

Prior Authorization Requirements List



Services Requiring Prior Authorization (Revised May 2024)

Please note: The terms prior authorization, prior approval, predetermination, advance notice, precertification, preauthorization and prior notification all refer to the same process.

CATEGORY	DETAILS	SUBMIT TO (PROVIDER USE ONLY)
Outpatient Services (furnished in a physician office, certified ambulatory surgery center, outpatient hospital, or any other location)	Ambulance services DME Gene Expression/Microarray Analysis Other Medical/Surgical/Diagnostic Services Reconstructive procedures Surgical Procedure Other additional services Please go to HERE for a list of codes that require prior authorization.	Care Management Web: https://login.coherehealth.com All contracted providers need to submit via the web. Only non-contracted providers can submit via fax. Fax: 1-877-321-6664 or Prior Approval Form
Diagnostic Radiology/Imaging (Outpatient)	Imaging Computed Tomography (CT) Magnetic Resonance Imaging/Angiography (MRI/MRA) Myocardial perfusion (SPECT/PET) and cardiac blood pool imaging Other Nuclear Medicine Position Emission Tomography (PET) A full listing by procedure is available at www.evicore.com/resources/healthplan/medical-mutual-of-ohio under Solution Resources.	eviCore Healthcare Web: https://www.evicore.com/pages/providerlogin.aspx Or Phone: 1-888-693-3211 Fax: 1-888-693-3210
Radiation/Oncology Services (outpatient)	Radiation/Oncology Brachytherapy Stereotactic Radiation Therapy Intensity Modulated Radiation Therapy (IMRT) Neutron Beam Radiation Therapy Intraoperative Radiation Therapy (IORT) Proton Beam Radiation Therapy Hyperthermia Treatment Radiation Treatment Delivery Radiologic Guidance Therapeutic Radiopharmaceuticals A full listing by procedure is available at www.evicore.com/resources/healthplan/medical-mutual-of-ohio under Solution Resources.	eviCore Healthcare Web: https://www.evicore.com/pages/providerlogin.aspx Or Phone: 1-888-693-3211 Fax: 1-866-699-8160.
Home Healthcare Services (All)	Home Health Care (HHC) No prior authorization is required for home health care services. The provider is responsible to ensure that home care services are medically necessary to be considered a covered service.	
CATEGORY	DETAILS	SUBMIT TO (PROVIDER USE ONLY)

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<p>Inpatient Services</p>	<p>Medical/Surgical Acute Care Admissions Acute Care Medical/Surgical</p> <p>Prior approval of normal deliveries is not required unless the length of stay for the mother or child exceeds 48 hours from the date of a vaginal delivery or 96 hours from the date of a C-section.</p>	<p>Medical Mutual contracting providers submit through MedCommunity: https://mmo-prd.assurecare.com/provider/login</p> <p>For all other providers please fax clinical information to 1-800-517-2583</p>
	<p>Medical/Surgical Post-Acute Admissions Acute Physical Rehabilitation Long Term Acute Care (LTAC) Skilled Nursing Facility (SNF)</p>	<p>Medical Mutual contracting providers submit through MedCommunity: https://mmo-prd.assurecare.com/provider/login</p> <p>For all other providers please fax clinical information to 1-800-517-2583</p>
	<p>Behavioral Health Admissions Acute Care Psychiatric/Substance Abuse Residential Inpatient</p>	<p>Medical Mutual contracting providers submit through MedCommunity: https://mmo-prd.assurecare.com/provider/login</p> <p>For all other providers, please fax clinical information to 1-800-524-9817</p>
<p>Therapy</p>	<p>Therapy Not all plans require prior approval for therapy services (i.e., Mutual Health Services). Please contact the For Providers number on the back of the Covered Person's ID card.</p> <p>Chiropractic/Osteopathic Manipulative Therapy Occupational Therapy Physical Therapy Speech Therapy</p> <p>A full listing by procedure is available at www.evicore.com/resources/healthplan/medical-mutual-of-ohio under Solution Resources.</p>	<p>eviCore Healthcare Web: https://www.evicore.com/pages/providerlogin.aspx</p> <p>Phone: 1-877-531-9139 Fax: 1-855-774-1319</p> <p>Therapy Authorization Forms: Physical, Occupational, Chiropractic or Speech Therapy</p>
<p>Nursing</p>	<p>Private Duty Nursing</p>	<p>Care Management Web: https://login.coherehealth.com</p> <p>All contracted providers need to submit via the web. Only non-contracted providers can submit via fax.</p> <p>Fax: 1-877-321-6664 or Prior Approval Form</p>

CATEGORY	DETAILS	SUBMIT TO (PROVIDER USE ONLY)
Transplants	Transplantation – <ul style="list-style-type: none"> • Blood component (e.g., Stem Cell, Bone Marrow) • Solid Organ (Except Corneal) • Pancreatic Islet Cell - Autologous 	Care Management Phone: 1-800-258-3175
Investigational / Experimental Services	The health plan defines investigational procedures, therapies, devices and supplies as services that are not approved by governing bodies OR do not demonstrate comparable or superior outcomes to current practice standards as evidenced by peer-reviewed published literature and/or clinical trials.	Please refer to our Corporate Medical Policies for Investigational/Experimental Services
Injectables	<p>Medical Mutual requires prior approval for the following drugs regardless of whether they are covered under the medical or pharmacy benefits:</p> <ul style="list-style-type: none"> • All new specialty drugs • All new drugs with significant safety, clinical or potential abuse or diversion concerns <p>This requirement is intended to ensure medications are used safely and will be effective for members. The prior approval criteria for these drugs are detailed in the Global PA/New Drug Prior Approval policy available at Medmutual.com/Provider</p> <p>Abatacept (Orencia IV and SC) Adalimumab (Humira) Adalimumab-afzb (Abrilada) Ado-trastuzumab emtansine (Kadcyla®) Aducanumab (Aduhelm™) Afamelanotide (Scenesse) Aflibercept (Eylea®, Eylea HD®) Agalsidase beta (Fabrazyme®) Alemtuzumab (Lemtrada®) (when utilized for treatment of multiple sclerosis) Alglucosidase alfa (Lumizyme®, Myozyme®) Alirocumab (Praluent®) Alpha1-proteinase inhibitors (Aralast NP™, Glassia™, Prolastin®, Prolastin®-C, Zemaira™) Amivantamab-vmjw (Rybrevant™) Anakinra (Kineret®) Anifrolumab-FNIA (Saphnelo™) Asparaginase Erwinia chrysanthemi (Erwinaze) Asparaginase Erwinia chrysanthemi (recombinant)-rwyn (Rylaze™) Atezolizumab (Tecentriq®) Atidarsagene Autotemcel (Lenmeldy) [New PA requirement effective 4/1/2024] Avacincapted pegol (Izervay) [New PA requirement effective 8/1/2023] Avalgucosidase alfa-ngpt (Nexviazyme™) Avelumab (Bavencio®) Axicabtagene ciloleucel (Yescarta®)</p>	Medical Drug Management Web: ih.magellanrx.com Fax: 1-888-656-1948 Phone: 1-800-424-7698 Prior Approval Form

CATEGORY	DETAILS	SUBMIT TO (PROVIDER USE ONLY)
<p>Injectables</p>	<p>Belantamab (Blenrep) Belimumab (Benlysta IV and SC) Bendamustine (Treanda, Belrapzo, Bendeka Vivimusta™) Benralizumab (Fasenra) Beremagene geperpavec-svdt (Vyjuvek) Betibeglogene autotemcel (Zynteglo) Bevacizumab (Avastin, Bevacizumab-awwb (mvasi), Bevacizumab-adcd (Vegzelma), Bevacizumab-bvzr (Zirabev) (prior approval is required for all conditions except diabetic macular edema, macular edema following retinal vein occlusion, or neovascular (wet) age-related macular degeneration) Bivigam Blinatumomab (Blincyto®) Botulinum Toxin Type A and B Bremelanotide (Vyleesi) Brexucabtagene autoleucl (Tecartus) Brodalumab (Siliq™) Brolucizumab-dbli (Beovu) Burosumab (Crysvita) Cabazitaxel (Jevtana) Cabotegravir/ rilpivirine (Cabenuva) Calaspargase Pegol-mknl (Asparlas) Canakinumab (Ilaris®) Caplacizumab-yhdp (Cablivi) Carfilzomib (Kyprolis®) Casimersen (Amondys 45) Cemiplimab-rwlc (Libtayo) Cerliponase alfa (Brineura®) Certolizumab pegol (Cimzia) Cetuximab (Erbix®) C1 esterase inhibitor (Berinert) C1 esterase inhibitor (Cinryze) C1 esterase inhibitor (Haegarda) Ciltacabtagene autoleucl (Carvykti) Cipaglucosidase (Pombiliti) <i>[New PA requirement effective 11/1/2023]</i> Copanlisib (Aliqopa®) Crisanlizumab-tmca (Adakveo) Cuvitru (immune globulin subcutaneous 20% solution) Daratumumab (Darzalex™) Daratumumab hyaluronidase-fihj (Darzalex Faspro) Darbepoetin alfa (Aranesp®) Daunorubicin/cytarabine (Vyxeos®) DaxibotulinumtoxinA-lanm (Daxxify) <i>[New PA requirement effective 8/1/2023]</i> <i>Delandistrogene moxeparvovec (Elevidys) [Not covered effective 7/30/2023]</i> Dostarlimab-gxly (Jemperli) Dupilumab (Dupixent®) Durvalumab (Imfinzi®) Ecallantide (Kalbitor) Eculizumab (Soliris®) Edaravone (Radicava®)</p>	<p>Medical Drug Management Web: ih.magellanrx.com Fax: 1-888-656-1948 Phone: 1-800-424-7698 Prior Approval Form</p>

