2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Service Category	Services/Procedures
Ambulance: Non-emergent Fixed Wing only	Requires prior authorization before transport
Behavioral Health Services	Day Treatment Electroconvulsive Therapy (ECT) Inpatient Psychiatric Intensive Outpatient Therapy Neuropsychological Testing Partial hospitalization Psychological Testing Substance Use Disorder Treatment/Rehabilitation
Bronchial Thermoplasty	Outpatient procedure for the treatment of asthma
Chiropractor Services	Medicare coverage for chiropractic services extends only to treatment by means of manual manipulation of the spine to correct a subluxation, provided such treatment is reasonable and medically necessary
Clinical Trials: Notification Only	A clinical trial is one type of clinical research that follows a pre-defined plan or protocol
Cochlear Implants & Surgery	Provides direct electrical stimulation to the auditory nerve, bypassing the usual transducer cells that are absent or nonfunctional in deaf cochlea
Cosmetic Procedures/Dermatology	Includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member Including, but not limited to the following: Chemical exfoliation, electrolysis Dermabrasion/chemical peel Laser treatment Skin injections and implants
Drug Testing	Quantitative tests for drugs of abuse

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Service Category	Services/Procedures
Durable Medical Equipment (DME)	BIPAP Bone Growth Stimulator Hospital Bed/Mattress Infusion Pumps Lift Devices including Hoyer TENS Units Vagus Nerve Stimulator Ventilators Wheelchairs, Custom Wheelchairs, Power Wound Vacuum (Negative Pressure) Devices Implantable Neurostimulator Continuous Glucose Monitor and supplies
Enhanced External Counterpulsation (EECP)	The noninvasive outpatient treatment for patients with coronary artery disease (CAD)
Experimental/Investigational Services	Any item or service potentially considered investigational or experimental must be authorized in advance
Gender Reassignment	General term to describe a surgery or surgeries that affirm a person's gender identity
Genetic Counseling and Testing	Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins
Home Health Services With	Home Health Aide Occupational Therapy Physical Therapy Skilled Nursing Visits Social Work Visits Speech Therapy
Hospice: Notification only	Home or Inpatient
Hyperbaric O2 Therapy	Includes HBO therapy administered in a chamber
Infertility	Drug Therapy, Testing, Treatment

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Service Category	Services/Procedures
Hospital Admission	Acute Inpatient Hospital Inpatient Rehabilitation Hospital Long Term Acute Care Hospital (LTAC) Skilled Nursing Facility (SNF)
Neuropsychological Testing	Evaluations for members with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning
Nutritional Supplements and/or services	Formula administered via a enteral feeding tube
Observation Stay	Prior Authorization required if >48 hours
Orthotics/Prosthetics	Prosthetic devices needed to replace a body part or function Limited coverage options for orthotic shoes and devices, including artificial limbs and eyes as well as braces for arms, legs, back, or neck, penile prosthetics
Outpatient Therapy • **Occupational Therapy (OT)** • **Physical Therapy (PT)** • **Speech-Language Therapy (ST)**	Requires authorization after 12 combined visits
Pain Management	Epidural Injections Facet Injections Median Branch Block Radio Frequency Ablation Trigger Point Sacroiliac joint injection (SI)
Radiation Therapy	Stereotactic radiotherapy Intensity modulated radiotherapy (IMRT) Proton beam therapy Neutron beam therapy
Radiology	MRI, MRA, PET Scan, CT, Cardiac Imaging PET MRA CT Cardiac Imaging **Visit www.radmd.com**
Sleep Studies	Surgery and treatment

Service Category	Services/Procedures
Surgeries, regardless of place of service continued	Abortion Bariatric Surgery Blepharoplasty Breast Augmentation (except following mastectomy) Breast Reduction Capsule Endoscopy Chondrocyte Implants Cochlear Implant Facial Osteotomy Hysterectomy Joint Replacements Mastectomy for Gynecomastia Oral Surgery -- Temporomandibular Joint Surgery Otoplasty Reconstructive and Plastic Surgery Rhinoplasty Sacral Nerve Neuromodulation Scar Revision Septoplasty Spinal Surgeries including Fusion, Stabilization, Discectomy Uvulopalatopharyngoplasty/Uvolopharyngoplasty Veins (ablation, ligation, stripping, sclerotherapy) X-Stop: Spinal Surgery
Transplants	All transplant evaluations and procedures, including but not limited to evaluation, transplant consult visits, HLA typing, donor search and transplant procedure

