL auto-injector	50242-215-55	4 mL
		75 mg/0.5 mL auto-injector	50242-214-55	0.5 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
Jubbonti	denosumab-bbdz	60 mg/1 mL PFS	61314-0240-63	1 mL
Wyost	denosumab-bbdz	120 mg/1.7 mL vials	61314-0228-94	1.7 mL
Stoboclo	denosumab-bmwo	60 mg/1 mL PFS	72606-0037-01	1 mL
Osenvelt	denosumab-bmwo	120 mg/1.7 mL vials	72606-0038-01	1.7 mL
Conexence	denosumab-bnht	60 mg/1 mL PFS	65219-0668-01	1 mL
Bomynta	denosumab-bnht	120 mg/1.7 mL vials	65219-0670-01	1.7 mL
		120 mg/1.7 mL PFS	65219-0672-01	1.7 mL
Bildyos	denosumab-nxxp	60 mg/1 mL PFS	78206-0193-01	1 mL
Bilprevda	denosumab-nxxp	120 mg/1.7 mL vials	78206-0195-01	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	200 mL
			70510-2171-02	
Reclast	zoledronic acid	4 mg/5 mL vials	00409-4215-01	5 mL
			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	
		4 mg/100 mL vials	70860-0210-51	100 mL
		4 mg/100 mL infusion	00409-4229-01	100 mL
			23155-0186-31	
			25021-0826-67	
			25021-0826-82	
		5mg/100 mL vials	00078-0435-61	100 mL
			25021-0830-82	
			43598-0331-11	
			51991-0064-98	
			55111-0688-52	
			63323-0966-00	
			67457-0619-10	

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Reclast	zoledronic acid	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 Keytruda	pembrolizumab 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
Skyrizi	risankizumab	600mg/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 Tofidence Tyenne	tocilizumab tocilizumab-bavi tocilizumab-aazg	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 every 4 weeks administration at doses up to 2.5 mg.
		Diabetic macular edema (DME)	
		Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)	
		Neovascular age-related macular degeneration (nAMD)	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Avastin	bevacizumab	Neovascular glaucoma	The recommended dose is every 4 weeks administration at doses up to 2.5 mg.
		Neovascularization of the iris (rubeosis iridis)	
		Proliferative diabetic retinopathy (DR)	
		Type I retinopathy of prematurity (ROP)	
		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	brolicizumab	Neovascular age-related macular degeneration (nAMD)	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.
		Diabetic macular edema (DME)	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.
Botox	onabotulinumtoxinA		Administered no more frequent than every 12 weeks.
Byooviz	ranibizumab-nuna	Neovascular age-related macular degeneration (nAMD)	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.
		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).
		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.
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)	

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Cimerli	ranibizumab-eqrn	Diabetic retinopathy (DR)	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 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 (nAMD)	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 (DME)	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).
		Diabetic retinopathy (DR)	
		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.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Eylea	aflibercept	Neovascular age-related macular degeneration (nAMD)	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).
		Retinopathy of prematurity (ROP)	The recommended dose is 0.4 mg (0.01 mL) per affected eye(s) and may be given bilaterally on the same day. Injections may be repeated in each eye. The treatment interval between doses injected into the same eye should be at least 10 days.
Eylea HD	aflibercept	Diabetic macular edema (DME)	The recommended dose is 8 mg (0.07 mL) into affected eye(s) every 4 weeks (approximately every 28 days +/- 7 days) for the first 3 doses, then 8 mg every 8 to 16 weeks +/- 1 week. Maximum of 12 doses per year per eye.
		Neovascular age-related macular degeneration (nAMD)	
		Diabetic retinopathy (DR)	
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.
Fynetra	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: <ul style="list-style-type: none"> <li>• 1.5 mg/kg once every week; or</li> <li>• 3 mg/kg once every 2 weeks; or</li> <li>• 6 mg/kg once every 4 weeks.</li> </ul>
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.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
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.
Remicade Avsola Inflectra Renflexis	infliximab infliximab-axxq infliximab-dyyb infliximab-abda	Crohn's disease, noninfectious uveitis, plaque psoriasis, psoriatic arthritis, ulcerative colitis	Administered at 0, 2, and 6 weeks, then every 8 weeks thereafter.
Remicade Avsola Inflectra Renflexis	infliximab infliximab-axxq infliximab-dyyb infliximab-abda	Sarcoidosis	Administered at week 0 and 2, then once every 4 to 6 weeks thereafter.
Remicade Avsola Inflectra Renflexis	infliximab infliximab-axxq infliximab-dyyb infliximab-abda	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.
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.
Lucentis	ranibizumab	Diabetic macular edema (DME) Diabetic retinopathy (DR)	The recommended dose is 0.3 mg to affected eye(s) once a month (approximately every 28 days).
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).
Lucentis	ranibizumab	Neovascular age-related macular degeneration (nAMD)	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.
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.
Niktimvo	axatilimab-csfr	Chronic graft-versus-host-disease (cGVHD)	0.3 mg/kg (maximum 35 mg) administered every 2 weeks
Nucala	mepolizumab	Asthma Chronic rhinosinusitis with nasal polyps Eosinophilic granulomatosis with polyangiitis (EGPA) Hypereosinophilic syndrome (HES)	Administered once every 4 weeks.
Nyvepria	pegfilgrastim-apgf	Oncology	Administered once every 2 weeks.