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<p>Injectables</p>	<p>Efbemalenograstim Alfa (Ryzneuta) <i>[New PA requirement effective 1/1/2024]</i> Efgartigimod alfa (Vyvgart) Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) Eflapegrastim-xnst (Rolvedon) Elapegademase-lvlr (Revcovi™) Elranatamab-bcmm (Elrexvio) Elivaldogene autotemcel (Skysona) Elosulfase alfa (Vimizim) Elotuzumab (Empliciti™) Emapalumab-lzsg (Gamifant) Emicizumab-kxwh (Hemlibra) Enfortumab vedotin-ejfv (Padcev) Enzyme Replacement Therapy for Gaucher Disease (imiglucerase, taliglucerase alfa, velaglucerase alfa) Epcoritamab-gxbm (Epkiny) Eplontersen (Wainua) <i>[New PA requirement effective 2/1/2024]</i> Epoprostenol (Flolan, Veletri) Eptinezumab-jjmr (Vyepiti) Erenumab-aooe (Aimovig™) Erythropoietin alfa (Epogen®, Procrit®, Retacrit) Esketamine (Spravato™) Etanercept (Enbrel) Eteplirsen (Exondys51) Etranocogene dezaparvovec-drlb (Hemgenix) Evinacumab-dgnb (Evkeeza) Evolocumab (Repatha®) Exagamglogene Autotemcel (Casgevy) <i>[New PA requirement effective 1/1/2024]</i> Fam-trastuzumab deruxtecan-nxki (Enhertu) Faricimab-svoa (Vabysmo) Filgrastim (Neupogen®) Filgrastim-aafi (Nivestym™) Fligrastim-sndz (Zarxio™) Flebogamma DIF Fosdenopterin (Nulibry™) Fremanezumab-vfrm (Ajovy™) Galcanezumab-gnlm (Emgality™) Galsulfase (Naglazyme®) Gammagard (all forms) Gammaked Gammaplex Gamunex (all forms) Gemcitabine (Infugem) <i>[New PA requirement effective 8/1/2023]</i> Gemtuzumab Ozogamicin (Mylotarg®) Glatiramer acetate (Copaxone, Glatopa) Glofitamab-bysp (Columvi) New Drug Prior Approval Policy (Global Prior Approval) Givosiran (Givlaari) Golimumab (Simponi ARIA and SC) Golodirsen (Vyondys 53) Growth Stimulating Drugs</p>	<p>Medical Drug Management Web: ih.magellanrx.com Fax: 1-888-656-1948 Phone: 1-800-424-7698 Prior Approval Form</p>

