McLaren HEALTH PLAN

McLaren Health Plan Medicaid/Healthy Michigan
McLaren Health Advantage
McLaren Health Plan Community (Marketplace/Exchange)

**Prior authorization is required by McLaren for all products for both primary or secondary payer unless Medicare is the primary payer (for hospital services only).**

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **NOC** | |
| Not Otherwise Classified (NOC), unlisted, unspecified codes, and manually priced codes. | Requires preauthorization |
| **Autism Services and ABA Therapy** | |
| Autism services and ABA Therapy **do not** require authorization up to the benefit limit for Community/Commercial and Health Advantage. ***Autism and ABA services are not covered by the plan for Medicaid. Refer to your local mental health center.*** | all codes |
| **Auditory and Oral Procedures** | |
| Auditory Procedures ***Medicaid Only: Authorization is not required for codes for BAHA hearing devices and procedures if services are provided In-Network. Listed codes otherwise require authorization. Refer to the preauthorization grid located at the end of this document for additional information.*** | 69710, 69711, 69714, 69715, 69718, 69728, 69729, 69730, L8627 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Auditory and Oral Procedures cont** | |
| Oral Surgery/Mandibular Surgery/Orthognathic Surgery | 21025, 21026, 21029, 21030, 21031, 21032, 21044, 21045, 21046, 21047, 21048, 21049, 21081, 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21206, 21208, 21210, 21215, 21244, 21245, 21246, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21081, 21440, 21445, 21497, 30545, 30560, 40804, 40818, 40840, 40842, 40843, 40844, 40845, 41500, 41510, 41820, 41821, 41822, 41823, 41825, 41826, 41827, 41828, 41830, 41850, 41870, 41872, 42120, 42299, 42300, 42305, 42310, 42330, 42340, 42400, 42405, 42408, 42409 |
| Procedures to Correct Obstructive Sleep Apnea | 0466T, 0467T, 0468T, 21193, 21194, 21195, 21196, 21198, 21199, 41512, 41530, 41599, 42145, 42299, 61886, 64569, 64570, 64568, 64582, 64583, 64584, S2080 |
| Temporomandibular Joint Syndrome (TMJ) Treatment | 21050, 21060, 21070, 21073, 21110, 21116, 21240, 21242, 21243, 21247, 21248, 21480, 21485, 21490 |
| **Behavioral Health** | |
| Inpatient Behavioral Health Services<br>Inpatient Substance Abuse Treatment (Rehabilitative Services only) | **Medicaid/Healthy Michigan** These benefits are managed by the Prepaid Inpatient Health Plan (PIHP)<br>**Commercial/Community and Health Advantage**: McLaren preauthorization required |
| Electroconvulsive Therapy<br>*Refer to the preauthorization grid located at the end of this document for additional information.* | 90870 |
| Mental Health Partial Hospitalization Programs -<br>*Commercial/Community and Health Advantage Only* | Requires preauthorization |
| Mental Health Residential Treatment Programs -<br>*Commercial/Community and Health Advantage Only* | Requires preauthorization |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Cardiac Procedures and Imaging** | |
| Cardiac procedures and imaging<br>***Authorization Requirements effective 8/1/2024***<br>***Authorization requirements apply to Medicaid and Healthy Michigan Plan only.*** | 33249, 33264, 33270, 78452, 93306, 93458 |
| **Cosmetic Procedures - Medical Necessity review required to determine cosmetic vs reconstructive** | |
| Blepharoplasty | 15820, 15821, 15822, 15823, 67904, 67912, 67916, 67917, 67923, 67924, 67904 |
| Breast Reconstruction Procedures | 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396 |
| Cosmetic Skin Procedures | 11200, 11201, 11951, 11952, 11954, 11960, 15769, 15771, 15772, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15819, 15824, 15825, 15826, 15828, 15829, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 17106, 17107, 17108, 17340, 17360, 17380, 69090 |
| Cosmetic Tattooing | 11920, 11921, 11922 |
| Cosmetic Vein Procedures | 36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36479, 36482, 36483, 37700, 37718, 37722, 37760, 37780, 37785 |
| Lipectomy | 15876, 15877, 15878, 15879 |
| Male Enhancement Procedures | All codes including but not limited to 53445, 54400, 54401, 54405, 54406, 54410, 54411, 54416, 54417, C1813, C2622 |
| Otoplasty | 69300 |
| Panniculectomy | 15830, 15847 |
| Pectus / Carinatum Reconstructive Repair | 21740, 21741, 21742, 21743 |
| Reconstructive Face Procedures | 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21295, 21296, 21299, 40510, 40520, 40527, 40530, 67901, 67902, 67903, 67906, 67909 |
| Rhinoplasty | 30120, 30150, 30160, 30400, 30410, 30420, 30430, 30435, 30450, 30620, 30460, 30462, 30468, 30540 |
| Septoplasty | 30620 |
| Surgical Treatment for Male Gynecomastia | 19300 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Durable Medical Equipment (DME)**<br>**Refer to the preauthorization grid located at the end of this document for additional information.** | |
| DME Purchase<br>All products which require authorization regardless of fee<br><br>****E0483 Medicaid only - Authorization is not required for the diagnosis of Cystic Fibrosis.**<br><br>**Medicaid and Healthy Michigan Plan; Items >$1,500**<br>**Commercial/Community HMO & POS; Items >$3,000**<br>**Health Advantage; Items >$5,000**<br><br>**See Wound Care (DME) category list below for additional codes.** | A4421, A4459, A4619, A5083, A6412, A6501, A6503, A6505, A6506, A6508, A6510, A6511, A6512, A6513, A6519, A6549, A6576, A6577, A6579, A6580, A7522, A9999, B4035, B4081, B4083, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9002, B9006, B9998, B9999**, E0193,** E0236, E0265, E0277, E0301, E0302, E0303, E0304, E0316, E0328, E0329, E0350, E0371, E0372, E0373, E0457, E0460, E0471, E0472, E0482, E0483**, E0625, E0635, E0637, E0638, E0639, E0642, E0651, E0652, E0656, E0657, E0667, E0670, E0675, E0678, E0679, E0681, E0682, E0694, E0745, E0764, E0782, E0783, E0786, E0954, E0983, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1012, E1017, E1018, E1035, E1161, E1230, E1231, E1233, E1234, E1235, E1229, E1231, E1232, E1234, E1235, E1236, E1237, E1239, E1356, E1357, E1399, E1639, E1805, E1810, E1815, E2230, E2295, E2298, E2300, E2301, E2311, E2324, E2327, E2328, E2330, E2331, E2358, E2506, E2508, E2510, E2511, E2599, E2609, E2617, E2625, E8000, K0005, K0009, K0010, K0011, K0108, K0606, K0607, K0608, K0609, K0802, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898, Q0479, Q0480, Q0481, Q0483, Q0489, S9379, T5001 |
| DME Rental<br>All products which require authoriztion regardless of fee<br><br>****E0483 Medicaid only - Authorization is not required for the diagnosis of Cystic Fibrosis.**<br><br>**Medicaid and Healthy Michigan Plan; Items >$500/month**<br>**Commercial/Community HMO & POS; Items >$100/month**<br>**Health Advantage; Items >$500/month** | A9999, E0193. E0194, E0236, E0277, E0302, E0304, E0328, E0329, E0371, E0372, E0373, E0439, E0450, E0457, E0460, E0461, E0463, E0464, E0465, E0466, E0470, E0471, E0472, E0482, E0483**, E0625, E0635, E0636, E0637, E0639, E0651, E0652, E0656, E0657, E0667, E0670, E0675, E0678, E0679, E0681, E0682, E0694, E0747, E0748, E0760, E0764, E0782, E0783, E0786, E0954, E0986, E0988, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1012, E1017, E1018, E1035, E1229, E1231, E1239, E1356, E1357, E1399, E1639, E1841, E2328, E2230, E2295, E2300, E2301, E2324, E2331, E2358, E2402, E2510, E2511, E2599, E2609, E2617, E2625, E8000, K0009, K0010, K0011, K0014, K0108, K0606, K0607, K0608, K0609, K0812, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898, S9379, T5001 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **DME** - *continued* | |
| Orthotics and Corrective Appliances Purchase<br><br>**Medicaid and Healthy Michigan Plan: items >$500**<br>**Commercial/Community HMO & POS: Items >$3,000**<br>**Health Advantage: Items >$5,000**<br>***Medicaid and Health Advantage Only: Authorization is not required for L3649***<br><br>***Prior auth for L1007 effective 3/1/2025*** | L0112, L0170, L0457, L0458, L0460, L0462, L0464, L0480, L0482, L0484, L0486, L0488, L0491, L0631, L0632, L0634, L0635, L0636, L0638, L0639, L0640, L0655, L0700, L0710, L0999, L1001, L1000, L1005, L1007*, L1300, L1320, L1499, L1680, L1685, L1690, L1700, L1710, L1720, L1730, L1755, L1840, L1844, L1860, L1907, L1945, L1960, L1970, L2000, L2010, L2020, L2030, L2034, L2036, L2037, L2038, L2106, L2108, L2116, L2128, L2136, L2280, L2350, L2510, L2627, L2628, L2999, L3020, L3160, L3649, L3730, L3740, L3763, L3900, L3904, L3915, L3923, L3927, L3999, L4000, L4010, L4020, L4631, S1040 |
| Prosthetics Purchase<br><br>**Medicaid and Healthy Michigan Plan; items >$500**<br>**Commercial/Community HMO & POS; items >$3,000**<br>**Health Advantage; items >$5,000** | L0720, L5010, L5020, L5060, L5100, L5105, L5150, L5160, L5200, L5210, L5220, L5230, L5250, L5270, L5280, L5301, L5311, L5312, L5331, L5341, L5500, L5505, L5510, L5520, L5530, L5535, L5540, L5560, L5570, L5580, L5595, L5600, L5610, L5611, L5613, L5616, L5639, L5640, E5647, L5673, L5681, L5683, L5701, L5702, L5703, L5706, L5707, L5716, L5718, L5722, L5724, L5726, L5728, L5780, L5782, L5816, L5818, L5822, L5824, L5830, L5840, L5845, L5857, L5858, L5859, L5926, L5985, L5961, L5985, L5987, L5988, L5989, L5964, L5966, L5973, L5979, L5980, L5981, L5985, L5956, L5987, L5988, L5989, L5990, L5999, L6000, L6010, L6020, L6025, L6026, L6050, L6100, L6110, L6120, L6130, L6200, L6205, L6250, L6300, L6310, L6350, L6360, L6400, L6450, L6500, L6550, L6570, L6623, L6624, L6628, L6629,L6632,L6637, L6641, L6642 L6646, L6686, L6688, L6689, L6690, L6693, L6696, L6697, L6698, L6703, L6707, L6709, L6712, L6713, L6714, L6721, L6722, L6880, L6881, L6883, L6884, L6885, L6920, L6925, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L7007, L7008, L7009, L7040, L7170, L7180, L7181, L7185, L7186, L7190, L7191, L7259, L7261, L7274, L7401, L7402, L7404, L7405, L7499, L8044, L8499, L8510, L8609, L8627, L8682, L8683, L8685, L8686, L8687, L8688, V2629 |
| Hearing Aids-<br>*Preauthorization for Hearing Aids is not required for CSHCS/Healthy Michigan/Medicaid members up to the benefit limit.*<br>*Refer to the preauthorization grid located at the end of this document for additional coverage information.*<br>*Preauthorization for Hearing Aids is not required for Commercial/Community members up to the benefit limit.*<br>*Refer to the preauthorization grid located at the end of this document for additional coverage information.* | V5030, V5040, V5050, V5060, V5100, V5120, V5130, V5140, V5170, V5181, V5200, V5210, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5274, V5298, V5299 ***(Commercial requires rider)*** |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **DME** - *continued* | |
| Vision Services<br>***Authorization requirements are for CSHCS, Medicaid and Healthy Michigan plans only*** . Consult the plan documents for coverage availability for Community and Health Advantage plans. | Photochromic, tinted, and dyed lenses: V2744-V2745<br>More than one pair of glasses simultaneously<br>Contact lenses (except under age 6 with diagnosis of aphakia - H270): V2500-V2599<br>Orthoptics and pleoptics training (age 21 and over): 92065-92066 |
| Continuous Glucose Monitors (CGMs) and Insulin Pumps -<br>*All codes for continuous glucose monitors, insulin pumps, and associated supplies require preauthorization.*<br><br>#Effective May 1, 2023, for ***Medicaid only*** , prior authorization is ***not*** required for **Continuous Glucose Monitors and Supplies** members with type I diabetes or diabetes in pregnancy, childbirth, and the puerperium period (insulin or non-insulin treated). Insulin pumps and supplies **do** require prior authorization. | A4239#, A9277#, E0784, E2102#, E2103#<br><br>***Effective 1/1/25 A9278 - As indicated in the MDHHS Medicaid Provider Manual, smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGMS are not classified as durable medical equipment and are not covered by Medicaid.*** |
| **Gender Affirmation Procedures** | |
| Gender Affirmation Procedures<br>The codes listed in this category pertain **ONLY** to gender affirmation procedures and require preauthorization.<br>However, codes used for these procedures may be listed elsewhere within this document.<br>**Please search the entire document to determine whether a code requires an auth.** | 15771, 17380, 17999, 19303, 19318, 19325, 19350, 53400, 53405, 53410, 53415, 53420, 53425, 53430, 54125, 54130, 54135, 54400, 54401, 54405, 54520, 54690, 55175, 55180, 55899, 55970, 55980, 56805, 57335, 58150, 58180, 58260, 58262, 58275, 58290, 58291, 58541, 58542, 58543, 58544, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58700, 58720, 58953, 58956, 58999 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Genetic Testing** | |
| Genetic Testing -<br>***All genetic testing codes, even if the code is not included in this list, may require Medical Director review and preauthorization.*** | **See Genetic Testing Code List on the following pages** |
| **Home Care Services** | |
| Home Care<br>*Refer to the preauthorization grid located at the end of this document for additional information.*<br><br>***Effective 1/1/20 for Medicaid only the first 24 billed home care visits per calendar year do not require prior authorization.***<br>***Home Health providers should call to verify how many annual visits have already been billed to prevent claims denial. All additional visits beyond the first 24 visits will require an authorization for claims processing.*** | Billed on institutional claim and type of bill 311 to 389 and revenue code 0550, 0551, 0552, 0559 |
| Hospice Care | Billed on institutional claim and type of bill 811 to 899 , revenue code 0651, 0652, 0655, 0656, 0658 |
| **Imaging** | |
| Imaging<br>***Authorization Requirements effective 8/1/2024***<br>***Authorization requirements apply to Medicaid and Healthy Michigan Plan only.*** | 78452 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Incontinence Supplies** | |
| Incontinence Supplies (covered benefit for Medicaid and Healthy Michigan Plan lines of business only)<br><br>Effective 4/1/2025, J & B Medical is the exclusive provider for incontinence supplies (see code list in the next box). Prior authorization is ***not*** required for supplies within quantity limits unless otherwise indicated. | A4310, A4311, A4312, A4314, A4415, A4320, A4326, A4328, A4330, A4331, A4333, A4334, A4335, A4338, A4340, A4344, A4349, A4351, A4352, A4353, A4354, A4357, A4358, A4402, A4520, A5112, A6250, T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4536, T4541, T4542, T4543, T4544 |
| **Inpatient Services** | |
| Bariatric Surgery<br>**4/1/26-43889 auth required Medicaid only** | 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43889 43999 |
| Inpatient Hospital Services -<br>*Preauthorization Exception - Routine delivery without sterilization requires notification only for all lines of business both contracted and non-contracted facilities. Non-contracted facilities reimbursed at member's OON benefit.* | All inpatient stays require authorization EXCEPT deliveries which require notification only.<br>**Medicaid Only** - Professional medical services rendered during an inpatient psychiatric stay require preauthorization.<br>**Authorization is obtained by admitting facility.** |
| Inpatient Rehabilitative Services | Requires preauthorization |
| LTACH | Requires preauthorization |
| Skilled Nursing Facility Services | Billed on institutional claim and type of bill 211 to 289 and revenue code 0110, 0120, 0130 |
| **Laboratory Testing** | |
| Definitive drug testing<br>***Effective 10/1/2024 for Medicaid/Healthy Michigan, Community, Marketplace, and Health Advantage*** | 80307, G0480, G0481, G0482, G0483 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Medical Respite/Recperative Care** | |
| Medical Respite Special Program<br>*Medicaid in-network only* | G9006, H0045 |
| **Neurostimulators** | |
| Neurostimulator<br>***Two separate authorizations are required; one for the trial and one for the permanent insertion of neurostimulators. Please ensure to submit authorizations for both procedures.*** | 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61870, 61880, 61885, 61886, 63650, 63661, 63663, 63664, 63685, 64550, 64565, 64566, 64568, 64569, 64555, 64570, 64575, 64580, 64581, 64590 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Out-of-Network (OON) Services** | |
| Out-of-Network (OON) Ambulatory Surgery Center -<br>*Health Advantage preauthorization is not required.*<br>*Individual Plans on the Exchange. Please verify out of network benefits prior to receiving services.* | Type of bill '83X' and OON |
| OON Outpatient Facility Services -<br>*Health Advantage preauthorization is not require.*<br>*Individual Plans on the Exchange. Please verify out of network benefits prior to receiving services.* | Revenue code 0360, 0361, 0362, 0367, 0369, 0481, 0490, 0499, 0790, 0799, 0360 to 0362, 0367, 0369, 0481, 0490, 0499, 0790, 0799 |
| OON Physician Services -<br>*Health Advantage preauthorization is not required.*<br>*Individual Plans on the Exchange. Please verify out of network benefits prior to receiving services.*<br>. | Billed on professional claim and OON |
| OON Dialysis -<br>*Commercial/Community and Health Advantage only*<br>*Medicaid preauthorization is* ***not*** *required* | all dialysis services provided by an out-of-network provider |
| **Pharmacy** | |
| Specialty Medications/Injections - | **See Medical Pharmacy Code List on the following pages** |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Radiation Services** | |
| Photochemotherapy | 96573, 96574, 96910, 96912, 96913, 96920, 96921, 96922, E0691, E0692, E0693, E0694 |
| Proton Beam Therapy | 77520, 77522, 77523, 77525 |
| **Rehabilitation Services** | |
| Medical Rehabilitation | 93668 |
| Procedures to Treat Asthma | 31660, 31661 |
| Occupational Therapy -<br><br>***Medicaid:*** *Preauthorization is not required up to the benefit limit.*<br>***Health Advantage:*** *Preauthorization is not required up to the benefit limit. Please refer to the summary plan document for benefit limits.*<br>***Community:*** *Preauthorization is not required up to the benefit limit. Please refer to the Certificate of Coverage for benefit limits.*<br>***Individual on the Exchange Plan:*** *All therapies must be provided by an in-network provider. Preauthorization is not required up to the benefit limit. Please refer to the Certificate of Coverage for benefit limits.* | **All lines of business: Preauthorization is required for requests over the benefit limit.**<br><br>**Medicaid Only:**<br>**Maximum of 144 billed units allowed per calendar year.**<br>**Please call Customer Service to confirm number of available units.** |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Rehabilitation Services Cont.** | |
| Physical Therapy -<br><br>***Medicaid:*** *Preauthorization is not required up to the benefit limit.*<br>***Health Advantage:*** *Preauthorization is not required up to the benefit limit. Please refer to the summary plan document for benefit limits.*<br>***Community:*** *Preauthorization is not required up to the benefit limit. Please refer to the Certificate of Coverage for benefit limits.*<br>**Individual on the Exchange Plan:** *All therapies must be provided by an in-network provider. Preauthorization is not required up to the benefit limit. Please refer to the Certificate of Coverage for benefit limits.* | **All lines of business: Preauthorization is required for requests over the benefit limit.**<br><br>**Medicaid Only:**<br>**Maximum of 144 billed units allowed per calendar year.**<br>**Please call customer service to confirm number of available units.** |
| Speech Therapy -<br><br>***Medicaid:*** *Preauthorization is not required up to the benefit limit of 36 visits per calendar year.*<br>***Health Advantage:*** *Preauthorization is not required up to the benefit limit. Please refer to the summary plan document for benefit limits.*<br>***Community:*** *Preauthorization is not required up to the benefit limit. Please refer to the Certificate of Coverage for benefit limits.*<br>***Individual on the Exchange Plan:*** *All therapies must be provided by an in-network provider. Preauthorization is not required up to the benefit limit. Please refer to the Certificate of Coverage for benefit limits.* | **All lines of business: Preauthorization is required for requests over the benefit limit.**<br><br>**Please call customer service to confirm number of available visits.** |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Reproductive Services** | |
| GYN Procedures | 58353, 58356 |
| Infertility Services | 0058T, 0357T, 54900, 54901, 55200, 55300, 58321, 58322, 58323, 58350, 58578, 58752, 58760, 58970, 58974, 58976, 58999, 76948, 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89300, 89210, 89322, 89323, 89324, 89325, 89326, 89327, 89328, 89329, 89330, 89331, 89325, 89329, 89330, 89331, 89353, 89335, 89337, 89342, 89344, 89346, 89352, 89353, 89354, 89356, 89398, S4011, S4012, S4013, S4014, S4015, S4016, S4017, S4018, S4020, S4021, S4022, S4023, S4025, S4026, S4027, S4028, S4030, S4031, S4026, S4027, S4028, S4030, S4031, S4035, S4037, S4040 |
| **Reproductive Services** - *continued* | |
| Termination of Pregnancy -<br>*Health Advantage preauthorization is not required.*<br>*Commercial/Community preauthorization is required.* | 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870, 59897, 59898, 59899 |
| Voluntary Sterilization -<br>*Medicaid requires preauthorization, a signed consent form, and a 30 day waiting period.*<br>*Health Advantage preauthorization is not required.*<br>*Commercial/Community preauthorization is required.* | 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58670, 58671, 58672, 58673, 58679, 58700, 58720, 58740, 58750, 58770, 58800, 58820, 58822, 58825, 58900, 58920, 58925, 58940, A4264 |
| **Spine Procedures** | |
| Spine procedures<br><br>**For Medicaid and Community/On Exchange auth is required for procedures performed in ALL settings, *including* an inpatient hospital** | 0200T, 22100, 22101, 22102, 22110, 22112, 22114, 22206, 22207, 22210, 22212, 22214, 22220, 22224, 22510, 22511, 22512, 22513, 22514, 22515, 22532, 22533, 22548, 22551, 22554, 22556, 22558, 22586, 22590, 22595, 22600, 22610, 22612, 22630, 22633, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22849, 22850, 22852, 22855, 22856, 22861, 22899, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63040, 63042, 63045, 63046, 63047, 63050, 63055, 63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170, 63172, 63173, 63185, 63190, 63191, 63200, 63250, 63251, 63252, 63265, 63267, 63268, 63270, 63271, 63272, 63286, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307, 63308 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Transitional Case Management for Recuperative Care** | |
| ***This is a Medicaid Program only***<br>Transitional Case Management for Recuperative Care | G9002 - Request must include MDHHS recuperative care authorization |
| **Transitional Care** | |
| Transitional Care Program - **Health Advantage Only** | Requires preauthorization |
| **Transplant Services** | |
| Cornea Transplant<br>***Medicaid only*** - auth is not require for cornea transplant. If performed during a hospital stay, an inpatient authorization is required. | 00144, 65710, 65750, 65755 |
| Heart Transplant | 33927, 33928, 33929, 33933, 33944, 33945 |
| Intestine Transplant | 44715, 44720, 44721, 44132 , 44133 , 44135 , 44136 , 44137 |
| Islet Transplant | 48160, G0341, G0342, G0343 |
| Kidney Transplant<br>***Medicaid only*** - auth is not require for a kidney transplant. If performed during a hospital stay, an inpatient authorization is required. | 50320, 50323, 50325, 50327, 50328, 50329, 50340, 50360, 50365, 50370, 50380 |
| Liver Transplant | 47135, 47136, 47143, 47144, 47145, 47146, 47147 |
| Lung Transplant | 32850, 32851, 32852, 32853, 32854, 32855, 32856, 33933 |
| Marrow Transplant | 38240, 38242 |
| Pancreas Transplant | 48550, 48551, 48552, 48554, 48556 |
| Stem Cell Transplant | 38205, 38206, 39208, 38209, 38210, 38211, 38212, 38213, 38214, 38215 , 38240, 38242 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|
| **Transportation Services** | |
| Emergency Air Ambulance -<br>Requires retro medical necessity review | A0430, A0431, A0435, A0436 |
| Meals/Lodging<br>Medicaid: Requires health plan notification.<br>Health Advantage: Transplant Related Only.<br>Refer to the preauthorization grid located at the end of this document for additional information. | A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0160, A0170, A0180, A0190, A0200, A0210 |
| Non-emergency Ambulance - Land | A0021, A0380, A0382, A0384, A0390, A0392, A0394, A0396, A0398, A0420, A0424, A0432, A0433, A0434, A0888, A0999, A0021, |
| **Urgent** | |
| Urgent Preauthorization Requests | Requests are considered urgent **only** when a delay in care could jeopardize the life/health of the member, jeopardize the member's ability to regain maximum function, or may subject the member to severe pain that cannot be adequately managed without the requested service. |
| **Urological Procedures** | |
| High Intensity Focused Ultrasound treatment (HIFU) | 55880 |
| **Wound Care (DME)** | |
| Specialty wound care dressings/supplies | Q4113, Q4114, Q4132, Q4133, Q4137, Q4141, Q4143, Q4145, Q4147, Q4148, Q4150, Q4150, Q4151, Q4152, Q4153, Q4154, Q4155, Q4156, Q4158, Q4159, Q4160, Q4161, Q4163, Q4164, Q4166, Q4168, Q4169, Q4170, Q4171, Q4173, Q4174, Q4175, Q4176, Q4178, Q4180, Q4184, Q4186, Q4187, Q4188, Q4190, Q4191, Q4193, Q4194, Q4195, Q4196, Q4197, Q4199, Q4201, Q4203, Q4204, Q4205, Q4217, Q4221, Q4222, Q4225, Q4226, Q4227, Q4229, Q4231, Q4232, Q4234, Q4235, Q4236, Q4238, Q4239, Q4246, Q4247, Q4248, Q4252, Q4253, Q4256, Q4257, Q4258, Q4259, Q4262, Q4263, Q4265, Q4266, Q4267, Q4268, Q4271, Q4276, Q4278, Q4279, Q4280, Q4281, Q4282, Q4283, Q4290, Q4293, Q4294, Q4295, Q4296, Q4297, Q4298, Q4299, Q4300, Q4301, Q 4302, Q4303, Q4304, Q4310, Q4332 |