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

STEP THERAPY

Medicare Part B Drugs

Procedure Code	Procedure Description
C9050	EMAPALUMAB-LZSG
J0129	ABATACEPT INJECTION
J0178	AFLIBERCEPT INJECTION
J0584	BUROSUMAB-TWZA 1M
J0585	ONABOTULINUMTOXINA
J0717	CERTOLIZUMAB PEGOL INJ 1MG
J0718	CERTOLIBUMAB PEGOL, INJ
J0800	CORTICOTROPIN INJECTION
J0897	DENOSUMAB INJECTION
J1300	ECULIZUMAB INJECTION
J1428	ETEPLIRSEN, 10 MG
J1459	IVIG PRIVIGEN 500 MG
J1555	CUVITRU, 100 MG
J1556	IMM GLOB BIVIGAM, 500MG
J1557	GAMMAPLEX INJECTION
J1559	HIZENTRA INJECTION
J1561	GAMUNEX-C/GAMMAKED
J1562	IMMUNE GLOBULIN 105 5 GRAMS, INJECTION
J1566	IMMUNE GLOBULIN, POWDER
J1568	OCTAGAM INJECTION
J1569	GAMMAGARD LIQUID INJECTION
J1599	IVIG NON-LYOPHILIZED
J1572	FLEBOGAMMA INJECTION
J1575	HYQVIA 100MG IMMUNEGLOBULIN
J1599	IVIG NON-LYOPHILIZED, NOS
J1602	GOLIMUMAB FOR IV USE 1MG
J1745	INFLIXIMAB (REMICADE)
J1930	LANREOTIDE INJECTION
J2323	NATALIZUMAB INJECTION
J2350	OCRELIZUMAB, 1 MG
J2353	OCTREOTIDE INJECTION, DEPOT
J2357	OMALIZUMAB INJECTION
J2503	PEGAPTANIB SODIUM INJECTION
J2778	RANIBIZUMAB INJECTION
J3262	TOCILIZUMAB, 1 MG
J3304	TRIAMCINOLONE ACE XR 1MG
J3357	USTEKINUMAB SUB CU 1 MG
J3380	VEDOLIZUMAB
J3396	VERTEPORFIN INJECTION
J7318	DUROLANE 1 MG

STEP THERAPY

Medicare Part B Drugs

J7320	GENVISC 850, 1MG
J7321	HYALGAN SUPARTZ VISCO-3 DOSE
J7322	HYMOVIS INJECTION 1 MG
J7323	EUFLEXXA INJ PER DOSE
J7324	ORTHOVISC INJ PER DOSE
J7325	SYNVISC OR SYNVISC-ONE
J7326	GEL-ONE
J7327	MONOVISC INJ PER DOSE
J7328	GELSYN-3 INJECTION 0.1 MG
J7329	HYALURONAN DERIVATIVE; TRIVISC IA 1 MG
J7331	HYALURONAN DERIVATIVE;SYNOJOYNT IA 1MG
J7332	HYALURONAN DERIVATIVE; TRILURON IA I MG
J9022	ATEZOLIZUMAB,10 MG
J9145	INJECTION DARATUMUMAB 10 MG
J9173	DURVALUMAB, 10 MG
J9176	ELOTUZUMAB, 1MG
J9308	RAMUCIRUMAB
J9312	RITUXIMAB, HYALURONIDASE
Q2041	AXICABTAGENE CILOLEUCEL CAR+
Q2042	TISAGENLECLEUCEL CAR-POS T
Q2043	SIPULEUCEL-T AUTO CD54+
Q5103	INFLIXIMAB (INFLECTRA)
Q5104 Q5109	INFLIXIMAB (RENFLEXIS) INFLIXIMAB-QBTX BIOSIMILAR 10 MG