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<p>Injectables</p>	<p>Guselkumab (Tremfya) Hemin (Panhematin™) Hizentra Ibalizumab-uiyk (Trogarzo) Icatibant (Firazyr®) Idecabtagene vicleucel (Abecma™) Idursulfase (Elaprase®) Iloprost (Ventavis) Immune globulins (administered intravenous and subcutaneous) Inclisiran (Leqvio) Inebilizumab-cdon (Uplinza) Infliximab (Remicade) Infliximab-dyyb (Inflectra®, Zymfentra) Infliximab-abda (Renflexis®) Infliximab-axxq (Avsola) Inotersen (Tegsedi) Inotuzumab Ozogamicin (Besponsa®) Interferon beta-1a (Avonex®, Plegridy™, Rebif®) Interferon beta-1b (Betaseron®, Extavia®) Ipilimumab (Yervoy®) Iobenguane I 131 (Azedra®) Irinotecan liposomal (Onivyde®) Isatuximab-irfc (Sarclissa) Ixabepilone (Ixempra®) Ixekizumab (Taltz®) Lanadelumab (Takhzyro®) Laronidase (Aldurazyme®) Lecanemab (Leqembi) <i>[New PA requirement effective 2/1/2024]</i> Leuprolide acetate IM for depot suspension (Lupron Depot) Levoleucovorin (Fusilev, Khapzory) Lifilucuel (Amtagvi) <i>[Not covered effective 3/1/2024]</i> Lisocabtagene maraleucel (Breyanzi) Lonapegsomatropin-TCGD (Skytrofa) Loncastuximab tesirine-lpyl (Zynlonta) Lovotibeglogene Autotemcel (Lyfgenia) <i>[New PA requirement effective 1/1/2024]</i> Lumasiran (Oxlumo) Lurbnectedin (Zepzelca) Luspatacept-aamt (Reblozyl) Lutetium Lu 177 dotatate (Lutathera®) Lutetium Lu177 vipivotide tetraxetan (Pluvicto) Margetuximab-cmkb (Margenza) Melfalan flufenamide (Pepaxto) Mepolizumab (Nucala®) Mirikizumab-mrkz (Omvoh™IV and SC) <i>[New PA requirement effective 11/1/2023]</i> Mirvetuximab soravtansine-gynx (Elahere) Mitomycin (Jelmyto) Methoxy polyethylene glycol-epoetin beta (Mircera®) Mogamulizumab-kpkc (Poteligeo®) Mosunetuzumab-axgb (Lunsumio) Moxetumomab pasudotox-tdfk (Lumoxiti)</p>	<p>Medical Drug Management Web: ih.magellanrx.com Fax: 1-888-656-1948 Phone: 1-800-424-7698 Prior Approval Form</p>

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<p>Injectables</p>	<p>Motixafortide (Aphexda) Nadofaragene firadenovec-vncg (Adstiladrin) Natalizumab (Tysabri) Naxitamab-gpgk (Danyelza) Necitumumab (Portrazza™) Nedosiran (Rivfloza) [New PA requirement effective 11/1/2023] Nelarabine (Arranon) Nivolumab (Opdivo®) Nivolumab/elatlimab-rmbw (Opdualag) Nusinersen (Spinraza®) Obinutuzumab (Gazyva®) Ocrelizumab (Ocrevus®) Octagam Ofatumumab (Kesimpta) Olipudase alfa-rpep (Xenopozyme) Omacetaxine mepesuccinate (Synribo®) Omalizumab (Xolair®) Onasemnogene abeparvovec (Zolgensma®) Paclitaxel albumin-bound (Abraxane) [New PA requirement effective 12/15/2023] Panzyga (IVIG) Pain Management Medications Panitumumab (Vectibix®) Patisirin (Onpattro®) Pegaspargase (Oncaspar) Pegcetacoplan (Empaveli) Pegcetacoplan (Syfovre) Pegfilgrastim (Neulasta®) Pegfilgrastim-apgf (Nyvepria) Pegfilgrastim-bmez (Ziextenzo) Pegfilgrastim-cbqv (Udenyca) Pegfilgrastim-fpgk (Stimufend) [New PA requirement effective 9/1/2023] Pegfilgrastim-pbbk (Fylnetra) Pegfilgrastim-jmdb (Fulphila™) Peginterferon alfa-2b (Sylatron™) Pegloticase (KRYSTEXXA) Pegunigalsidase (Elfabrio) Pegvaliase-pqpz (Palynziq) Pembrolizumab (Keytruda®) Pemetrexed (Pemfexy) Pertuzumab (Perjeta®) Pertuzumab, Transtuzumab, hyaluronidase-zzxf (Phesgo) Plasminogen, human-tvmh (Ryplazim™) Polatuzumab vedotin-piiq (Polivy) Pozelimumab-bbfg (Veopoz) [New PA requirement effective 8/1/2023] Privigen Ramucirumab (Cyramza®) Ranibizumab (Lucentis®) Ranibizumab (Susvimo) Ranibizumab-eqrn (Cimerli)</p>	<p>Medical Drug Management Web: ih.magellanrx.com Fax: 1-888-656-1948 Phone: 1-800-424-7698 Prior Approval Form</p>