Medication Name		Diagnosis	Maximum Frequency	
Brand	Generic			
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, Crohn's disease	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.	
		Graft-versus-host disease (GVHD) prophylaxis	Administered on day before transplantation, followed by a dose on day 5, 14, and 28 after transplant.	
Pavblu	afibercept-ayyh	Diabetic macular edema (DME)	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).	
		Diabetic retinopathy (DR)		
		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.
		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).
PiaSky	crovalimab-akkz	Paroxysmal nocturnal hemoglobinuria (PNH)	One loading dose administered intravenously on Day 1, followed by four additional weekly loading doses administered subcutaneously (on days 2, 8, 15, and 22). The maintenance dose starts on day 29 and is then administered every 4 weeks subcutaneously.	
Prolia Bildyos Conexence Jubbonti Stoboclo	denosumab denosumab-nxxp denosumab-bnht denosumab-bbdz denosumab-bmwo	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.
Bkemv	eculizumab-aeeb	aHUS, MG, NMOSD, PNH	Administered once weekly for 5 doses, then every 2 weeks thereafter.
Epysqli	eculizumab-aagh	aHUS, MG, NMOSD, PNH	Administered once weekly for 5 doses, then every 2 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 Imuldosa	ustekinumab ustekinumab-srlf	Psoriasis, psoriatic arthritis	Administered subcutaneously - initially and 4 weeks later, then every 12 weeks thereafter.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Otulfi Pyzchiva Selarsdi Steqeyma Yesintek	ustekinumab-aaaz ustekinumab-ttwe ustekinumab-aeKn ustekinumab-stba ustekinumab-kfce	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.
Susvimo	ranibizumab	Neovascular age-related macular degeneration (nAMD) Diabetic macular edema (DME)	The recommended dose is 2 mg to affected eye(s) continuously delivered via ocular implant every 24 weeks (approximately 6 months). If clinically necessary, supplemental treatment with 0.5 mg intravitreal injection may be administered in the affected eye(s) while the implant is in place.
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.
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.
Tezspire	tezepelumab-ekko	Asthma	Administered once every 4 weeks.
Tremfya	guselkumab	Ulcerative colitis	Administered intravenously initially at Week 0, Week 4, and Week 8, then administered subcutaneously every 4 or 8 weeks thereafter.
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 (nAMD)	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

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Vabysmo	faricimab	Neovascular age-related macular degeneration (nAMD)	dosing every 8 weeks, some patients may need dosing every 4 weeks.
		Diabetic macular edema (DME)	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.
		Macular edema following retinal vein occlusion (RVO)	The recommended dose is 6 mg (0.05 mL) by intravitreal injection every 4 weeks (approximately every 28 ±7 days, monthly) for 6 months.
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.
		Chronic inflammatory demyelinating polyneuropathy (CIDP)	Administered once weekly.
Xeomin	incobotulinumtoxinA		Administered no more frequent than every 12 weeks.
Xgeva Bilprevida Bomynta Osenvelt Wyost	denosumab denosumab-nxxp denosumab-bnht denosumab-bmwo denosumab-bbdz	Oncology related indications	Per FDA and/or NCCN labeling; Maintenance dosing: administered once every 4 weeks.  Giant cell tumor of the bone and hypercalcemia of malignancy: Additional doses of 120 mg on days 8 and 15 of the first month of therapy are recommended.
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 total serum IgE levels.