# MHP Service Codes Requiring Preauthorization - Effective April 1, 2026

| Referral Category Name | Definitions |
|---|---|

## Authorization Guidelines:

**This is not a complete listing of services that may require preauthorization, and all services must be medically necessary. The Provider Referral and Preauthorization Form, Certificate of Coverage, Plan Document or Policy includes more detailed information on covered services, limitations and preauthorization requirements per line of business.**

**MHP reserves the right to perform ad hoc audits post-payment to determine medical necessity and/or industry standard treatment protocols for medical and pharmacy services. Any procedure or service cosmetic in nature will be subject to clinical review at any time.**

**Any medication (J-Code) prescribed against FDA/manufacturer guidelines requires preauthorization.**

**This list is updated at least quartlerly. The most current version is available on our website at McLarenHealthPlan.org. Please contact MHP Customer Service at (888) 327-0671 with any questions.**

McLaren HEALTH PLAN

McLaren Health Plan Medicaid/Healthy Michigan
McLaren Health Advantage
McLaren Health Plan Community (Marketplace/Exchange)

# Genetic and MolecularTesting Codes

| Procedure Code | Notes |
|---|---|
| 81161 | |
| 81162 | |
| 81200 | |
| 81201 | |
| 81206 | |
| 81207 | |
| **81222** | **Medicaid only** - no auth required |
| **81223** | **Medicaid only** - no auth required |
| 81229 | |
| 81292 | |
| 81240 | |
| 81241 | |
| 81243 | |
| 81251 | |
| 81255 | |
| 81257 | |
| 81260 | |
| 81268 | |
| 81270 | |
| 81279 | |
| 81294 | |

| Procedure Code | Notes |
|---|---|
| 81295 | |
| 81297 | |
| 81298 | |
| 81307 | |
| 81317 | |
| 81319 | |
| 81400 | |
| 81401 | |
| 81403 | |
| 81404 | |
| 81405 | |
| 81406 | |
| 81407 | |
| 81408 | |
| 81410 | |
| 81411 | |
| 81412 | |
| 81413 | |
| 81414 | |
| 81415 | |
| 81416 | |
| 81417 | |
| 81418 | |
| 81419 | |
| 81422 | |
| 81425 | |
| 81426 | |
| 81427 | |
| 81430 | |
| 81431 | |
| 81432 | |
| 81434 | |
| 81435 | |
| 81437 | |

| Procedure Code | Notes |
|---|---|
| 81439 | |
| 81440 | |
| 81441 | |
| 81442 | |
| 81443 | |
| 81445 | |
| 81448 | |
| 81449 | |
| 81450 | |
| 81451 | |
| 81455 | |
| 81456 | |
| 81457 | |
| 81458 | |
| 81459 | |
| 81460 | |
| 81462 | |
| 81463 | |
| 81464 | |
| 81465 | |
| 81470 | |
| 81471 | |
| 81479 | |
| 81482 | |
| 81493 | |
| 81500 | |
| 81504 | |
| 81506 | |
| 81507 | |
| 81509 | |
| 81518 | |
| 81519 | |
| 81520 | |
| 81521 | |

| Procedure Code | Notes |
|---|---|
| 81522 | |
| 81523 | |
| 81525 | |
| 81529 | |
| 81538 | |
| 81540 | |
| 81541 | |
| 81542 | |
| 81546 | |
| 81551 | |
| 81552 | |
| 81554 | |
| 81560 | |
| 81595 | |
| 81539 | |
| 81546 | |
| 81554 | |
| 81599 | |
| **86146*** | No auth required for pregnant women over the age of 40 and services are provided in-network for Medicaid, Community, and Health Advantage |
| **86147*** | No auth required for pregnant women over the age of 40 and services are provided in-network for Medicaid, Community, and Health Advantage |
| **86148*** | No auth required for pregnant women over the age of 40 and services are provided in-network for Medicaid, Community, and Health Advantage |
| 86321 | |
| 86849 | |
| 88121 | |
| 88261 | |
| 88299 | |
| 88399 | |
| 88749 | |
| 89290 | |
| 89291 | |
| 0004M | |

| Procedure Code | Notes |
|---|---|
| 0006M | |
| 0007M | |
| 0011M | |
| 0012M | |
| 0013M | |
| 0017M | |
| 0001U | |
| 0003U | |
| 0005U | |
| 0007U | |
| 0008U | |
| 0009U | |
| 0010U | |
| 0016U | |
| 0017U | |
| 0018U | |
| 0019U | |
| 0022U | |
| 0023U | |
| 0026U | |
| 0029U | |
| 0030U | |
| 0031U | |
| 0032U | |
| **0033U** | **Medicaid Only** - no auth required |
| 0034U | |
| 0036U | |
| 0037U | |
| 0040U | |
| 0045U | |
| 0046U | |
| 0047U | |
| 0048U | |
| 0049U | |

| Procedure Code | Notes |
|---|---|
| 0050U | |
| 0053U | |
| 0055U | |
| 0060U | |
| 0068U | |
| 0069U | |
| 0070U | |
| 0071U | |
| 0072U | |
| 0073U | |
| 0074U | |
| 0075U | |
| 0076U | |
| 0079U | |
| 0084U | |
| 0086U | |
| 0087U | |
| 0088U | |
| 0089U | |
| 0090U | |
| 0094U | |
| 0096U | |
| 0101U | |
| 0102U | |
| 0103U | |
| 0105U | |
| 0109U | |
| 0111U | |
| 0112U | |
| 0113U | |
| 0114U | |
| 0118U | |
| 0120U | |
| 0129U | |

| Procedure Code | Notes |
|---|---|
| 0130U | |
| **0131U** | **Medicaid Only** - no auth required |
| **0132U** | **Medicaid Only** - no auth required |
| 0133U | |
| 0134U | |
| **0135U** | **Medicaid Only** - no auth required |
| 0136U | |
| 0137U | |
| 0138U | |
| 0140U | |
| 0141U | |
| 0142U | |
| 0152U | |
| 0153U | |
| 0154U | |
| 0155U | |
| 0156U | |
| 0157U | |
| 0158U | |
| 0159U | |
| 0160U | |
| 0161U | |
| 0162U | |
| 0169U | |
| 0170U | |
| 0171U | |
| 0172U | |
| 0172U | |
| 0173U | |
| 0175U | |
| 0177U | |
| 0179U | |
| 0180U | |
| 0181U | |

| Procedure Code | Notes |
|---|---|
| 0182U | |
| 0183U | |
| 0184U | |
| 0185U | |
| 0186U | |
| 0187U | |
| 0188U | |
| 0189U | |
| 0190U | |
| 0192U | |
| 0193U | |
| 0194U | |
| 0195U | |
| 0196U | |
| 0197U | |
| 0198U | |
| 0199U | |
| 0200U | |
| 0201U | |
| 0203U | |
| 0205U | |
| 0209U | |
| 0211U | |
| 0212U | |
| 0213U | |
| 0214U | |
| 0215U | |
| 0216U | |
| 0217U | |
| 0218U | |
| 0219U | |
| 0221U | |
| 0222U | |
| 0227U | |

| Procedure Code | Notes |
|---|---|
| 0228U | |
| 0229U | |
| 0230U | |
| 0231U | |
| 0232U | |
| 0233U | |
| 0234U | |
| 0235U | |
| 0236U | |
| 0237U | |
| 0238U | |
| 0239U | |
| 0242U | |
| 0244U | |
| 0245U | |
| 0246U | |
| 0250U | |
| 0252U | |
| 0253U | |
| 0254U | |
| 0258U | |
| 0260U | |
| 0262U | |
| 0264U | |
| 0265U | |
| 0266U | |
| 0267U | |
| 0268U | |
| 0269U | |
| 0270U | |
| 0271U | |
| 0272U | |
| 0273U | |
| 0274U | |

| Procedure Code | Notes |
|---|---|
| 0276U | |
| 0277U | |
| 0278U | |
| 0279u | |
| 0282U | |
| 0285U | |
| 0286U | |
| 0287U | |
| 0288U | |
| 0289U | |
| 0290U | |
| 0291U | |
| 0292U | |
| 0293U | |
| 0294U | |
| 0296U | |
| 0297U | |
| 0298U | |
| 0299U | |
| 0300U | |
| 0301U | |
| 0302U | |
| 0306U | |
| 0307U | |
| 0313U | |
| 0314U | |
| 0315U | |
| 0317U | |
| 0318U | |
| 0319U | |
| 0320U | |
| 0326U | |
| 0327U | |
| 0329U | |

| Procedure Code | Notes |
|---|---|
| 0331U | |
| 0332U | |
| 0333U | |
| 0335U | |
| 0336U | |
| 0339U | |
| 0340U | |
| 0341U | |
| 0343U | |
| 0345U | |
| 0347U | |
| 0348U | |
| 0349U | |
| 0350U | |
| 0355U | |
| 0356U | |
| 0362U | |
| 0363U | |
| 0364U | |
| 0368U | |
| 0378U | |
| 0379U | |
| 0388U | |
| 0389U | |
| 0391U | |
| 0392U | |
| 0400U | |
| 0401U | |
| 0403U | |
| 0405U | |
| 0409U | |
| 0410U | |
| 0411U | |
| 0413U | |

| Procedure Code | Notes |
|---|---|
| 0414U | |
| 0417U | |
| 0419U | |
| 0420U | |
| 0422U | |
| 0423U | |
| 0424U | |
| 0425U | |
| 0426U | |
| 0428U | |
| 0433U | |
| 0434U | |
| 0437U | |
| 0438U | |
| 0449U | |
| G9143 | |
| G9840 | |
| G9841 | |
| S3800 | |
| S3840 | |
| S3841 | |
| S3842 | |
| S3844 | |
| S3845 | |
| S3846 | |
| S3849 | |
| S3850 | |
| S3852 | |
| S3853 | |
| S3844 | |
| S3845 | |
| S3846 | |
| S3849 | |
| S3850 | |

| Procedure Code | Notes |
|---|---|
| S3852 | |
| S3853 | |
| S3854 | |
| S3861 | |
| S3865 | |
| S3866 | |
| S3870 | |

## Authorization Guidelines:

**This is not a complete listing of services that may require preauthorization, and all services must be medically necessary. The Provider Referral and Preauthorization Form, Certificate of Coverage, Plan Document or Policy includes more detailed information on covered services, limitations and preauthorization requirements per line of business.**

**MHP reserves the right to perform ad hoc audits post-payment to determine medical necessity and/or industry standard treatment protocols for medical and pharmacy services. Any procedure or service cosmetic in nature will be subject to clinical review at any time.**

**Any medication prescribed against FDA/manufacturer guidelines requires preauthorization.**

**This list is updated at least quartlerly. The most current version is available on our website at McLarenHealthPlan.org. Please contact MHP Customer Service at (888) 327-0671 with any questions.**

McLaren Health Plan Medicaid/Healthy Michigan
McLaren Health Advantage
McLaren Health Plan Community (Marketplace/Exchange)

