tividenofusp alfa-eknm (Avlayah)

Medical Benefit Drug Policy

1. All requests for this drug must receive authorization prior to drug administration for claim payment.
2. Criteria for coverage is pending P&T Committee approval.
3. In the interim, all requests for coverage will be reviewed for medical necessity.

Place of Service

Home Infusion Administration
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

References

1. Avlayah ((tividenofusp alfa-eknm) Prescribing Information. Denali Therapeutics Inc., South San Francisco, CA: 3/2026.

Review History

Date of Last Annual Review: NA
Changes from previous policy version:

- placeholder

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee