



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 March 1, 2026

Referral Category Name	Definitions
<b>NOC</b>	
Not Otherwise Classified (NOC), unlisted, unspecified codes, and manually priced codes.	Requires preauthorization
<b>Autism Services and ABA Therapy</b>	
Autism services and ABA Therapy <b>do not</b> require authorization up to the benefit limit for Community/Commercial and Health Advantage. <b>Autism and ABA services are not covered by the plan for Medicaid. Refer to your local mental health center.</b>	all codes
<b>Auditory and Oral Procedures</b>	
Auditory Procedures <b>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.</b>	69710, 69711, 69714, 69715, 69718, 69728, 69729, 69730, L8627

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

Referral Category Name	Definitions
<b>Auditory and Oral Procedures cont</b>	
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
<b>Behavioral Health</b>	
Inpatient Behavioral Health Services Inpatient Substance Abuse Treatment (Rehabilitative Services only)	<b>Medicaid/Healthy Michigan</b> These benefits are managed by the Prepaid Inpatient Health Plan (PIHP) <b>Commercial/Community and Health Advantage:</b> McLaren preauthorization required
Electroconvulsive Therapy <i>Refer to the preauthorization grid located at the end of this document for additional information.</i>	90870
Mental Health Partial Hospitalization Programs - <i>Commercial/Community and Health Advantage Only</i>	Requires preauthorization
Mental Health Residential Treatment Programs - <i>Commercial/Community and Health Advantage Only</i>	Requires preauthorization

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

Referral Category Name	Definitions
<b>Cardiac Procedures and Imaging</b>	
Cardiac procedures and imaging <i>Authorization Requirements effective 8/1/2024</i> <i>Authorization requirements apply to Medicaid and Healthy Michigan Plan only.</i>	33249, 33264, 33270, 78452, 93306, 93458
<b>Cosmetic Procedures - Medical Necessity review required to determine cosmetic vs reconstructive</b>	
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 March 1, 2026

Referral Category Name	Definitions
<b>Durable Medical Equipment (DME)</b> <b>Refer to the preauthorization grid located at the end of this document for additional information.</b>	
DME Purchase All products which require authorization regardless of fee  <b>**E0483 Medicaid only - Authorization is not required for the diagnosis of Cystic Fibrosis.</b>  <b>Medicaid and Healthy Michigan Plan; Items &gt;\$1,500</b> <b>Commercial/Community HMO &amp; POS; Items &gt;\$3,000</b> <b>Health Advantage; Items &gt;\$5,000</b>  <b>See Wound Care (DME) category list below for additional codes.</b>	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, E1234, E1235, E1229, E1231, 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 All products which require authorization regardless of fee  <b>**E0483 Medicaid only - Authorization is not required for the diagnosis of Cystic Fibrosis.</b>  <b>Medicaid and Healthy Michigan Plan; Items &gt;\$500/month</b> <b>Commercial/Community HMO &amp; POS; Items &gt;\$100/month</b> <b>Health Advantage; Items &gt;\$500/month</b>	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 March 1, 2026

Referral Category Name	Definitions
<i>DME - continued</i>	
<p>Orthotics and Corrective Appliances Purchase</p> <p><b>Medicaid and Healthy Michigan Plan: items &gt;\$500</b>  <b>Commercial/Community HMO &amp; POS: Items &gt;\$3,000</b>  <b>Health Advantage: Items &gt;\$5,000</b>  <b>Medicaid and Health Advantage Only: Authorization is not required for L3649</b></p> <p><i>*Prior auth for L1007 effective 3/1/2025</i></p>	<p>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</p>
<p>Prosthetics Purchase</p> <p><b>Medicaid and Healthy Michigan Plan; items &gt;\$500</b>  <b>Commercial/Community HMO &amp; POS; items &gt;\$3,000</b>  <b>Health Advantage; items &gt;\$5,000</b></p>	<p>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</p>
<p>Hearing Aids-</p> <p><i>Preauthorization for Hearing Aids is not required for CSHCS/Healthy Michigan/Medicaid members up to the benefit limit.</i>  <i>Refer to the preauthorization grid located at the end of this document for additional coverage information.</i>  <i>Preauthorization for Hearing Aids is not required for Commercial/Community members up to the benefit limit.</i>  <i>Refer to the preauthorization grid located at the end of this document for additional coverage information.</i></p>	<p>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 <b>(Commercial requires rider)</b></p>

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

Referral Category Name	Definitions
<i>DME - continued</i>	
<p>Vision Services <b>Authorization requirements are for CSHCS, Medicaid and Healthy Michigan plans only</b>. Consult the plan documents for coverage availability for Community and Health Advantage plans.</p>	<p>Photochromic, tinted, and dyed lenses: V2744-V2745 More than one pair of glasses simultaneously Contact lenses (except under age 6 with diagnosis of aphakia - H270): V2500-V2599 Orthoptics and pleoptics training (age 21 and over): 92065-92066</p>
<p>Continuous Glucose Monitors (CGMs) and Insulin Pumps - <i>All codes for continuous glucose monitors, insulin pumps, and associated supplies require preauthorization.</i></p> <p>#Effective May 1, 2023, for <b>Medicaid only</b>, prior authorization is <b>not</b> required for <b>Continuous Glucose Monitors and Supplies</b> members with type I diabetes or diabetes in pregnancy, childbirth, and the puerperium period (insulin or non-insulin treated). Insulin pumps and supplies <b>do</b> require prior authorization.</p>	<p>A4239#, A9277#, E0784, E2102#, E2103#</p> <p><b>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.</b></p>
<b>Gastrointestinal (GI) Procedures</b>	
<p>Upper Gastrointestinal Endoscopy, Colonoscopy</p> <p><b>Effective 3/1/2026 No authorization is required for this category and accompanying codes.</b></p>	
<b>Gender Affirmation Procedures</b>	
<p>Gender Affirmation Procedures</p> <p>The codes listed in this category pertain <b>ONLY</b> to gender affirmation procedures and require preauthorization.</p> <p>However, codes used for these procedures may be listed elsewhere within this document.</p> <p><b>Please search the entire document to determine whether a code requires an auth.</b></p>	<p>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</p>

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

Referral Category Name	Definitions
<b>Genetic Testing</b>	
Genetic Testing - <i>All genetic testing codes, even if the code is not included in this list, may require Medical Director review and preauthorization.</i>	<b>See Genetic Testing Code List on the following pages</b>
<b>Home Care Services</b>	
Home Care <i>Refer to the preauthorization grid located at the end of this document for additional information.</i>  <b>Effective 1/1/20 for Medicaid only the first 24 billed home care visits per calendar year do not require prior authorization. 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.</b>	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
<b>Imaging</b>	
Imaging <b>Authorization Requirements effective 8/1/2024</b> <b>Authorization requirements apply to Medicaid and Healthy Michigan Plan only.</b>	78452

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

Referral Category Name	Definitions
<b>Incontinence Supplies</b>	
<p>Incontinence Supplies (covered benefit for Medicaid and Healthy Michigan Plan lines of business only)</p> <p>Effective 4/1/2025, J &amp; B Medical is the exclusive provider for incontinence supplies (see code list in the next box). Prior authorization is <b>not</b> required for supplies within quantity limits unless otherwise indicated.</p>	<p>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</p>
<b>Inpatient Services</b>	
Bariatric Surgery	43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999
<p>Inpatient Hospital Services -</p> <p><i>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.</i></p>	<p>All inpatient stays require authorization EXCEPT deliveries which require notification only.</p> <p><b>Medicaid Only</b> - Professional medical services rendered during an inpatient psychiatric stay require preauthorization.</p> <p><b>Authorization is obtained by admitting facility.</b></p>
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
<b>Laboratory Testing</b>	
<p>Definitive drug testing</p> <p><b>Effective 10/1/2024 for Medicaid/Healthy Michigan, Community, Marketplace, and Health Advantage</b></p>	80307, G0480, G0481, G0482, G0483

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

Referral Category Name	Definitions
<b>Medical Respite/Recreative Care</b>	
Medical Respite Special Program <i>Medicaid in-network only</i>	G9006, H0045
<b>Neurostimulators</b>	
Neurostimulator <b><i>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.</i></b>	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
<b>Ophthalmic (Eye) Procedures</b>	
Ophthalmic/Eye Procedures <b>Effective 3/1/2026 No authorization is required for this category and accompanying codes.</b>	

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

Referral Category Name	Definitions
<b>Out-of-Network (OON) Services</b>	
Out-of-Network (OON) Ambulatory Surgery Center - <i>Health Advantage preauthorization is not required. Individual Plans on the Exchange. Please verify out of network benefits prior to receiving services.</i>	Type of bill '83X' and OON
OON Outpatient Facility Services - <i>Health Advantage preauthorization is not require. Individual Plans on the Exchange. Please verify out of network benefits prior to receiving services.</i>	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 - <i>Health Advantage preauthorization is not required. Individual Plans on the Exchange. Please verify out of network benefits prior to receiving services.</i>	Billed on professional claim and OON
OON Dialysis - <i>Commercial/Community and Health Advantage only Medicaid preauthorization is <b>not</b> required</i>	all dialysis services provided by an out-of-network provider
<b>Pharmacy</b>	
Specialty Medications/Injections -	<b>See Medical Pharmacy Code List on the following pages</b>

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

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

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

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

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

Referral Category Name	Definitions
<b>Reproductive Services</b>	
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
<b>Reproductive Services - continued</b>	
Termination of Pregnancy - <i>Health Advantage preauthorization is not required. Commercial/Community preauthorization is required.</i>	59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870, 59897, 59898, 59899
Voluntary Sterilization - <i>Medicaid requires preauthorization, a signed consent form, and a 30 day waiting period. Health Advantage preauthorization is not required. Commercial/Community preauthorization is required.</i>	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
<b>Spine Procedures</b>	
Spine procedures  <b>For Medicaid and Community/On Exchange auth is required for procedures performed in ALL settings, including an inpatient hospital</b>	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 March 1, 2026

Referral Category Name	Definitions
<b>Transitional Case Management for Recuperative Care</b>	
<i><b>This is a Medicaid Program only</b></i> Transitional Case Management for Recuperative Care	G9002 - Request must include MDHHS recuperative care authorization
<b>Transitional Care</b>	
Transitional Care Program - <b>Health Advantage Only</b>	Requires preauthorization
<b>Transplant Services</b>	
Cornea Transplant <i><b>Medicaid only</b></i> - 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 <i><b>Medicaid only</b></i> - 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 March 1, 2026

Referral Category Name	Definitions
<b>Transportation Services</b>	
Emergency Air Ambulance - Requires retro medical necessity review	A0430, A0431, A0435, A0436
Meals/Lodging Medicaid: Requires health plan notification. Health Advantage: Transplant Related Only. 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,
<b>Urgent</b>	
Urgent Preauthorization Requests	Requests are considered urgent <b>only</b> 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.
<b>Urological Procedures</b>	
High Intensity Focused Ultrasound treatment (HIFU)	55880
<b>Wound Care (DME)</b>	
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 March 1, 2026

Referral Category Name	Definitions
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### Authorization Guidelines:

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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.

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HEALTH PLAN

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

### Genetic and Molecular Testing Codes

Procedure Code	Notes
81161	
81162	
81200	
81201	
81206	
81207	
<b>81222</b>	<b>Medicaid only</b> - no auth required
<b>81223</b>	<b>Medicaid only</b> - no auth required
81229	
81292	
81240	
81241	
81243	
81251	
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81294	

Procedure Code	Notes
81295	
81297	
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Procedure Code	Notes
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81465	
81470	
81471	
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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	
<b>86146*</b>	No auth required for pregnant women over the age of 40 and services are provided in-network for Medicaid, Community, and Health Advantage
<b>86147*</b>	No auth required for pregnant women over the age of 40 and services are provided in-network for Medicaid, Community, and Health Advantage
<b>86148*</b>	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	
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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	
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0101U	
0102U	
0103U	
0105U	
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0112U	
0113U	
0114U	
0118U	
0120U	
0129U	

Procedure Code	Notes
0130U	
0131U	
0132U	
0133U	
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Procedure Code	Notes
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0184U	
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0199U	
0200U	
0201U	
0203U	
0205U	
0209U	
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0212U	
0213U	
0214U	
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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	
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0258U	
0260U	
0262U	
0264U	
0265U	
0266U	
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Procedure Code	Notes
0276U	
0277U	
0278U	
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0282U	
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0289U	
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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	

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### 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 <b>pre</b> -exposure prophylaxis ( <b>not for use as hiv treatment</b> )	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 <b>pre</b> -exposure prophylaxis ( <b>not for use as hiv treatment</b> )	added 10/1/2025
J0799-HIV prep-fda approved-NOC	Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis ( <b>not for use as hiv treatment</b> ), 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 deficiency)	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-Casgevvy	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 <sup>15</sup> vector genomes	added 7/1/2020
J3401- Vyjuvek	Beremagene geperpavec-svdt topical admin, containing nominal 5 x 10 <sup>9</sup> 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-mrzk, 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-dblj, 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- Xenpозym	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	lutrisiran, 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	artesianate, 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	onabotulinumtoxin a, 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	daxibotulinumtoxin a-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 <b>pre-exposure prophylaxis (not for use as hiv treatment)</b>	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 <b>pre-exposure prophylaxis (not for use as hiv treatment)</b>	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 ( <b>not for use as hiv treatment</b> ), 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	cipaglucoasidase 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 dezaparovec-drlb, per therapeutic dose (factor IX deficiency)	added 4/1/2023
J1412- Roctavian	valoctocogene roxaparovec-rvox/ml, contain nominal 2x10 <sup>13</sup> vector genome	added 1/1/2024
J1413- Elevidys	delandistrogene moxeparovec-rokl, per therapeutic dose	added 1/1/2024
J1414- Beqvez	fidanacogene elaparovec-dzkt, per therapeutic dose	added 4/1/2025
J1426-Amondys45	casimersen, 10 mg	added 10/1/2021
J1427- Vilterso	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 immunoglobulin	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, (ciplra), 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 (luprate), 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-xiiv, 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- Vyepsti	eptinezumab-jjmr, 1 mg	added 1/1/2024
J3060- Eleyso	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 acetate 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- Casgev	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-vjbc, 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 <sup>15</sup> vector genomes	added 7/1/2020
J3401- Vyjuvek	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 <sup>9</sup> 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 Immunosuppressive	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 mafodotin-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-mzww, 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 vicleucl/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 autoleucl 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 autoleucl, including leukapheresis and dose preparation procedures, per therapeutic dose	added 4/1/2025
Q2058- Aucatzyl	Obecabtagene autoleucl, 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**Bomynta/ Conexence	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-aaaz, 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- Orenzia	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- Oxlumio	lumasiran, 0.5 mg	added 11/1/24
J0225- Amvuttra	lutrisiran, 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- Fasenna	benralizumab, 1 mg	added 4/1/2022
J0584- Crysvida	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 immunoglobulin	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-xiyy, 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- Eleyso	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-vjvk, 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 <sup>15</sup> 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 quarterly. The most current version is available on our website at [McLarenHealthPlan.org](http://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.**

<b>X= Requires Pre-Authorization NC= Not covered by this product NR= Auth not required RN=Requires Notification</b>	<b>Medicaid</b>	<b>Healthy Michigan Medicaid</b>	<b>Commercial/Community HMO/POS</b>	<b>Health Advantage (HA)</b>
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)** <b>Individual Plans on the Exchange should verify out of network benefits prior to receiving services.</b>	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	<b>HMO=NC POS=X</b>	<b>NC</b>
Cardiac procedures and imaging 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
<b>MEDICAID</b> DME Purchase- (Durable Medical Equipment) - (allowable line by line as per Medicaid fee schedule)	>\$1500	>\$1500		
<b>MEDICAID</b> 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 <b>Medicaid only</b> 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 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	<b>Transplant related only</b>
Medication non-formulary drug requests (see formulary)***	X	X	X	X
Mental Health <b>Outpatient</b> 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
	X	X	X	X
Laboratory Testing	See referral categories grid	See referral categories grid	See referral categories grid	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 <b>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.</b>	Auth required only when exceeding benefit limit	Auth required only when exceeding benefit limit	Auth required only when exceeding benefit limit  <b>Individual on Exchange: In-Network benefit only</b>	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	<b>Transplant related only</b>
Urological Procedures (55880)	X	X	X	X
Vision Services	X	X	NC	NC
<b><i>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.</i></b>				
<b><i>**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.</i></b>				
<b><i>**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.</i></b>				
<b><i>***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***</i></b>				

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