# Medical Pharmacy

***Buy & Bill  Medicaid Only: Physicians administering "Carved Out" C, J, S, and Q codes must bill Fee For Service.***

| Procedure Code | Description | Notes |
|---|---|---|
| J0217-Lamzede | velmanase alfa-tycv 1 mg | added 4/1/2024 |
| J0738-Yeztugo-INJ | lenacapavir 1mg-fda approved prescription, only for hiv **pre**-exposure prophylaxis (**not for use as hiv treatment**) | added 10/1/2025 |
| J0739-Apretude | cabotegravir 1mg (PrEP) | added 7/1/2022 |
| J0741-Cabenuva | cabotegravir/rilpivirine 2mg/3mg | added 10/1/2021 |
| J0752-Yeztugo (oral) | oral lenacapavir 300mg-fda approved prescription, only for hiv **pre**-exposure prophylaxis (**not for use as hiv treatment**) | added 10/1/2025 |
| J0799-HIV prep-fda approved-NOC | Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis (**not for use as hiv treatment**), not otherwise classified | added 10/1/2025 |
| J1322-Vimizim | elosulfase alfa 1 mg | added 4/1/2019 |
| J1411-Hemgenix | etranacogene dezaparvovec-drlb, per therapeutic dose (factor IX defficiancy) | added 1/1/2024 |
| J1413-Elevidys | delandistrogene moxeparvovec-rokl, per therapeutic dose | added 1/1/2024 |
| J1426-Amondys | casimersen 10 mg | added 10/1/2021 |
| J1427-Viltepso | viltolarsen 10 mg | added 4/1/2021 |
| J1428-Exondys | eteplirsen 10 mg | added 10/1/2018 |
| J1429-Vyondys | golodirsen 10 mg | added 7/1/2020 |
| J1746-Trogarzo | ibalizumab-uiyk 10 mg | added 1/1/2023 |
| J1961-Sunleca | lenacapavir 1 mg | added 7/1/2023 |
| J2326-Spinraza | nusinersen 0.1 mg | added 1/1/2018 |
| J3392-Casgevy | exagamglogene autotemcel, per treatment | Added 4/1/2025 |
| J3393-Zynteglo | betibeglogene autotemcel, per treatment | added 8/1/2024 |
| J3394-Lyfgenia | lovotibeglogene autotemcel, per treatment | added 8/1/2024 |
| J3398-Luxturna | voretigene neparvovec-rzyl 1billion vector genomes | added 1/1/2019 |
| J3399-Zolgensma | onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes | added 7/1/2020 |
| J3401-  Vyjuvek | Beremagene geperpavec-svdt topical admin, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1ml | added 10/1/25 |
| Q2041-Yescarta | Axicabtagene ciloleucel car+ up to 200 million autologous anti-cd19 car pos viable t cells, include leukapheresis/dose prep procedures, per therapeutic dose | added 1/1/2019 |
| Q2042-Kymriah | Tisagenlecleucel car-pos t up to 600 million car-positive viable t cells, including leukapheresis/dose prep procedures, per therapeutic dose | added 1/1/2019 |

| | | |
|---|---|---|
| Q2053-Tecartus | Brexucabtagene car pos t; Brexucabtagene autoleucel up to 200 million autologous anti-cd19 car positive viable t cells, include leukapheresis/dose prep procedures, per therapeut dose | added 4/1/2021 |
| Q2054-Breyanzi | Lisocabtagene maraleucel up to 110 million autologous anti-cd19 car-positive viable t cells, include leukapheresis/dose prep procedures, per therapeutic dose | added 10/1/2021 |
| Q2055-Abecma | Idecabtagene car pos t-Idecabtagene vicleucel up to 510million autologous b-cell maturation antigen (bcma) directed car-positive t cells, include leukapheresis/dose prep procedures, per therap dose | added 1/1/2022 |
| Q2056-Carvykti | Ciltacabtagene autoleucel up to 100 million autologous b-cell maturation antigen(bcma)directed car-positive t cells, include leukapheresis, dose prep proc/per therap dose, Ciltacabtagene car-pos t | added 10/1/2022 |
| Q2057-Tecelra | Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose | MDHHS added 4/1/2025 |
| Q2058-Aucatzyl | Obecabtagene autoleucel, up to 410 million cd19 car-positive viable t cells, including leukapheresis/dose preparation procedures, per therapeutic dose | MDHHS added 4/1/2025 |

***Specialty Medications/Injections -***

***If the submitted claim PRIMARY DIAGNOSIS is cancer, preauthorization for In Network Facilities is not required for codes listed with asterisks*****

***Any temporary, miscellaneous, or newly released C, J, S, Q codes may require authorization.***

| Procedure Code | Description | Notes |
|---|---|---|
| C9046- Goprelto | Cocaine hydrochloride nasal solution 1mg | added 7/1/2020 |
| C9047- Cablivi | caplacizumab-yhdp, 1 mg | added 7/1/2020 |
| C9101- Olinvyk | oliceridine, 0.1 mg | Removed 1/1/2026 |
| C9142**Alymsys | bevacizumab-maly: biosimilar-Avastin, 10mg | Removed 4/1/2025-Changed to Q5126** |
| C9143-Numbrino | Cocaine hydrochloride nasal solution 1mg | added 4/1/2023 |
| C9166- Cosentyx | secukinumab, intravenous, 1 mg | added 7/1/2024 (Changed to J3247) |
| C9168- Omvoh | mirikizumab-mrkz, 1 mg | added 7/1/2024 (Changed to J2267) |
| C9169- Anktiva | nogapendekin alfa inbakicept-pmln, intravesical 1mcg | added 10/1/2024 (Changed to J9028) |
| C9172- Beqvez | fidanacogene elaparvovec-dzkt, per therapeutic dose | added 10/1/2024 (Changed to J1414) |
| C9175-Grafapex | Injection, treosulfan, 50 mg | added 7/1/2025 |
| C9257**Avastin | bevacizumab, 0.25 mg | Removed 1/1/2026 |
| C9293**Voraxaze | glucarpidase, 10 units | added 7/1/2020**No auth Cancer diagnosis, in network facilities |
| C9305-Imaavy | nipocalimab-aahu, 3 mg | added 10/1/25 |

| | | |
|---|---|---|
| C9399** Biologic Unclassified | Unclassified drugs or biological | added 7/1/2020**No auth Cancer diagnosis, in network facilities |
| C9482- Sotalol | sotalol hydrochloride, 1 mg | Removed 1/1/2026 |
| J0013 - Spravato | Esketamine, nasal spray, 1 mg | Added 1/1/2026 |
| J0129- Orencia | abatacept/maltose 10mg (not for self administered use) | added 10/1/2018 |
| J0172- Aduhelm | aducanumab-avwa, 2 mg | added 7/1/2022 |
| J0174- Leqmbi | lecanemab-irmb, 1 mg | added 10/1/2024 |
| J0175- Kisunla | donanemab-azbt, 2 mg | added 10/1/2024 |
| J0177- Eylea HD | aflibercept hd, 1 mg | added 7/1/2024 |
| J0178- Eylea | Aflibercept, intraocular, 1 mg | added 10/1/2022 |
| J0179- Beovu | Brolucizumab-dbll, intraocular, 1mg | added 4/1/2021 |
| J0180-Fabrazyme | agalsidase beta, 1 mg | added 10/1/2018 |
| J0185**Cinvanti | aprepitant, 1 mg | Removed 1/1/2026 |
| J0202- Lemtrada | alemtuzumab, 1 mg | added 2/12/2021 |
| J0217- Lamzede | velmanase alfa-tycv, 1 mg | added 1/1/2024 |
| J0218- Xenpozym | olipudase alfa-rpcp, 1 mg | added 4/1/2023 |
| J0219-Nexviazyme | avalglucosidase alfa-ngpt, 4 mg | added 1/1/2023 |
| J0220- NOS-Alglucosidase alfa | alglucosidase alfa, 10 mg, not otherwise specified | added 1/1/2023 |
| J0221- Lumizyme | alglucosidase alfa, (lumizyme), 10 mg | added 10/1/2018 |
| J0222- Onpattro | Patisiran Sodium, lipid complex, 0.1mg | added 1/1/2023 |
| J0223- Givlaari | givosiran sodium, 0.5 mg | added 7/1/2020 |
| J0224- Oxlumo | lumasiran, 0.5 mg | added 10/1/2021 |
| J0225- Amvuttra | vutrisiran, 1 mg | added 1/1/2023 |
| J0256-(NOS)Alpha 1 proteinase inhibitor | alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg | added 1/1/2023 |
| J0257- Glassia | alpha 1 proteinase inhibitor (human), 10mg | added 1/1/2023 |
| J0391-Artesunate | artesunate, 1 mg | added 1/1/2024 |
| J0402- Abilify Asimtufi | aripiprazole, (abilify asimtufii), 1 mg | added 1/1/2024 |
| J0458-Emblaveo | aztreonam/avibactam 7.5mg/2.5mg (10mg) | added 10/1/25 |
| J0490- Benlysta | belimumab, 10 mg | added 1/1/2014 |
| J0517- Fasenra | benralizumab, 1 mg | added 1/1/2019 |
| J0567- Brineura | cerliponase alfa, 1 mg | added 1/1/2019 |
| J0577- Brixadi | buprenorphine extended-release, less than or equal to 7 days of therapy | added 7/1/2024 |
| J0578- Brixadi | buprenorphine extended-release, greater than 7 days and up to 28 days of therapy | added 7/1/2024 |
| J0584- Crysvita | burosumab-twza 1 mg | added 7/1/2024 |
| J0585- Botox | onabotulinumtoxina, 1 unit | added 4/1/2022 |
| J0586- Dysport | abobotulinumtoxin a, 5 units | added 7/1/2024 |
| J0587- Myobloc | rimabotulinumtoxin b, 100 units | added 7/1/2024 |
| J0588- Xeomin | incobotulinumtoxin a, 1 unit | added 4/1/2022 |
| J0589- Daxxify | daxibotulinumtoxina-lanm, 1 unit | added 7/1/2024 |
| J0593- Takhzyro | lanadelumab-flyo, 1mg | added 7/1/2024 |
| J0596- Ruconest | c1 esterase inhibitor (recombinant) 10units | added 8/1/2024 |
| J0597- Berinert | c-1 esterase inhibitor(human)10units | added 1/1/2019 |

| | | |
|---|---|---|
| J0598- Cinryze | c-1 esterase inhibitor(human) 10units | added 1/1/2019 |
| J0599- Haegarda | c-1 esterase inhibitor (human) 10 units | added 1/1/2019 |
| J0614-Grafapex | Injection, treosulfan, 50 mg | added 10/1/25 |
| J0638- Ilaris | canakinumab, 1 mg | added 11/1/2024 |
| J0641** NOS Levoleucovorin | levoleucovorin 0.5mg, not otherwise specified | Removed 10/1/25; **No auth Cancer diagnosis, in network facilities |
| J0654 - Triostat | Injection, liothyronine, 1 mcg | Added 1/1/2026 |
| J0675-Hemabate | carboprost tromethamine, 0.1 mg | added 10/1/25 |
| J0695- Zerbaxa | ceftolozane 50 mg and tazobactam 25 mg | added 1/1/2018 |
| J0717- Cimzia | certolizumab pegol, 1mg | added 1/1/2019 |
| J0725- Novarel/ Profasi/ Pregnyl | chorionic gonadotropin, per 1,000 usp units | added 1/1/2014 |
| J0738-Yeztugo-INJ | lenacapavir 1mg-fda approved prescription, only for hiv **pre**-exposure prophylaxis (**not for use as hiv treatment**) | added 10/1/2025 |
| J0739- Apretude | cabotegravir 1mg, fda approved prescription-only use as hiv pre-exposure prophylaxis (not for treatment of hiv) | added 7/1/2022 |
| J0741- Cabenuva | cabotegravir and rilpivirine, 2mg/3mg | added 1/1/2024 |
| J0752-Yeztugo (oral) | oral lenacapavir 300mg-fda approved prescription, only for hiv **pre**-exposure prophylaxis (**not for use as hiv treatment**) | added 10/1/2025 |
| J0791- Adakveo | crizanlizumab-tmca, 5 mg | added 1/1/2024 |
| J0799-HIV prep-fda approved-NOC | Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis (**not for use as hiv treatment**), not otherwise classified | added 10/1/2025 |
| J0800- Acthar Gel | corticotropin, up to 40 units | Removed 10/1/25 (changed to J0801) |
| J0801- Acthar Gel | corticotropin (acthar gel), up to 40 units | added 1/1/2024 |
| J0802- Corticotropin | corticotropin (acthar gel), up to 40 units, (ani manufacturer) | added 1/1/2024 |
| J0881** Aranesp | darbepoetin alfa, 1 mcg (non-esrd use) | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J0882** Aranesp ESRD | darbepoetin alfa, 1 mcg (for esrd on dialysis) | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J0885** Epogen/Procrit | epoetin alfa, (for non-esrd use), 1000 units | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J0887** Mircera ESRD | epoetin beta, 1 mcg, (for esrd on dialysis) | added 4/1/2017**No auth Cancer diagnosis, in network facilities |
| J0888** Mircera | epoetin beta, 1 mcg, (for non esrd use) | added 1/1/2018**No auth Cancer diagnosis, in network facilities |
| J0896- Reblozyl | luspatercept-aamt, 0.25 mg | added 10/1/2024 |
| J0897** Prolia/XGEVA | denosumab, 1 mg | added 4/1/2022**No auth Cancer diagnosis, in network facilities |
| J0901- Vafseo | Vadadustat, oral, 1 mg (esrd on dialysis) | added 4/1/2025 |