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<p>Injectables</p>	<p>Ranibizumab-nuna (Byooviz) Ravulizumab-cwvz (Ultomiris) Recombinant C1 esterase inhibitor (Ruconest®) Repository Corticotropin Injection (H.P. Acthar Gel) Repositroy Corticotropin injection (Cortrophin Gel) Reslizumab (Cinqair®) Retifanlimab-dlwr (Zynyz) Risankizumab-rzaa (Skyrizi) Rituximab (Rituxan) Rituximab-abbs (Truxima) Rituximab-pvvr (Ruxience) Rituximab and Hyaluronidase (Rituxan Hycela) Romidepsin (Istodax®) Romiplostim (Nplate®) Romosozumab-aqqg (Evenity™) Ropeginterferon alfa-2b- NJFT (Besremi™) Rozanolixizumab-noli (Rystiggo) <i>[New PA requirement effective 8/1/2023]</i> Sacituzumab govitecan-hziy (Trodelvy) Sargramostim (Leukine®) Sarilumab (Kevzara®) Satralizumab (Enspryng) Sebelipase alfa (Kanuma) Secukinumab (Cosentyx™ IV and SC) Setmelanotide (Imcivree) Siltuximab (Sylvant®) Sipuleucel-T (Provenge) Sirolimus albumin-bound nanoparticles (Fyarro) Sodium thiosulfate (Pedmark) Sotatercept (Winrevair) <i>[New PA requirement effective 4/1/2024]</i> Spesolimab-sbzo (Spevigo) Surimlimab-jome (Enjaymo) Synagis (Palivizumab) and RSV IVIG Respigam Tafasitamab-cxix (Monjuvi) Tagraxofusp-erzs (Elzonris) Taliglucerase alfa (Elelyso) Talimogene laherparepvc (Imlygic®) TBO-Filgrastim (Granix™) Tebentafusp-tebn (Kimmtrak) Teclistamab-cqyv (Tecayli) Teplizumab-mzwv (Tziel) Teprotumumab-trbw (Tepezza) Testosterone cypionate (Depo®-Testosterone) Testosterone enanthate (Delatestryl®, Xyosted®) Testosterone pellet (Testopel®) Testosterone undecanoate (Aveed®) Tezepelumab-ekko (Tezspire) Tildrakizumab-asmn (Ilumya™) Tisagenlecleucel (Kymriah®) Tislelizumab (Tevimbra) <i>[New PA requirement effective 4/1/2024]</i> Tisotumab vedotin-tftv Tocilizumab (Actemra IV and SC)</p>	<p>Medical Drug Management Web: ih.magellanrx.com Fax: 1-888-656-1948 Phone: 1-800-424-7698 Prior Approval Form</p>

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	<p>Tocilizumab-bavi (Tofidence) <i>[New PA requirement effective 11/1/2023]</i></p> <p>Tofersen (Qalsody)</p> <p>Toripalimab-tpzi (Loqtorzi) <i>[New PA requirement effective 10/1/2023]</i></p> <p>Trabectedin (Yondelis®)</p> <p>Tralokinumab (Adbry)</p> <p>Trastuzumab (Herceptin®)</p> <p>Trastuzumab-dkst (Ogivri™)</p> <p>Trastuzumab-dttb (Ontruzant)</p> <p>Trastuzumab-pkrb (Herzuma)</p> <p>Trastuzumab-qyyp (Trazimera)</p> <p>Trastuzumab-anns (Kanjinti)</p> <p>Trastuzumab/hyaluronidase-oysk (Herceptin Hylecta™)</p> <p>Tremelimumab-actl (Imjudo)</p> <p>Treprostinil (Remodulin, Tyvaso)</p> <p>Triamcinolone acetonide extended-release injectable (Zilretta™)</p> <p>Trilaciclib (Cosela)</p> <p>Ublituximab (Briumvi)</p> <p>Ustekinumab (Stelara IV and SC)</p> <p>Vedolizumab (Entyvio® IV and SC)</p> <p>Valoctocogene roxaparvovec-rvox (Roctavian) <i>[New PA requirement effective 8/1/2023]</i></p> <p>Velmanase alfa-tycv (Lamzede)</p> <p>Velaglucerase alfa (Vpriv)</p> <p>Verteporfin (Visudyne)</p> <p>Vestronidase alfa-vjvk (Mepsevii)</p> <p>Viltolarsen (Viltepso)</p> <p>Vincristine liposomal (Marqibo®)</p> <p>Viscosupplementation Injections (e.g., Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Supartz FX, Synvisc, Synvisc-One, Gel-Syn, Durolane, Trivisc, Synjoynt, Triluron, Viscos 3)</p> <p>Voretigene Neparvovec-rzyl (Luxturna)</p> <p>Vosoritide (Voxzogo)</p> <p>Vutrisiran (Amvuttra)</p> <p>Zilbrysq (zilucoplan) <i>[New PA requirement effective 12/1/2023]</i></p> <p>Ziv-aflibercept (Zaltrap)</p>	

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