Medical Benefit Therapeutic Equivalent Medications – Excluded Drug List with Preferred Alternatives

Last Updated: January 1, 2025

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Instructions for Use

This Excluded Medications List with Preferred Alternatives list provides the listing of certain medical benefit medications that are healthcare provider administered, that have been deemed Therapeutically Equivalent by the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee. Therapeutic Equivalence is defined as having essentially the same efficacy and adverse effect profile to another covered medication/product.

The Excluded Medications List with Preferred Alternatives list applies to: UnitedHealthcare Commercial plan members, including All Savers and affiliate plans such as UnitedHealthcare of the Mid-Atlantic, UnitedHealthcare Oxford, Neighborhood Health Partnership and UnitedHealthcare of the River Valley.

This list is supported by the applicable Medical Benefit Drug Policy titled Medical Benefit Therapeutic Equivalent Medications – Excluded Drugs.

When determining whether Medical Benefit Drug Exclusions applies to the individual member, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Medical Benefit Drug Policy is based. In the event of a conflict, the member specific benefit plan document supersedes the applicable Medical Benefit Drug Policy and List. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Medical Benefit Drug Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Benefit Considerations

UnitedHealthcare benefit documents define therapeutically equivalent as when medications/products have essentially the same efficacy and adverse effect profile. This determination is made by the UnitedHealthcare P&T Committee and is not intended to imply therapeutic equivalence as defined by the FDA Orange Book. The medications may be excluded from coverage while the medications are listed on this document or will be reviewed against available clinical evidence, which includes applicable Medical Benefit Drug Policies, if required by law.

Medication List

Excluded Medication	HCPCS Code(s)	Must Try All Unless Noted Otherwise
Alyglo™	J1552	Bivigam®, Cutaquig®, Cuvitru®, Flebogamma® DIF, Gammagard® Liquid, Gammagard® S/D, Gammaked™, Gammaplex®, Gamunex®-C, Hizentra®, HyQvia®, Octagam®, Privigen®, Xembify®
Asceniv™	J1554	Bivigam®, Cutaquig®, Cuvitru®, Flebogamma® DIF, Gammagard® Liquid, Gammagard® S/D, Gammaked™, Gammaplex®, Gamunex®-C, Hizentra®, HyQvia®, Octagam®, Privigen®, Xembify®
Beovu®	J0179	Avastin®, Cimerli™, Eylea®, Lucentis®, Vabysmo™
Byooviz™	Q5124	Avastin®, Cimerli™, Eylea®, Lucentis®, Vabysmo™
Elfabrio®	J2508	Fabrazyme®
Gel-One®	J7326	Durolane®, Euflexxa®, Gelsyn-3®
GenVisc 850®	J7320	Durolane®, Euflexxa®, Gelsyn-3®
Hyalgan®	J7321	Durolane®, Euflexxa®, Gelsyn-3®
Hymovis®	J7322	Durolane®, Euflexxa®, Gelsyn-3®
Monovisc®	J7327	Durolane®, Euflexxa®, Gelsyn-3®
Orthovisc®	J7324	Durolane®, Euflexxa®, Gelsyn-3®
Panzyga® (IV)	J1576	Bivigam®, Cutaquig®, Cuvitru®, Flebogamma® DIF, Gammagard® Liquid, Gammagard® S/D, Gammaked™, Gammaplex®, Gamunex®-C, Hizentra®, HyQvia®, Octagam®, Privigen®, Xembify®
Supartz®	J7321	Durolane®, Euflexxa®, Gelsyn-3®
Synojoynt®	J7331	Durolane®, Euflexxa®, Gelsyn-3®
Synvisc®	J7325	Durolane®, Euflexxa®, Gelsyn-3®
Synvisc-One®	J7325	Durolane®, Euflexxa®, Gelsyn-3®
Triluron®	J7332	Durolane®, Euflexxa®, Gelsyn-3®
TriVisc®	J7329	Durolane®, Euflexxa®, Gelsyn-3®
Visco-3™	J7321	Durolane®, Euflexxa®, Gelsyn-3®

List History/Revision Information

Date	Summary of Changes
01/01/2025	• Updated list of excluded medications: ○ Added Alyglo™ (HCPCS code J1552) to exclusions ○ Removed Cutaquig® (SC) (HCPCS code J1551) from exclusions ○ Modified list of preferred alternative medications for Asceniv™ and Panzyga® (IV); added Cutaquig®
07/01/2024	• Updated list of excluded medications: ○ Removed Cuvitru® (SC) (HCPCS code J1555) from exclusions ○ Modified list of preferred alternative medications for Asceniv™, Cutaquig® (SC), and Panzyga® (IV); added Cuvitru® • Updated list of applicable HCPCS codes for Elfabrio®; removed C9399
01/01/2024	• Updated list of related policies; added reference link to the Medical Benefit Drug Policy titled: ○ *Medical Therapies for Enzyme Deficiencies* ○ *Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors* • Updated list of excluded medications; added Elfabrio® (HCPCS codes C9399 and J2508)

Date	Summary of Changes
10/01/2023	• Updated list of excluded medications: ○ Added: ▪ Beovu® (HCPCS code J0179) ▪ Byooviz™ (HCPCS code Q5124) ▪ Cuvitru® (SC) (HCPCS code J1555) ○ Removed Cuvitru® from list of preferred alternative medications for Asceniv™, Cutaquig® (SC), and Panzyga® (IV)
07/01/2023	• Updated list of CPT/HCPCS codes to reflect quarterly edits: ○ Added J1576 ○ Removed 90283 and J1599