| | | |
|---|---|---|
| J1072- Azmiro | testosterone cypionate (azmiro), 1 mg | added 4/1/2025 |
| J1073 - Tesopel | Testosterone pellet, 75 mg | Added 1/1/2026 |
| J1170- Dilaudid | hydromorphone, up to 4 mg | added 1/1/2020 (changed to J1171) |
| J1171- Dilaudid | hydromorphone, 0.1 mg | added 10/1/2024 |
| J1201- Quzyttir | cetirizine hydrochloride, 0.5 mg | added 1/1/2020 |
| J1203- Pombiliti | cipaglucosidase alfa-atga, 5 mg | added 7/1/2024 |
| J1290- Kalbitor | ecallantide, 1 mg | added 1/1/2014 |
| J1299- Soliris | eculizumab, 2 mg | added 4/1/2025 |
| J1300- Soliris | eculizumab, 10 mg | added 1/1/2014-(changed to J1299) |
| J1301- Radicava | edaravone, 1 mg | added 10/1/2024 |
| J1302- Enjaymo | sutimlimab-jome, 10 mg | added 7/1/2024 |
| J1303- Ultomiris | ravulizumab-cwvz, 10 mg | added 7/1/2024 |
| J1304- Qalsody | tofersen, 1 mg | added 1/1/2024 |
| J1305- Evkeeza | evinacumab-dgnb, 5mg | added 10/1/2024 |
| J1307- Piasky | crovalimab-akkz, 10 mg | added 4/1/2025 |
| J1322- Vimizim | elosulfase alfa, 1 mg | added 1/1/2020 |
| J1325- Veletri | epoprostenol, 0.5mg | added 1/1/2014 |
| J1411- Hemgenix | etranacogene dezaparvovec-drlb, per therapeutic dose (factor IX defficiancy) | added 4/1/2023 |
| J1412- Roctavian | valoctocogene roxaparvovec-rvox/ml, contain nominal 2x10^13 vector genome | added 1/1/2024 |
| J1413- Elevidys | delandistrogene moxeparvovec-rokl, per therapeutic dose | added 1/1/2024 |
| J1414- Beqvez | fidanacogene elaparvovec-dzkt, per therapeutic dose | added 4/1/2025 |
| J1426-Amondys45 | casimersen, 10 mg | added 10/1/2021 |
| J1427- Viltepso | viltolarsen, 10 mg | added 4/1/2021 |
| J1428- Exondys | eteplirsen, 10 mg | added 4/1/2019 |
| J1429- Vyondys | golodirsen, 10 mg | added 1/1/2021 |
| J1442- Neupogen | filgrastim(g-csf)1mcg, excludes biosimilars | added 1/1/2021 |
| J1447** Granix | tbo-filgrastim, 1 microgram | added 1/1/2020**No auth Cancer diagnosis, in network facilities |
| J1449- Rolvedon | eflapegrastim-xnst, 0.1 mg | added 4/1/2023 |
| J1458-Naglazyme | galsulfase, 1 mg | added 4/1/2015 |
| J1459- Privigen | immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg | added 4/1/2014 |
| J1460-GamaSTAN | gamma globulin, intramuscular, 1 cc | added 4/1/2014 |
| J1551- Cutaquig | immune globulin (cutaquig), 100 mg | added 10/1/2022 |
| J1552- Alyglo | immune globulin (alyglo), 500 mg | added 4/1/2025 |
| J1554- Asceniv | immune globulin (asceniv), 500 mg, (100 mg/mL)(5g in 50 mL solution) | added 7/1/2021 |
| J1555- Cuvitru | immune globulin (cuvitru), 100 mg | added 7/1/2018 |
| J1556- Bivigam | immune globulin (bivigam), 500 mg | added 4/1/2017 |
| J1557- Gammaplex | immune globulin intravenous, non-lyophilized(e.g. liquid)500mg | added 4/1/2024 |
| J1558- Xembify | immune globulin (xembify), 100 mg | added 10/1/2024 |
| J1559- Hizentra | immune globulin (hizentra), 100 mg | added 10/1/2018 |
| J1560-GamaSTAN S/D | gamma globulin, IM, over 10 cc | added 7/1/2014 |

| | | |
|---|---|---|
| J1561- Gamunex-c/gammaked | immune globulin, non-lyophilized (e.g., liquid), 500 mg | added 7/1/2014 |
| J1562-Vivaglobin | immune globulin (vivaglobin), 100 mg | added 7/1/2017 |
| J1566-NOS-IV Immune globulin, lyophilized | immune globulin-intravenous-lyophilized (e.g. powder)not otherwise specified-500mg | added 7/1/2014 |
| J1568- Octagam | immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg | added 7/1/2014 |
| J1569- Gammagard | immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg | added 7/1/2014 |
| J1572- Flebogamma | immune globulin, IV, non-lyophilized (e.g. liquid), 500mg | added 7/1/2014 |
| J1575- Hyqvia | immune globulin/hyaluronidase, (hyqvia), 100 mg immuneglobulin | added 7/1/2016 |
| J1576- Panzyga | immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg | added 7/1/2023 |
| J1599- NOS IVIG; Immune Globulin | immune globulin, IV, non-lyophilized (eg, liquid) not otherwise specified, 500mg | added 10/1/2018 |
| J1602-Simponi Aria | golimumab, 1 mg, for intravenous use | added 10/1/2018 |
| J1628- Tremfya | guselkumab, 1 mg | added 10/1/2019 |
| J1632- Zulresso | brexanolone, 1 mg | added 10/1/2020 |
| J1640-Panhematin | hemin, 1 mg | added 10/1/2014 |
| J1675** Supprelin | histrelin acetate, 10 micrograms | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J1740- Boniva | ibandronate sodium, 1 mg | removed 4/1/2025, added 4/1/2024 |
| J1743- Elaprase | idursulfase, 1 mg | added 10/1/2018 |
| J1744- Firazyr | icatibant, 1 mg | added 4/1/2024 |
| J1745- Remicade | infliximab, excludes biosimilar, 10 mg | added 4/1/2014 |
| J1746- Trogarzo | ibalizumab-uiyk, 10 mg | added 7/1/2023 |
| J1747- Spevigo | spesolimab-sbzo, 1 mg | added 4/1/2023 |
| J1748- Zymfentra | infliximab-dyyb 10mg | added 10/1/2024 |
| J1786- Cerezyme | imiglucerase, 10 units | added 10/1/2018 |
| J1823- Uplizna | inebilizumab-cdon, 1 mg | added 1/1/2021 |
| J1826- Avonex | interferon beta-1a, 30 mcg | added 1/1/2014 |
| J1830-Betaseron/ Extavia | interferon beta-1b, 0.25 mg (not for use when drug is self administered) | added 1/1/2014 |
| J1930** Somatuline Depot | lanreotide, 1 mg | added 1/1/2019**No auth Cancer diagnosis, in network facilities |
| J1931-Aldurazyme | laronidase, 0.1 mg | added 10/1/2018 |
| J1932** Somatuline Depot | lanreotide, (cipla), 1 mg | added 1/1/2023**No auth Cancer diagnosis, in network facilities |
| J1941- Furoscix | furosemide (furoscix), 20 mg | added 1/1/2024 |
| J1943-Aristada Initio | aripiprazole lauroxil, 1 mg | added 1/1/2020 |
| J1944- Aristada | aripiprazole lauroxil, (aristada), 1 mg | added 1/1/2020 |
| J1950** Lupron Depot | leuprolide acetate (for depot suspension), per 3.75 mg | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J1952** Camcevi | Leuprolide mesylate inject 1mg, camcevi | added 1/1/2022**No auth Cancer diagnosis, in network facilities |

| | | |
|---|---|---|
| J1954** Luprate | leuprolide acetate for depot suspension (lutrate), 7.5 mg | added 4/1/2023**No auth Cancer diagnosis, in network facilities |
| J1961- Sunleca | lenacapavir, 1 mg | added 7/1/2023 |
| J2182- Nucala | mepolizumab, 1 mg | added 7/1/2018 |
| J2267- Omvoh | mirikizumab-mrkz, 1 mg | added 10/1/2024 |
| J2277- Aphexda | motixafortide, 0.25 mg | added 7/1/2024 |
| J2278- Prialt | ziconotide, 1 microgram | added 7/1/2019 |
| J2323- Tysabri | natalizumab, 1 mg | added 7/1/2014 |
| J2326- Spinraza | nusinersen, 0.1 mg | added 1/1/2018 |
| J2327- Skyrizi | risankizumab-rzaa, intravenous, 1 mg | added 4/1/2023 |
| J2329- Briumvi | ublituximab-xiiy, 1mg | added 7/1/2023 |
| J2350- Ocrevus | ocrelizumab, 1 mg | added 1/1/2024 |
| J2351- Ocrevus Zunovo | ocrelizumab, 1 mg & hyaluronidase-ocsq | added 4/1/2025 |
| J2353** Sandostatin LAR | octreotide, depot form for IM 1mg | added 10/1/2020**No auth Cancer diagnosis, in network facilities |
| J2355** Neumega | oprelvekin, 5 mg | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J2356- Tezspire | tezepelumab-ekko, 1 mg | added 10/1/2022 |
| J2357- Xolair | omalizumab, 5 mg | added 10/1/2014 |
| J2427- Invega Hafyera/Trinza | paliperidone palmitate extended release 1 mg | added 7/1/2023 |
| J2428- Erzofri | paliperidone palmitate extended release 1 mg | added 4/1/2025 |
| J2468** Posfrea | palonosetron hydrochloride (posfrea), 25 micrograms | added 10/1/2024**No auth Cancer diagnosis, in network facilities |
| J2502- Signifor LAR | pasireotide long acting, 1 mg | added 4/1/2017 |
| J2506- Neulasta | pegfilgrastim, excludes biosimilar, 0.5 mg | Removed 1/1/2026 |
| J2507- Krystexxa | pegloticase, 1 mg | added 1/1/2014 |
| J2508- Elfabrio | pegunigalsidase alfa-iwxj, 1 mg | added 1/1/2024 |
| J2777- Vabysmo | faricimab-svoa, 0.1 mg | Removed 1/1/2026 |
| J2779- Susvimo | ranibizumab, via sustained release intravitreal implant (susvimo), 0.1 mg | added 10/1/2022 |
| J2781- Empaveli | pegcetacoplan, intravitreal, 1 mg | added 1/1/2024 |
| J2782- Izervay | avacincaptad pegol, 0.1 mg | added 7/1/2024 |
| J2786- Cinqair | reslizumab, 1 mg | added 7/1/2018 |
| **J2796** Nplate | romiplostim, 10 micrograms | Removed 1/1/2026 |
| J2802- Nplate | romiplostim, 1 microgram | Removed 1/1/2026 |
| J2840- Kanuma | sebelipase alfa, 1 mg | added 10/1/2024 |
| J2941- Somatropin | somatropin, 1 mg (Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Serostim, Zomacton | added 10/1/2024 |
| J2998- Ryplazim | plasminogen, human-tvmh, 1 mg | added 10/1/2022 |