Medication Name		Diagnosis	Maximum Frequency
Brand	Generic		
Xolair	omalizumab	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.

Requests outside of this criteria will be reviewed for medical necessity on a case-by-case basis.

## 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
C9399	Unclassified drugs or biologicals
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)
J0177	Injection, aflibercept HD, 1 mg
J0178	Injection, aflibercept, 1 mg
J0179	Injection, brolocizumab-dbl, 1 mg
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
J1073	Testosterone pellet, implant, 75 mg
J1299	Injection, eculizumab, 2 mg
J1301	Injection, edaravone, 1 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
J1304	Injection, tofersen, 1 mg
J1306	Injection, inclisiran, 1 mg
J1307	Injection, crovalimab-akkz, 10 mg
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J1602	Injection, golimumab, 1 mg, for intravenous use
J1628	Injection, guselkumab, 1 mg

HCPCS Code	Description
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
J2777	Injection, faricimab-svoa, 0.1 mg
J2778	Injection, ranibizumab, 0.1 mg
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 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
J3490	Unclassified drugs
J3590	Unclassified biologics
J7170	Injection, emicizumab-kxwh, 0.5 mg
J9022	Injection, atezolizumab, 10 mg
J9023	Injection, avelumab, 10 mg
J9035	Injection, bevacizumab, 10 mg
J9038	Injection, axatilimab-csfr, 0.1 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
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg
Q5099	Injection, ustekinumab-stba (Steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (Yesintek), biosimilar, 1 mg
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg

HCPCS Code	Description
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5108	Injection, pegfilgrastim-jmdb (Fulphila), biosimilar, 0.5 mg
Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 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 (ZIEXTENZO), biosimilar, 0.5 mg
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg
Q5122	Injection, pegfilgrastim-apgf (Nyvepria), biosimilar, 0.5 mg
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg
Q5126	injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Q5127	Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg
Q5128	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg
Q5130	Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg
Q5136	Injection, denosumab (jubbonti/wyost), biosimilar, 1 mg
Q5147	Injection, aflibercept-ayyh (Pavblu), biosimilar, 0.1 mg
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg
Q5157	Injection, denosumab (stoboclo/osenvelt), biosimilar, 1 mg
Q5158	Injection, denosumab-bnht (Bomynta/Conexxence), biosimilar, 1 mg
Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg
Q9999	Injection, ustekinumab-aaaz (otulfi), biosimilar, 1 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 100mg/4mL vial
70121-1754-07	Alymsys 100mg/4mL vial
70121-1755-01	Alymsys 400mg/16mL vial
70121-1755-07	Alymsys 400mg/16mL vial
71336-1003-01	Amvuttra 25 mg/0.5 mL PFS

National Drug Code	Description
50242-0060-01 50242-0060-10	Avastin 100 mg/4 mL vial
50242-0061-01 50242-0061-10	Avastin 400 mg/16 mL vial 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
78206-0193-01	Bildyos 60 mg/1 mL PFS
78206-0195-01	Bilprevda 120 mg/1.7 mL vials
55513-0180-01	Bkemv 300mg/30 mL vial
65219-0670-01	Bomyntra 120 mg/1.7 mL vials
65219-0672-01	Bomyntra 120 mg/1.7 mL PFS
00023-1145-01	Botox 100 units vial
00023-3921-02	Botox 200 units vial
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
59310-0610-31	Cinqair 100mg/10mL vial
65219-0668-01	Conexxence 60 mg/1 mL PFS
72960-0112-01	Daxxify 100 unit vial
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	Depo-Testosterone (testosterone cypionate) 200 mg/mL vial

National Drug Code	Description
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
51759-0208-13	Epysqli 300mg/30mL vial
00310-1830-30	Fasenra 30mg/mL pre-filled pen
00310-1730-30	Fasenra 30mg/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	Fylneta 6mg/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
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
51407-0929-11 69448-0017-63	Imuldosa 45 mg/0.5 mL PFS
51407-0930-11 69448-0018-63	Imuldosa 90 mg/1 mL PFS
51407-0931-11 69448-0019-26	Imuldosa 130 mg/26 mL vials
00069-0809-01	Inflectra 100 mg vial
61314-0240-63	Jubbonti 60 mg/1 mL PFS
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 8mg/mL vial
00078-1000-60	Leqvio 284mg/1.5mL PFS
61755-0008-01	Libtayo 350mg/7mL vial