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Prior Authorization

Medicare Part B Drugs

Procedure Code	Procedure Description
A9513	LUTETIUM LU 177 DOTATAT THER
C9035	ARISTADA INITIO
C9036	PATISIRAN
C9037	RISPERIDONE
C9038	MOGAMULIZUMAB-KPKC
C9040	FREMANEZUMAB-VFRM, 1MG
C9043	LEVOLEUCOVORIN
C9044	CEMIPLIMAB-RWLC
C9045	MOXETUMOMAB PASUDOTOX-TDFK
C9049	TAGRAXOFUSP-ERZS
C9051	OMADACYCLINE
C9054	LEFAMULIN XENLETA 1 MG
C9055	BREXANOLONE 1 MG
C9130	IVIG BIVIGAM
C9133	FACTOR IX RECOMBINANT
C9134	FACTOR XIII A-SUBUNIT RECOMB
C9136	FACTOR VIII (ELOCTATE)
C9399	UNCLASSIFIED DRUGS OR BIOLOG
J0135	ADALIMUMAB INJECTION
J0179	BROLUCIZUMAB-DBLL I MG
J0180	AGALSIDASE BETA INJECTION
J0202	ALEMTUZUMAB
J0220	ALGLUCOSIDASE ALFA INJECTION
J0221	LUMIZYME INJECTION
J0222	PATISIRAN, 0.1 MG
J0256	ALPHA 1 PROTEINASE INHIBITOR
J0257	GLASSIA INJECTION
J0364	APOMORPHINE HYDROCHLORIDE
J0490	BELIMUMAB INJECTION
J0517	BENRALIZUMAB, 1 MG
J0567	CERLIPONASE ALFA 1 MG
J0570	BUPRENORPHINE IMPLANT 74.2MG
J0584	BUROSUMAB-TWZA 1 MG
J0586	ABOBOTULINUMTOXINA
J0587	RIMABOTULINUMTOXINB
J0588	INCOBOTULINUMTOXIN A
J0593	LANADELUMAB-FLYO, 1 MG
J0598	C-1 ESTERASE, CINRYZE
J0599	HAEGARDA 10 UNITS
J0604	CINACALCET ORAL I MG

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Prior Authorization **Medicare Part B Drugs**	J0606	ETELCALCETIDE, 0.1 MG
	J0630	CALCITONIN SALMON INJECTION
	J0638	CANAKINUMAB INJECTION
	J0641	LEVOLEUCOVORIN INJECTION
	J0642	LEVOLEUCOVORIN (KHAPZORY) 0.5 MG
	J0775	COLLAGENASE, CLOST HIST INJ
	J0881	DARBEPOETIN ALFA, NON-ESRD
	J0885	EPOETIN ALFA, NON-ESRD
	J0888	EPOETIN BETA NON ESRD
	J0894	DECITABINE INJECTION
	J1190	DEXRAZOXANE HCL INJECTION
	J1301	EDARAVONE, 1 MG
	J1324	ENFUVIRTIDE INJECTION
	J1438	ETANERCEPT INJECTION
	J1439	FERRIC CARBOXYMALTOS 1MG
	J1442	FILGRASTIM EXCL BIOSIMIL
	J1443	FERRIC PYROPHOSPHATE CIT
	J1458	GALSULFASE INJECTION
	J1628	GUSELKUMAB, 1 MG
	J1640	HEMIN, 1 MG
	J1645	DALTEPARIN SODIUM
	J1675	HISTRELIN ACETATE
	J1743	IDURSULFASE INJECTION
	J1744	ICATIBANT INJECTION
	J1746	IBALIZUMAB-UIYK, 10 MG
	J1786	IMUGLUCERASE INJECTION
	J1817	INSULIN FOR INSULIN PUMP USE
	J1931	LARONIDASE INJECTION
	J2170	MECASERMIN INJECTION
	J2182	MEPOLIZUMAB, 1MG
	J2212	METHYLNALTREXONE INJECTION
	J2315	NALTREXONE, DEPOT FORM
	J2355	OPRELVEKIN INJECTION
	J2440	PAPAVERIN HCL INJECTION
	J2505	PEGFILGRASTIM 6MG
	J2507	PEGLOTICASE INJECTION
	J2562	PLERIXAFOR INJECTION
	J2783	RASBURICASE
	J2786	RESLIZUMAB, 1MG
	J2793	RILONACEPT INJECTION
	J2796	ROMIPLOSTIM INJECTION
	J2797	ROLAPITANT, 0.5 MG