| | | |
|---|---|---|
| J3031- Ajovy | fremanezumab-vfrm, 1mg (for medicare when administered under direct physician supervision, not for self-administered use) | added 10/1/2020 |
| J3032- Vyepti | eptinezumab-jjmr, 1 mg | added 1/1/2024 |
| J3060- Elelyso | taliglucerase alfa, 10 units | added 10/1/2018 |
| J3110- Forteo | teriparatide, 10 mcg | added 10/1/2014 |
| J3111- Evenity | romosozumab-aqqg, 1 mg | added 4/1/2023 |
| J3241- Tepezza | teprotumumab-trbw, 10 mg | added 4/1/2020 |
| J3245- Ilumya | tildrakizumab, 1 mg | added 4/1/2020 |
| J3247- Cosentyx | secukinumab, intravenous, 1 mg | added 10/1/2024 |
| J3262** ACTEMRA | tocilizumab, 1 mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J3285-Remodulin | treprostinil, 1 mg | added 10/1/2044 |
| J3299- Xipere | triamcinolone aceto suprachoroidal 1mg | Removed 1/1/2026 |
| J3304- Zilretta | triamcinolone acetonide 1mg, preservative-free, extended-release, microsphere form | added 10/1/2019 |
| J3316- Triptodur | triptorelin, extended-release, 3.75 mg | added 10/1/2019 |
| J3357-STELARA-SC | Ustekinumab, for subcutaneous 1 mg | added 10/1/2014 |
| J3358-STELARA-IV | Ustekinumab, for intravenous 1 mg | added 10/1/2019 |
| J3380- Entyvio | vedolizumab, intravenous, 1 mg | added 1/1/2016 |
| J3385- Vpriv | velaglucerase alfa, 100 units | added 1/1/2014 |
| J3391- Lenmeldy | atidarsagene autotemcel, per treatment | added 7/1/2025 |
| J3392- Casgevy | exagamglogene autotemcel, per treatment | added 4/1/2025 |
| J3393- Zynteglo | betibeglogene autotemcel, per treatment | added 10/1/2024 |
| J3394- Lyfgenia | lovotibeglogene autotemcel, per treatment | added 10/1/2024 |
| J3397- Mepsevii | vestronidase alfa-vjbk, 1 mg | added 10/1/2024 |
| J3398- Luxturna | voretigene neparvovec-rzyl, 1 billion vector genomes | added 1/1/2019 |
| J3399- Zolgensma | onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes | added 7/1/2020 |
| J3401- Vyjuvek | Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml | added 1/1/2024 |
| J3402-Ryoncil | remestemcel-l-rknd, per therapeutic dose | added 10/1/2025 |
| J3403-Encelto | Revakinagene taroretcel-lwey, per implant | added 10/1/2025 |
| J3489** Reclast/ Zometa | zoledronic acid, 1 mg | added 1/1/2014**No auth Cancer diagnosis, in network facilities |
| J3490- Drug Unspecified | Unclassified drug (no code assigned yet) | added 1/1/2014 |
| J3590- Biologic Unspecified | Unclassified Biologic (no code assigned) | added 1/1/2014 |
| J3591-(ESRD)Drug/ Biologic Unclassified | Unclassified drug or biological used for esrd on dialysis | added 1/1/2019 |
| J7168- Kcentra | Prothrombin complex concentrate (human) per i.u. of factor ix activity | added 10/1/2021 |

| | | |
|---|---|---|
| J7169- Andexxa | coagulation factor xa (recombinant), inactivated-zhzo (andexxa), 10 mg | added 1/1/2020 |
| J7170- Hemlibra | emicizumab-kxwh, 0.5 mg | added 10/1/2024 |
| J7171- Adzynma | adamts13, recombinant-krhn, 10 iu | added 10/1/2024 |
| J7172-Hympavzi | marstacimab-hncq, 0.5 mg | added 7/1/25 |
| J7173- Alhemo | Injection, concizumab-mtci, 0.5 mg | added 10/1/2025 |
| J7174- Qfitlia | Injection, fitusiran, 0.04 mg | added 10/1/2025 |
| J7210- Afstyla | factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u. | added 1/1/2019 |
| J7308- Levulan/ Kerastick | Aminolevulinic acid hcl (topical admin) 20%, single unit dosage form (354 mg) | added 1/1/2018 |
| J7312- OZURDEX | dexamethasone-intravitreal implant-0.1mg | added 1/1/2018 |
| J7318- Durolane/ Orthovisc | Hyaluronan or derivative, durolane, for intra-articular 1 mg | added 1/1/2020 |
| J7330- Carticel | Autologous Cultured Chondrocytes, implant | added 1/1/2014 |
| J7352- Scenesse | Afamelanotide implant, 1 mg | added 4/1/2021 |
| J7353- Nexobrid | Anacaulase-bcdb, 8.8% gel, 1 gram | added 1/1/2024 |
| J7354- Ycanth | Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg) | added 7/1/2024 |
| J7355- Idose TR | travoprost, intracameral implant, 1mcg | added 10/1/2024 |
| J7356- Vyalev | Inj, foscarbidopa 0.25mg/foslevodopa 5mg | added 7/1/2025 |
| J7402- Sinuva | Mometasone furoate sinus implant 10mcg | added 7/1/2021 |
| J7599- NOS, Drug Immunosuppresive | Immunosuppressive drug, not otherwise classified | added 1/1/2018 |
| J7686- Tyvaso | Treprostinil, inhalation sol, fda-approved final product/non-compounded/DME admin , unit dose form, 1.74mg | added 1/1/2020 |
| J7699- NOS, (DME) inhaled Drugs | Not otherwise classified drug, inhalation solution administered through dme | added 1/1/2014 |
| J7799- NOS, (DME) non-inhaled Drugs | Not otherwise classified drug, other than inhalation drugs, admin through dme | added 1/1/2014 |
| J7999- NOS, Drug Compounded | Compounded drug, not otherwise classified | added 4/1/2017 |
| J8498- NOS, Rectal Antiemetic | Antiemetic drug, rectal/suppository, not otherwise specified | added 1/1/2014 |
| J8499** NOS, Prescription Drug, Non chemotherapeutic | Prescription drug, oral, non chemotherapeutic, not otherwise specified | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J8541- Hemady | Dexamethasone (hemady), oral, 0.25 mg | added 10/1/2024 |
| J8999** NOS, Prescription Drug, Chemotherapeutic | Prescription drug, oral, chemotherapeutic, not otherwise specified | added 1/1/2014**No auth Cancer diagnosis, in network facilities |

| | | |
|---|---|---|
| J9021** Rylaze | asparaginase, recombinant, (rylaze) 0.1mg | added 1/1/2023**No auth Cancer diagnosis, in network facilities |
| J9028- Anktiva | nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram | added 4/1/2025 |
| J9029- Adstiladrin | Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose | added 7/1/2023 |
| J9035** Avastin | bevacizumab, 10 mg | added 1/1/2016**No auth Cancer diagnosis, in network facilities |
| J9037** Blenrep | belantamab mafodontin-blmf, 0.5 mg | added 7/1/2021**No auth Cancer diagnosis, in network facilities |
| J9061** Rybrevant | amivantamab-vmjw, 2 mg | added 1/1/2023**No auth Cancer diagnosis, in network facilities |
| J9144** Darzalex Faspro | daratumumab, 10 mg and hyaluronidase-fihj | added 1/1/2021**No auth Cancer diagnosis, in network facilities |
| J9173** Imfinzi | durvalumab, 10 mg | added 1/1/2024; **No auth Cancer diagnosis, in network facilities |
| J9217** Lupron Depot | Leuprolide acetate (for depot suspension), 7.5 mg | added 4/1/2017**No auth Cancer diagnosis, in network facilities |
| J9218** Lupron | Leuprolide acetate, per 1 mg | added 4/1/2017**No auth Cancer diagnosis, in network facilities |
| J9219** Lupron Implant | Leuprolide acetate implant, 65 mg | added 1/1/2018**No auth Cancer diagnosis, in network facilities |
| J9223** Zepzelca | lurbinectedin, 0.1 mg | added 4/1/2021**No auth Cancer diagnosis, in network facilities |
| J9226-Supprelin LA | Histrelin implant (supprelin la), 50 mg | added 1/1/2019 |
| J9228** Yervoy | ipilimumab, 1 mg | added 1/1/2024; **No auth Cancer diagnosis, in network facilities |
| J9256 - Imaavy | Injection, nipocalimab-aahu, 3 mg | Added 1/1/2026 |
| J9271** Keytruda | pembrolizumab, 1 mg | added 1/1/2024; **No auth Cancer diagnosis, in network facilities |
| J9272** Jempreli | Inj dostarlimab-gxly, 100 mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J9276- Zihera | Injection, zanidatamab-hrii, 2 mg | added 7/1/2025 |
| J9281** Jelmyto | Mitomycin pyelocalyceal instillation, 1 mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J9282 - Zusduri | Mitomycin, intravesical instillation, 1 mg | Added 1/1/2026 |
| J9289** Opdivo Qvantig | Injection, nivolumab, 2 mg and hyaluronidase-nvhy | added 7/1/2025 |
| J9298** Opdualag | nivolumab & relatlimab-rmbw, 3mg/1mg | added 1/1/2023**No auth Cancer diagnosis, in network facilities |
| J9299** Opdivo | nivolumab, 1 mg | added 1/1/2024; **No auth Cancer diagnosis, in network facilities |
| J9312** Rituxan | rituximab, 10 mg | added 1/1/2020**No auth Cancer diagnosis, in network facilities |
| J9316** Phesgo | pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J9317** Trodelvy | sacituzumab govitecan-hziy, 2.5 mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |

| | | |
|---|---|---|
| J9318** Istodax | Inj romidepsin non-lyophilized 0.1mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J9319** Istodax | romidepsin, lyophilized, 0.1 mg | added 7/1/2022**No auth Cancer diagnosis, in network facilities |
| J9331** Fyarro | sirolimus protein-bound particles, 1 mg | added 10/1/2022**No auth Cancer diagnosis, in network facilities |
| J9332- Vyvgart | efgartigimod alfa-fcab, 2mg | added 1/1/2023 |
| J9333- Rystiggo | rozanolixizumab-noli, 1 mg | added 1/1/2024 |
| J9334- Vyvgart Hytrulo | efgartigimod alfa-2 mg/hyaluronidase-qvfc | added 1/1/2024 |
| J9345- Zynyz | retifanlimab-dlwr, 1 mg | added 8/1/2024 |
| J9349** Monjuvi | tafasitamab-cxix, 2 mg | added 7/1/2021**No auth Cancer diagnosis, in network facilities |
| J9359** Zynlonta | loncastuximab tesirine-lpyl, 0.075 mg | added 1/1/2023**No auth Cancer diagnosis, in network facilities |
| J9361** Ryzneuta | efbemalenograstim alfa-vuxw, 0.5 mg | added 10/1/2024**No auth Cancer diagnosis, in network facilities |
| J9376- Veopoz | pozelimab-bbfg, 1 mg | added 7/1/2024 |
| J9381- Tzield | teplizumab-mzwv, 5 mcg | added 7/1/2023 |
| J9999** NOS, Drug Antineoplastic | Not otherwise classified antineoplastic | added 6/1/2022**No auth Cancer diagnosis, in network facilities |
| Q2041- Yescarta | Axicabtagene ciloleucel car+, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis & dose preparation procedures, per therapeutic dose | added 1/1/2019 |
| Q2042- Kymriah | Tisagenlecleucel car-pos t, up to 600 million car-positive viable t cells, including leukapheresis & dose prep procedures, per therapeutic dose | added 1/1/2019 |
| Q2043** Provenge | Sipuleucel-t auto cd54+, minimum 50 million autologous cd54+ cells activated w pap-gm-csf, including leukapheresis & all other prep procedures, per infusion | added 4/1/2022**No auth Cancer diagnosis, in network facilities |
| Q2053- Tecartus | Brexucabtagene car pos t; Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis/dose preparation procedures, per therapeut dose | added 7/1/2021 |
| Q2054- Breyanzi | Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, include leukapheresis & dose prep procedure per therapeutic dose | added 10/1/2021 |

| | | |
|---|---|---|
| Q2055- Abecma (Car-T) | Idecabtagene car pos t, Idecabtagene vicleucel/up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells/including leukapheresis & dose prep procedures, per therapeutic dose | added 1/1/2022 |
| Q2056- Carvykti | Ciltacabtagene autoleucel up to 100million autologous b-cell maturation antigen(bcma) directed car-positive t cells, including leukapheresis, dose prep procedures, per therapeutic dose, Ciltacabtagene car-pos t | added 1/1/2023 |
| Q2057- Tecelra | Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose | added 4/1/2025 |
| Q2058- Aucatzyl | Obecabtagene autoleucel, up to 410 million cd19 car-positive viable t cells, including leukapheresis & dose prep procedures, per therapeut dose | added 7/1/2025 |
| Q3027- Avonex | interferon beta-1a, 1 mcg for IM use | added 1/1/2019 |
| Q4081** Epogen/ Procrit (ESRD) | epoetin alfa, 100units (esrd on dialysis) | added 1/1/2018**No auth Cancer diagnosis, in network facilities |
| Q5098- Imuldosa | Injection, ustekinumab-srlf (imuldosa), Stelara biosimilar, 1 mg | added 7/1/2025 |
| Q5099- Steqeyma | Injection, ustekinumab-stba (steqeyma), Stelara biosimilar, 1 mg | added 7/1/2025 |
| Q5100- Yesintek | Injection, ustekinumab-kfce (yesintek), Stelara biosimilar, 1 mg | added 7/1/2025 |
| Q5101** Zarxio | filgrastim-sndz-biosimilar-Neupogen, (zarxio), 1mcg | Added 7/1/2020**No auth Cancer diagnosis, in network facilities |
| Q5103- Inflectra | infliximab-dyyb-biosim-Remicade 10mg | added 1/1/2018 |
| Q5104- Renflexis | Infliximab-abda 10mg, biosim-Remicade | added 1/1/2018 |
| Q5105** Retacrit (ESRD on dialysis) | epoetin alfa-epbx, biosimilar-Epogen/Procrit(esrd on dialysis), 100units | added 1/1/2019**No auth Cancer diagnosis, in network facilities |
| Q5106** Retacrit (non-ESRD) | Epoetin alfa-epbx 1000units, non-esrd use, biosimilar-Epogen/Procrit(retacrit) | added 1/1/2019**No auth Cancer diagnosis, in network facilities |
| Q5107** Mvasi | Bevacizumab-awwb 10mg, biosimilar-Avastin | added 1/1/2020**No auth Cancer diagnosis, in network facilities |
| Q5108** Fulphila | Pegfilgrastim-jmdb 0.5mg, biosimilar-Neulasta(fulphila) | added 1/1/2019**No auth Cancer diagnosis, in network facilities |
| Q5109- Ixifi | Infliximab-qbtx 10mg, biosimilar-Remicade | added 1/1/2020 |
| Q5110** Nivestym | Filgrastim-aafi 1mcg, biosimilar-Neupogen(nivestym) | added 1/1/2020**No auth Cancer diagnosis, in network facilities |
| Q5111** Udenyca | Pegfilgrastim-cbqv 0.5mg, biosimilar-Neulasta(udenyca) | **No auth Cancer diagnosis, in network facilities |
| Q5115** Truxima | rituximab-abbs, biosimilar-Rituxan(Truxima), 10 mg | added 10/1/2022**No auth Cancer diagnosis, in network facilities |
| Q5118** Zirabev | Bevacizumab-bvz, biosimilar-Avastin(zirabev) 10mg | **No auth Cancer diagnosis, in network facilities |
| Q5119** Ruxience | Rituximab-PVVR 10mg, biosimilar-Rituxan(ruxience) | added 7/1/2022**No auth Cancer diagnosis, in network facilities |

