

Provider Administered Drugs – Preferred Products

Policy Number: 2025D0112D

Effective Date: July 1, 2025

[Instructions for Use](#)

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Related Policies

None

Coverage Rationale

[See Benefit Considerations](#)

This policy provides parameters for coverage of preferred medications covered under the medical benefit.

Medical Necessity Plans

The [Preferred Drug Products](#) table below lists the UnitedHealthcare preferred products and respective non-preferred products. Coverage will be provided for the UnitedHealthcare preferred product contingent on the coverage criteria in the [Diagnosis-Specific Criteria](#) section.

Coverage for any respective non-preferred product will be provided contingent on the criteria in the [Preferred Drug Products Criteria](#) and the [Diagnosis-Specific Criteria](#) sections. Members new to therapy will be required to utilize the UnitedHealthcare preferred product unless they meet the criteria in this section.

Preferred Product Criteria

Treatment with the respective non-preferred product specified in the [Non- Preferred Drug Products](#) table below is medically necessary for proven indications when both of the following are met:

- History of intolerance or contraindication to one of the UnitedHealthcare's preferred products; and
- Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with the respective non-preferred product.

Medical Drug Products

Below are UnitedHealthcare preferred medical drug products with a brand/generic alternative non-preferred products:

UnitedHealthcare Preferred Drug Products	UnitedHealthcare Non-Preferred Drug Products
<ul style="list-style-type: none"> Treprostinil 20mg/20mL Solution for Injection (00781-3420) (Sandoz Inc. a Novartis Company) Treprostinil 50mg/20mL Solution for Injection (00781-3425) (Sandoz Inc. a Novartis Company) Treprostinil 100mg/20mL Solution for Injection (00781-3427) (Sandoz Inc. a Novartis Company) Treprostinil 200mg/20mL Solution for Injection (00781-3430) (Sandoz Inc. a Novartis Company) Treprostinil 20mg/20mL Solution for Injection (00781-3420) (Sandoz Inc. a Novartis Company) Treprostinil 50mg/20mL Solution for Injection (00781-3425) (Sandoz Inc. a Novartis Company) 	<ul style="list-style-type: none"> Remodulin (treprostinil) 1mg/mL Solution for Injection (66302-0101) (United Therapeutics Corporation) Remodulin (treprostinil) 2.5mg/mL Solution for Injection (66302-0102) (United Therapeutics Corporation) Remodulin (treprostinil) 5mg/mL Solution for Injection (66302-0105) (United Therapeutics Corporation) Remodulin (treprostinil) 10mg/mL Solution for Injection (66302-0110) (United Therapeutics Corporation) Treprostinil 20mg/20mL Solution for Injection (00703-0666) (Teva Pharmaceuticals USA)

UnitedHealthcare Preferred Drug Products	UnitedHealthcare Non-Preferred Drug Products
<ul style="list-style-type: none">Treprostinil 100mg/20mL Solution for Injection (00781-3427) (Sandoz Inc. a Novartis Company)Treprostinil 200mg/20mL Solution for Injection (00781-3430) (Sandoz Inc. a Novartis Company)	<ul style="list-style-type: none">Treprostinil 50mg/20mL Solution for Injection (00703-0676) (Teva Pharmaceuticals USA)Treprostinil 100mg/20mL Solution for Injection (00703-0686) (Teva Pharmaceuticals USA)Treprostinil 200mg/20mL Solution for Injection (00703-0696) (Teva Pharmaceuticals USA)Treprostinil 20mg/20mL Solution for Injection (43598-0649-11) (Dr. Reddy's Laboratories, Inc.)Treprostinil 50mg/20mL Solution for Injection (43598-0646-11) (Dr. Reddy's Laboratories, Inc.)Treprostinil 100mg/20mL Solution for Injection (43598-0647-11) (Dr. Reddy's Laboratories, Inc.)Treprostinil 200mg/20mL Solution for Injection (43598-0648-11) (Dr. Reddy's Laboratories, Inc.)

Diagnosis-Specific Criteria

Refer to the drug-specific coverage policy if noted in the *Related Policies* section above.

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 the member specific benefit plan document 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
J3285	Injection, treprostinil, 1 mg

Benefit Considerations

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy.

Policy History/Revision Information

Date	Summary of Changes
07/01/2025	<p>Coverage Rationale</p> <ul style="list-style-type: none">Revised list of non-preferred medical drug products; removed the following Par Sterile Products (NDCs inactive):<ul style="list-style-type: none">Treprostinil 20mg/20mL Solution for Injection (42023-0206-01)Treprostinil 50mg/20mL Solution for Injection (42023-0207-01)Treprostinil 100mg/20mL Solution for Injection (42023-0208-01)Treprostinil 200mg/20mL Solution for Injection (42023-0209-01) <p>Supporting Information</p> <ul style="list-style-type: none">Updated <i>Benefit Considerations</i> section to reflect the most current informationArchived previous policy version 2024D0112C

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific

benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. 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.