Category	Code	Description
Prior Authorization Medicare Part B Drugs	J2820	SARGRAMOSTIM INJECTION
	J2840	SEBELIPASE ALFA 1 MG
	J2940	SOMATREM INJECTION
	J2941	SOMATROPIN INJECTION
	J3095	TELAVANCIN INJECTION
	J3110	TERIPARATIDE INJECTION
	J3111	ROMOSOZUMAB-AQQG 1 MG
	J3140	TESTOSTERONE SUSPENSION INJ
	J3240	THYROTROPIN INJECTION
	J3245	TILDRAKIZUMAB 1 MG
	J3262	TOCILIZUMAB I MG
	J3285	TREPROSTINIL INJECTION
	J3316	TRIPTORELIN XR 3.75 MG
	J3385	VELAGLUCERASE ALFA
	J3397	VESTRONIDASE ALFA-VJBK
	J3398	LUXTURNA 1 BILLION VEC G
	J3591	ESRD ON DIALYSI DRUG/BIO NOC
	J7170	EMICIZUMAB-KXWH 0.5 MG
	J7175	FACTOR X, (HUMAN), 1IU
	J7177	FIBRYGA, 1 MG
	J7179	VONVENDI INJ 1 IU VWF:RCO
	J7180	FACTOR XIII ANTI-HEM FACTOR
	J7181	FACTOR XIII RECOMB A-SUBUNIT
	J7182	FACTOR VIII RECOMB NOVOEIGHT
	J7183	WILATE INJECTION
	J7185	XYNTHA INJ
	J7186	ANTIHEMOPHILIC VIII/VWF COMP
	J7187	HUMATE-P, INJ
	J7188	FACTOR VIII RECOMB OBIZUR
	J7189	FACTOR VIIA
	J7190	FACTOR VIII
	J7191	FACTOR VIII (PORCINE)
	J7192	FACTOR VIII RECOMBINANT NOS
	J7193	FACTOR IX NON-RECOMBINANT
	J7194	FACTOR IX COMPLEX
	J7195	FACTOR IX RECOMBINANT NOS
	J7196	ANTITHROMBIN RECOMBINANT
	J7197	ANTITHROMBIN III INJECTION
	J7198	ANTI-INHIBITOR
	J7199	HEMOPHILIA CLOT FACTOR NOC
	J7200	FACTOR IX RECOMBINAN RIXUBIS
	J7201	FACTOR IX ALPROLIX RECOMB

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Prior Authorization Medicare Part B Drugs	J7202	FACTOR IX IDELVION INJ
	J7203	FACTOR IX RECOMB GLY REBINYN
	J7207	FACTOR VIII PEGYLATED RECOMB
	J7208	JIVI 1 IU
	J7209	FACTOR VIII NUWIQ RECOMB 1IU
	J7311	FLUOCINOLONE ACETONIDE IMPLT
	J7312	DEXAMETHASONE INTRA IMPLANT
	J7313	FLUOCINOL ACET INTRAVIT IMP
	J7314	YUTIQ, 0.01 MG
	J7401	MOMETASONE FUROATE SINUS IMP
	J7518	MYCOPHENOLIC ACID
	J7527	ORAL EVEROLIMUS
	J7677	REVEFENACIN INH NON-COM 1MCG
	J7686	TREPROSTINIL, NON-COMP UNIT
	J8565	GEFITINIB ORAL
	J8650	NABILONE ORAL
	J8705	TOPOTECAN ORAL
	J9015	ALDESLEUKIN INJECTION
	J9017	ARSENIC TRIOXIDE INJECTION
	J9019	ERWINAZE INJECTION
	J9023	AVELUMAB, 10 MG
	J9027	CLOFARABINE INJECTION
	J9034	BENDEKA 1 MG
	J9035	BEVACIZUMAB INJECTION
	J9036	BELRAPZO/BENDAMUSTINE
	J9039	BLINATUMOMAB
	J9041	VELCADE 0.1 MG
	J9042	BRENTUXIMAB VEDOTIN INJ
	J9043	CABAZITAXEL INJECTION
	J9044	BORTEZOMIB, NOS, 0.1 MG
	J9047	CARFILZOMIB, 1 MG
	J9055	CETUXIMAB INJECTION
	J9057	COPANLISIB, 1 MG
	J9118	CALASPARGASE PEGOL-MKNL
	J9153	DAUNORUBICIN, CYTARABINE
	J9199	GEMCITABINE HCL INFUGEM
	J9203	INJ GEMTUZUMAB OZOGAMICIN 0.1 MG
	J9205	IRINOTECAN LIPOSOME 1 MG
	J9212	INTERFERON ALFACON-1 INJ
	J9213	INTERFERON ALFA-2A INJ
	J9215	INTERFERON ALFA-N3 INJ
	J9216	INTERFERON GAMMA 1-B INJ