National Drug Code	Description
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
50881-0034-12	Niktimvo 9 mg/0.18 mL vial
50881-0023-11	Niktimvo 22 mg/0.44 mL vial
50881-0012-10	Niktimvo 50 mg/ 1 mL vial
00173-0881-01	Nucala 100 mg vials
00173-0904-42	Nucala 40mg/0.4mL PFS
00173-0892-01	Nucala 100mg/mL PFS
00173-0892-42	Nucala 100mg/mL PFS
00069-0324-01	Nyvepria 6 mg/0.6 mL PFS
50242-0150-01	Ocrevus 300mg/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 120mg/12 mL vials
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
72606-038-01	Osenvelt 120 mg/1.7 mL vial
65219-0824-01	Otulfli 45 mg/0.5 mL PFS
65219-0826-26	Otulfli 90 mg/1 mL PFS
65219-0828-05	Otulfli 130 mg/26 mL vials
50242-0115-01	PiaSky 340 mg/2 mL vial
55513-0710-01	Prolia 60 mg/1 mL PFS
61314-0651-01	Pyzchiva 45 mg/0.5 mL PFS
61314-0652-01	Pyzchiva 90 mg/1 mL PFS
61314-0654-94	Pyzchiva 130 mg/26 mL vials
64406-0109-01	Qalsody 100mg/15mL vial
70510-2171-01 70510-2171-02	Radicava 30mg/100mL 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

National Drug Code	Description
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 13.2mg/0.6mL 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
51759-0505-32	Selarsdi 45 mg/0.5 mL PFS
51759-0607-32	Selarsdi 90 mg/1 mL PFS
51759-0708-13	Selarsdi 130 mg/26 mL vials
57894-0350-01	Simponi Aria 50 mg/4 mL vial
00074-5015-01	Skyrizi 600mg/10 mL vials
25682-0001-01	Soliris 300 mg/30 mL vial
00597-0035-10	Spevigo 450mg/7.5mL 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 6mg/0.6mL PFS
72606-0037-01	Stoboclo 60 mg/1 mL PFS
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
55513-0123-01	Tezspire 210mg/1.91mL pre-filled pen
55513-0112-01	Tezspire 210mg/1.91mL PFS
64406-0022-01 64406-0023-01 64406-0024-01	Tofidence 20 mg/mL vials
00069-0305-01 00069-0306-01	Trazimera 420 mg vial
57894-0650-02	Tremfya 200 mg/20 mL vial
63459-0103-10	Truxima 100 mg/10 mL vial
63459-0104-50	Truxima 500 mg/50 mL vial
65219-0590-04 65219-0592-10 65219-0594-20	Tyenne 20mg/mL vials

National Drug Code	Description
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	Vegzelma 100 mg/4 mL vial
32228-0011-02	
32228-0011-03	Vegzelma 400 mg/16 mL vial
32228-0011-04	
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
61314-0228-94	Wyost 120 mg/1.7 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 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
00409-4229-01	Zoledronic Acid 4 mg/100 mL infusion
23155-0186-31	
25021-0826-67	
25021-0826-82	
70860-0210-51	Zoledronic Acid 4 mg/100 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	

National Drug Code	Description
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 95<sup>th</sup> percentile for adult body weight (140 kg) and body surface area (2.71 meters<sup>2</sup>) in the U.S. (adult male, 30 to 39 years, Fryar, 2021).<sup>59</sup>

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
05/01/2026	<p><b>Coverage Rationale</b>  <b>Maximum Allowed Quantities by HCPCS Units</b></p> <ul style="list-style-type: none"> <li>• Updated list of applicable HCPCS codes to reflect quarterly edits: <ul style="list-style-type: none"> <li><b>Bilydos</b> <ul style="list-style-type: none"> <li>○ Replaced C9399, J3490, and J3590 with Q5162</li> </ul> </li> <li><b>Bilprevda</b> <ul style="list-style-type: none"> <li>○ Replaced C9399 and J9999 with Q5162</li> </ul> </li> </ul> </li> </ul> <p><b>Applicable Codes</b></p> <ul style="list-style-type: none"> <li>• Updated list of applicable HCPCS codes to reflect quarterly edits; added Q5162</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Archived previous policy version CSPA2026D0034AR</li> </ul>

## 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, 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<sup>®</sup> 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.