| | | |
|---|---|---|
| Q5120- Ziextenzo | Pegfilgrastim-bmez 0.5mg,biosim-Neulasta | added 1/1/2020 |
| Q5121- Avsola | infliximab-axxq, biosim-Remicade 10mg | added 7/1/2022 |
| Q5122- Nyvepria | pegfilgrastim-apgf, biosim-Nuelasta 0.5mg | added 7/1/2022 |
| Q5123** Riabni | rituximab-arrx, biosimilar-Rituxan 10mg | added 7/1/22**No auth Cancer diagnosis, in network facilities |
| Q5125- Releuko | filgrastim-ayow, biosim-Neupogen 1mcg | added 1/1/2023 |
| Q5126** Alymsys | bevacizumab-maly, biosim-Avastin 10mg | added 4/1/2023**No auth Cancer diagnosis, in network facilities |
| Q5127- Stimufend | pegfilgrastim-fpgk, biosimilar-Neulasta(stimufend)0.5mg | added 4/1/2023**No auth Cancer diagnosis, in network facilities |
| Q5128- Cimerli | ranibizumab-eqrn, biosim-Lucentis 0.1mg | Removed 4/1/25, added 4/1/2023 |
| Q5129- Vegzelma | bevacizumab-adcd, biosim-Avastin, 10mg | added 4/1/2023 |
| Q5130- Fylnetra | pegfilgrastim-pbbk, biosim-Neulasta-0.5mg | added 4/1/2023 |
| Q5133- Tofidence | tocilizumab-bavi, biosim-Actemra, 1mg | added 7/1/2024 |
| Q5134- Tyruko | natalizumab-sztn, biosimilar-Tysabri 1mg | added 7/1/2024 |
| Q5135** Tyenne | tocilizumab-aazg, biosimilar-Actemra 1mg | added 10/1/2024**No auth Cancer diagnosis, in network facilities |
| Q5136** Jubbonti/Wyost | denosumab-bbdz, biosimilar-prolia/xgeva, 1mg | added 10/1/2024**No auth Cancer diagnosis, in network facilities |
| Q5137-Wezlana-SC | ustekinumab-auub, biosim-Stelara SC 1mg | added 10/1/2024 |
| Q5138-Wezlana-IV | ustekinumab-auub, biosim-Stelara IV 1mg | added 10/1/2024 |
| Q5147- Pavblu | aflibercept-ayyh, biosimilar-Eylea, 1 mg | added 4/1/25 |
| Q5148- Nypozi | filgrastim-txid 1mcg, biosimilar-Neupogen | added 4/1/25 |
| Q5149- Enzeevu | aflibercept-abzv, biosimilar-Eylea, 1mg | added 4/1/25 |
| Q5150- Ahzantive | aflibercept-mrbb, biosimilar-Eylea, 1mg | added 4/1/25 |
| Q5151- Epysqli | eculizumab-aagh, biosimilar-Soliris, 2 mg | added 4/1/25 |
| Q5152- Bkemv | eculizumab-aeeb, biosimilar-Soliris, 2 mg | added 4/1/25 |
| Q5153- Opuviz | aflibercept-yszy, Eylea biosimilar, 1 mg | added 7/1/2025 |
| Q5157**Stoboclo /Osenvelt | denosumab-bmwo, biosimilar, 1 mg | added 10/1/25**No auth Cancer diagnosis, in network facilities |
| Q5158**Bomyntra/ Conexxence | denosumab-bnht, biosimilar, 1 mg | added 10/1/25**No auth Cancer diagnosis, in network facilities |
| Q9991- Sublocade | buprenorphine extended-release (sublocade), less than or equal to 100 mg | added 1/1/2019 |
| Q9992- Sublocade | buprenorphine extended-release (sublocade), greater than 100 mg | added 1/1/2019 |
| Q9996-Pyzchiva-SC | ustekinumab-ttwe, biosim-Stelara SC, 1mg | added 4/1/25 |

| | | |
|---|---|---|
| Q9997-Pyzchiva-IV | ustekinumab-ttwe, biosim-Stelara-IV 1mg | added 4/1/25 |
| Q9998- Selarsdi | ustekinumab-aekn, biosim-Stelara SC 1mg | added 4/1/25 |
| Q9999- Otulfi | ustekinumab-aauz, biosimilar, 1 mg | added 4/1/25 |
| S0013- Spravato | Esketamine, nasal spray, 1 mg | added 7/1/2021 |
| S0189- Testopel | Testosterone pellet, 75 mg | added 7/1/2022 |

**Site of Care restrictions:**

**For Health Advantage and Community Plans (Large Group, Small Group, Individual Group). CODES EXCLUDED FROM HOSPITAL INFUSIONS. ONLY given by home health care provider in the member's home or at an infusion center that is not located within or affiliated with hospital.**

| Procedure Code | Description | Site of Care Requirement |
|---|---|---|
| J0129- Orencia | abatacept/maltose 10mg (not for self administered use) | added 10/1/2018 |
| J0172- Aduhelm | aducanumab-avwa, 2 mg | added 7/1/2024 |
| J0174- Leqmbi | lecanemab-irmb, 1 mg | added 10/1/2024 |
| J0180- Fabrazyme | agalsidase beta, 1 mg | added 8/1/2019 |
| J0202- Lemtrada | alemtuzumab, 1 mg | added 4/1/2024 |
| J0218- Xenpozym | olipudase alfa-rpcp, 1 mg | added 4/1/2024 |
| J0219- Nexviazyme | avalglucosidase alfa-ngpt, 4 mg | added 8/1/2024 |
| J0221- Lumizyme | alglucosidase alfa, (lumizyme), 10 mg | added 8/1/2019 |
| J0222- Onpattro | Patisiran Sodium, lipid complex, 0.1mg | added 8/1/2024 |
| J0223- Givlaari | givosiran sodium, 0.5 mg | added 11/1/24 |
| J0224- Oxlumo | lumasiran, 0.5 mg | added 11/1/24 |
| J0225- Amvuttra | vutrisiran, 1 mg | added 8/1/2024 |
| J0256- NOS- Alpha 1 proteinase inhib | alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg | added 4/1/2024 (8/1/2024); must bill S9346-Home Infusion for J0256 |
| J0257- Glassia | alpha 1 proteinase inhibitor(human) 10mg | added 8/1/2024 |
| J0490- Benlysta | belimumab, 10 mg | added 8/1/2019 |
| J0491- Saphnelo | anifrolumab-fnia, 1 mg | added 11/1/24 |
| J0517- Fasenra | benralizumab, 1 mg | added 4/1/2022 |
| J0584- Crysvita | burosumab-twza 1 mg | added 4/1/2024 |
| J0596- Ruconest | c1 esterase inhibitor(recombinant) 10units | added 8/1/2024 |
| J0597- Berinert | c-1 esterase inhibitor(human), 10units | added 8/1/2019 |
| J0598- Cinryze | c-1 esterase inhibitor(human), 10units | added 8/1/2019 |
| J0638- Ilaris | canakinumab, 1 mg | added 11/1/24 |
| J0717- Cimzia | certolizumab pegol, 1mg | added 8/1/2019 |
| J0739- Apretude | cabotegravir 1mg, fda approved prescription, only use as hiv pre-exposure prophylaxis (not for use hiv treatment) | added 4/1/2024 |
| J0741- Cabenuva | cabotegravir and rilpivirine, 2mg/3mg | added 1/1/2024 |
| J0791- Adakveo | crizanlizumab-tmca, 5 mg | added 8/1/2024 |
| J0896- Reblozyl | luspatercept-aamt, 0.25 mg | added 8/1/2024 |

| | | |
|---|---|---|
| J0897**Prolia/XGEVA | denosumab, 1 mg | added 4/1/2022 |
| J1290- Kalbitor | ecallantide, 1 mg | added 8/1/2024 |
| J1300- Soliris | eculizumab, 10 mg | added 8/1/2019 |
| J1301- Radicava | edaravone, 1 mg | added 8/1/2024 |
| J1302- Enjaymo | sutimlimab-jome, 10 mg | added 4/1/2024 |
| J1303- Ultomiris | ravulizumab-cwvz, 10 mg | added 4/1/2024 |
| J1305- Evkeeza | evinacumab-dgnb, 5mg | added 8/1/2024 |
| J1322- Vimizim | elosulfase alfa, 1 mg | added 8/1/2024 |
| J1426-Amondys45 | casimersen, 10 mg | added 8/1/2024 |
| J1427- Viltepso | viltolarsen, 10 mg | added 11/1/24 |
| J1428- Exondys | eteplirsen, 10 mg | added 8/1/2019 |
| J1429- Vyondys | golodirsen, 10 mg | added 8/1/2024 |
| J1459- Privigen | immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg | added 8/1/2019 |
| J1460- GamaSTAN | gamma globulin, intramuscular, 1 cc | added 4/1/2024 |
| J1551- Cutaquig | immune globulin (cutaquig), 100 mg | added 11/1/24 |
| J1554- Asceniv | immune globulin (asceniv), 500 mg, (100 mg/mL)(5g in 50 mL solution) | added 4/1/2024 |
| J1555- Cuvitru | immune globulin (cuvitru), 100 mg | added 11/1/24 |
| J1556- Bivigam | Injection, immune globulin (bivigam)500mg | added 11/1/24 |
| J1557- Gammaplex | immune globulin(gammaplex) IV, non-lyophilized(e.g. liquid)500mg | added 8/1/2019 |
| J1558- Xembify | immune globulin (xembify), 100 mg | added 11/1/24 |
| J1559- Hizentra | immune globulin (hizentra), 100 mg | added 4/1/2024 |
| J1560- GamaSTAN S/D | gamma globulin, intramuscular, >10 cc | added 4/1/2024 |
| J1561- Gamunex-c/gammaked | immune globulin, non-lyophilized (e.g., liquid), 500 mg | added 8/1/2019 |
| J1566- NOS-IV Immune globulin, lyophilized | immune globulin-IV-lyophilized (e.g. powder) not otherwise specified, 500mg | added 8/1/2019 |
| J1568- Octagam | immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg | added 8/1/2019 |
| J1569- Gammagard | immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg | added 8/1/2019 |
| J1572- Flebogamma | immune globulin, IV, non-lyophilized (e.g. liquid), 500mg | added 8/1/2019 |
| J1575- Hyqvia | immune globulin/hyaluronidase, (hyqvia), 100 mg immuneglobulin | added 4/1/2024 |
| J1599- NOS IVIG; Immune Globulin | immune globulin, IV, non-lyophilized (eg, liquid) not otherwise specified, 500mg | added 8/1/2019 |
| J1602-Simponi Aria | golimumab, 1 mg, for intravenous use | added 8/1/2019 |
| J1743- Elaprase | idursulfase, 1 mg | added 8/1/2019 |
| J1744- Firazyr | icatibant, 1 mg | added 4/1/2024 |
| J1745- Remicade | infliximab, excludes biosimilar, 10 mg | added 8/1/2019 |
| J1746- Trogarzo | ibalizumab-uiyk, 10 mg | added 4/1/2024 |
| J1786- Cerezyme | imiglucerase, 10 units | added 8/1/2019 |
| J1823- Uplizna | inebilizumab-cdon, 1 mg | Added 11/1/2024 |
| J1931- Aldurazyme | laronidase, 0.1 mg | added 8/1/2019 |