Category	Code	Description
	J9225	VANTAS IMPLANT
	J9226	SUPPRELIN LA IMPLANT
	J9228	IPILIMUMAB INJECTION
	J9229	INOTUZUMAB OZOGAM 0.1 MG
	J9261	NELARABINE INJECTION
	J9262	OMACETAXINE MEP, 0.01MG
	J9264	PACLITAXEL PROTEIN BOUND
	J9266	PEGASPARGASE INJECTION
	J9271	PEMBROLIZUMAB
	J9285	OLARATUMAB, 10 MG
	J9299	NIVOLUMAB
	J9301	OBINUTUZUMAB INJ
	J9303	PANITUMUMAB INJECTION
	J9305	PEMETREXED INJECTION
	J9306	PERTUZUMAB, 1 MG
	J9309	POLATUZUMAB VEDOTIN-PIIQ 1 MG
	J9311	RITUXIMAB INJECTION
	J9352	TRABECTEDIN 0.1MG
	J9354	ADO-TRASTUZUMAB EMT 1MG
Prior Authorization **Medicare Part B Drugs**	J9355	TRASTUZUMAB INJECTION
	J9356	HERCEPTIN HYLECTA, 10MG
	J9395	FULVESTRANT
	J9400	ZIV-AFLIBERCEPT, 1MG
	J9999	CHEMOTHERAPY DRUG
	Q0138	FERUMOXYTOL, NON-ESRD
	Q0515	SERMORELIN ACETATE INJECTION
	Q2026	RADIESSE INJECTION
	Q2027	SCULPTRA INJECTION
	Q2028	SCULPTRA, 0.5MG
	Q2041	KTE-C19 TO 200 M A ANTI-CD19 CAR POS T CE P TD
	Q2042	TISAGENLECLEUCEL TO 600 M CAR-POS VI T CE PER TD
	Q2050	DOXORUBICIN INJ 10MG
	Q3025	IM INJ INTERFERON BETA 1-A
	Q3026	SUBC INJ INTERFERON BETA-1A
	Q3027	BETA INTERFERON IM 1 MCG
	Q4074	ILOPROST NON-COMP UNIT DOSE
	Q5103	INFLECTRA
	Q5104	RENFLEXIS
	Q5107	MVASI 10 MG
	Q5108	FULPHILA
	Q5111	UDENYCA 0.5 MG
	Q5112	ONTRUZANT 10 MG

2020.2 Medicare Prior Authorization List

SNP/MAPD/MMP **Effective 6.1.2020**

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website. Please verify eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. OUT OF AREA DIAYLSIS DOES NOT REQUIRE PRIOR AUTHORIZATION.

Prior Authorization **Medicare Part B Drugs**	Q5113	HERZUMA 10 MG
	Q5114	OGIVRI 10 MG
	Q5115	TRUXIMA 10 MG
	Q5116	TRAZIMERA 10 MG
	Q5117	KANJINTI 10 MG
	Q9991	BUPRENORPH XR 100 MG OR LESS
	Q9992	BUPRENORPHINE XR OVER 100 MG
	S0145	PEG INTERFERON ALFA-2A/180