| | | |
|---|---|---|
| J2182- Nucala | mepolizumab, 1 mg | added 4/1/2022 |
| J2323- Tysabri | natalizumab, 1 mg | added 1/1/2024 |
| J2326- Spinraza | nusinersen, 0.1 mg | added 4/1/2024 |
| J2327- Skyrizi | risankizumab-rzaa, intravenous, 1 mg | added 4/1/2024 |
| J2329- Briumvi | ublituximab-xiiy, 1mg | added 1/1/2024 |
| J2350- Ocrevus | ocrelizumab, 1 mg | added 1/1/2024 |
| J2356- Tezspire | tezepelumab-ekko, 1 mg | added 8/1/2024 |
| J2357- Xolair | omalizumab, 5 mg | added 4/1/2022 |
| J2507- Krystexxa | pegloticase, 1 mg | added 11/1/2024 |
| J2840- Kanuma | sebelipase alfa, 1 mg | added 11/1/2024 |
| J2998- Ryplazim | plasminogen, human-tvmh, 1 mg | added 8/1/2024 |
| J3032- Vyepti | eptinezumab-jjmr, 1 mg | added 1/1/2024 |
| J3060- Elelyso | taliglucerase alfa, 10 units | added 8/1/2019 |
| J3111- Evenity | romosozumab-aqqg, 1 mg | added 1/1/2024 |
| J3241- Tepezza | teprotumumab-trbw, 10 mg | added 4/1/2024 |
| J3245- Ilumya | tildrakizumab, 1 mg | added 8/1/2024 |
| J3262** ACTEMRA | tocilizumab, 1 mg | added 8/1/2019 |
| J3357- STELARA-SC | Ustekinumab, for subcutaneous 1 mg | added 8/1/2019 |
| J3358- STELARA-IV | Ustekinumab, for intravenous 1 mg | added 1/1/2024 |
| J3380- Entyvio | vedolizumab, intravenous, 1 mg | added 8/1/2019 |
| J3385- Vpriv | velaglucerase alfa, 100 units | added 8/1/2019 |
| J3397- Mepsevii | vestronidase alfa-vjbk, 1 mg | added 11/1/2024 |
| J3398- Luxturna | voretigene neparvovec-rzyl, 1 billion vector genomes | added 4/1/2024 |
| J3399- Zolgensma | onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes | added 11/1/2024 |
| J7170- Hemlibra | emicizumab-kxwh, 0.5 mg | added 8/1/2024 |
| J9022- Tecentriq | Injection, atezolizumab, 10 mg | added 11/1/2024 |
| J9023- Bavencio | Injection, avelumab, 10 mg | added 11/1/2024 |
| J9119- Libtayo | Injection, cemiplimab-rwlc, 1 mg | added 11/1/2024 |
| J9173** Imfinzi | durvalumab, 10 mg | added 1/1/2024 |
| J9228** Yervoy | ipilimumab, 1 mg | added 1/1/2024 |
| J9271** Keytruda | pembrolizumab, 1 mg | added 1/1/2024 |
| J9272** Jempreli | Inj dostarlimab-gxly, 100 mg | added 1/1/2024 |
| J9298** Opdualag | nivolumab & relatlimab-rmbw, 3mg/1mg | added 11/1/2024 |
| J9299** Opdivo | nivolumab, 1 mg | added 1/1/2024 |
| J9332- Vyvgart | efgartigimod alfa-fcab, 2mg | added 11/1/2024 |
| J9345- Zynyz | retifanlimab-dlwr, 1 mg | added 8/1/2024 |

## Authorization Guidelines:

**This is not a complete listing of services that may require preauthorization, and all services must be medically necessary. The Provider Referral and Preauthorization Form, Certificate of Coverage, Plan Document or Policy includes more detailed information on covered services, limitations and preauthorization requirements per line of business.**

**MHP reserves the right to perform ad hoc audits post-payment to determine medical necessity and/or industry standard treatment protocols for medical and pharmacy services. Any procedure or service cosmetic in nature will be subject to clinical review at any time.**

**Any medication prescribed against FDA/manufacturer guidelines requires preauthorization.**

**This list is updated at least quartlerly. The most current version is available on our website at McLarenHealthPlan.org. Please contact MHP Customer Service at (888) 327-0671 with any questions.**

McLaren Health Plan Medicaid/Healthy Michigan Dental

**Providers please submit prior authorization requests for the following procedures directly to Delta Dental**

1-866-558-0280

# MHP Dental Codes Requiring Preauthorization - Effective February 1, 2026

| Dental Procedure Code | Definitions |
|---|---|
| D2710 | Crown Resin-Based Indirect |
| D2712 | Crown 3/4 Resin-Based Compos |
| D2722 | Crown Resin W/ Noble Metal |
| D2740 | Crown Porcelain/Ceramic |
| D2750 | Crown Porcelain W/ H Noble M |
| D2751 | Crown Porcelain Fused Base M |
| D2752 | Crown Porcelain W/ Noble Met |
| D2753 | Crown Porc Fused To Titanium |
| D2780 | Crown 3/4 Cast Hi Noble Met |
| D2781 | Crown 3/4 Cast Base Metal |
| D2782 | Crown 3/4 Cast Noble Metal |
| D2783 | Crown 3/4 Porcelain/Ceramic |
| D2790 | Crown Full Cast High Noble M |
| D2791 | Crown Full Cast Base Metal |
| D2792 | Crown Full Cast Noble Metal |
| D2794 | Crown-Titanium |
| D2950 | Core Build-Up Incl Any Pins |
| D4341 | Periodontal Scaling & Root |
| D4342 | Periodontal Scaling 1-3teeth |

**This is not a complete listing of services that may require Preauthorization and all services rendered must be medically necessary.**
**The Certificate of Coverage or Plan Document includes more detailed information.**

| **X= Requires Pre-Authorization**<br>**NC= Not covered by this product**<br>**NR= Auth not required**<br>**RN=Requires Notification** | **Medicaid** | **Healthy Michigan Medicaid** | **Commercial/ Community HMO/POS** | **Health Advantage (HA)** |
|---|---|---|---|---|
| All Inpatient Services -obtained by admitting facility. Exception - Deliveries without sterilization only requires notification for all lines of business both contracted & non-contracted facilities. Community HMO/POS/HA - Non-contracted facilities are reimbursed at member's out-of-network benefit. | X | X | X | X |
| Inpatient Mental Health (MH)-obtained by admitting facility | NC | NC | X | X |
| All Out of Network Services (non-contracted providers)**<br>Individual Plans on the Exchange should verify out of network benefits prior to receiving services. | X | X | X** | X** |
| Ambulance: Non-Urgent Transportation | X | X | X | X |
| Ambulance: Air, Emergent (Requires post-service review) | post-service | post-service | post-service | post-service |
| Applied Behavioral Analysis (ABA Therapy) | NC | NC | NR | NR |
| Autism Services | NC | NC | NR | NR |
| BAHA (L8691, L8692, L8693, L8694) (Commercial requires rider) | NR | NR | **HMO=NC POS=X** | **NC** |
| Cardiac procedures and imaging<br>Refer to the Referral Categories Grid | X | X | NR | NR |
| Chiropractic (Medicaid up to 18 visits per calendar year. Additional visits require preauthorization) | NR | NR | NR | NR |
| Community Health Worker | NR | NR | NC | NC |
| Continuous Glucose Monitors/Supplies (see categories for exceptions) | X | X | X | X |
| Cosmetic Services | X | X | X | X |
| **MEDICAID** DME Purchase- (Durable Medical Equipment) - (allowable line by line as per Medicaid fee schedule) | >$1500 | >$1500 | | |
| **MEDICAID** DME Rental-(allowable line by line as per Medicaid fee schedule) | >$500/Mth | >$500/Mth | | |
| DME Purchase -(billable charges line by line) | | | >$3000 | >$5000 |
| DME Rentals (billable charges line by line) | | | >$100/Mth | >$500/Mth |
| Doula Services **Medicaid only**<br>Auth not required up to benefit limit | NR | NR | NC | NC |
| Electroconvulsive Therapy (ECT) | NC** | NC** | X | X |

| | | | | |
|---|---|---|---|---|
| Emergency Medical Response System | NC | NC | NC | NC |
| Genetic Testing,Diagnosis and Treatment | X | X | X | X |
| Gender Reaffirmation Procedures | X | X | X | X |
| Hearing Aids (Commercial requires rider) | NR | NR | **HMO=NC POS=NR** | NC |
| Home Health Care (see categories for exceptions) | X | X | X | X |
| Hospice | X | X | X | NR |
| Imaging<br>Refer to the Referral Categories Grid | X | X | NR | NR |
| Incontinence Supplies (Medicaid) | see grid | see grid | NC | NC |
| Infertility Testing and Services | X | X | X | X |
| Injectables/IV Therapy (SeeMedical Pharmacy Code List) | X | X | X | X |
| In-Office Laboratory Procedure (Presumptive Drug Class Screening) | NC | NC | NC | NC |
| Insulin Pumps/Supplies | X | X | X | X |
| Maternity Services-Out of Network | NR | NR | X** | NR** |
| Meals and Lodging (Medicaid notification is required) | RN | RN | NC | **Transplant related only** |
| Medication non-formulary drug requests (see formulary)*** | X | X | X | X |
| Mental Health **Outpatient** Services: | NR | NR | NR | NR |
| In Network Consultations and Management | NR | NR | NR | NR |
| In Network Eating Disorders | NR | NR | NR | NR |
| In Network Substance Abuse | NC | NC | NR | NR |
| Laboratory Testing | X<br>See referral categories grid | X<br>See referral categories grid | X<br>See referral categories grid | X<br>See referral categories grid |
| Oral procedures including TMJ and orthognathic | X | X | X | X |
| Podiatry Office Visits | NR | NR | NR | NR |
| Private Duty Nursing Services | NC | NC | NC | NC |
| Procedures to Treat Asthma (Bronchial Thermoplasty) | X | X | X | X |
| Prosthetics and Orthotics | >$500 | >$500 | >$3000 | >$5000 |
| Proton Beam Therapy | X | X | X | X |
| Rehabilitative Outpatient Facility Services | X | X | X | NR |
| Routine Prenatal Care In and Out of Network | NR | NR | X** | X** |
| Site of Service | see grid | see grid | see grid | NR |
| Spine Procedures | see grid | see grid | see grid | NR |
| Skilled Nursing Home | X | X | X | X |
| Sterilization-Voluntary | X | X | X | NR |
| Termination of Pregnancy | X | X | X | NR |

| | | | | |
|---|---|---|---|---|
| Therapies: Physical, Occupational and Speech<br>**For Medicaid: For PT/OT, benefit limit equals 144 units per calendar year. Number of units billed may vary per visit. Please call Customer Service to confirm number of units available. ST benefit is 36 visits per calendar year. Please call Customer Service to confirm number of visits available.** | Auth required only when exceeding benefit limit | Auth required only when exceeding benefit limit | Auth required only when exceeding benefit limit<br><br>**Individual on Exchange:** In-Network benefit only | Auth required only when exceeding benefit limit |
| Transitional Case Management for Recuperative Care | X | X | NC | NC |
| Transplant Services (Organ and Tissue) | see specific organ | see specific organ | X | X |
| Transportation | NR | NR | NC | **Transplant related only** |
| Urologocial Procedures (55880) | X | X | X | X |
| Vision Services | X | X | NC | NC |

***This is not a complete listing of services that may require Pre-Authorization and all services must be medically necessary. The Certificate of Coverage, Plan Document or Policy includes more detailed information.***

*****Health Advantage/Community/Commercial: Not all Out of Network services require Pre-Authorization.***
***Member will have higher out of pocket costs associated with Out of Network providers.***
*****Individual Plans on the Exchange should verify out of network benefits prior to receiving services.***

*****Medicaid/Healthy Michigan - This benefit is managed by the Prepaid Inpatient Health Plan (PIHP) or the Community Mental Health Center (CMH)***
***Medicaid/Healthy Michigan - Some Services covered under the Medicaid Mental Health Benefit***
***Medicaid sterilization requests require informed consent and a 30-day waiting period.Copies must be submitted with pre-authorization request.***

*****McLaren Health Plan does not pay for services, treatment or drugs, that are experimental, investigational or prescribed against FDA or manufacturer guidelines. Any service that may be classified as experimental or off-label should be prior authorized before the service is rendered*****

**If you have any questions, please call (888) 327-0671 or visit our website for clarification - McLarenHealthPlan.org**