



Dear physician or administrator:

Effective Jan. 1, 2027, we will update our prior authorization and notification lists (PALs) for all Medicare Advantage (MA) and Dual Eligible Special Needs Plans (D-SNPs).\*

You can view the PALs and find information about the changes to these lists by visiting Humana's provider website at [Provider.Humana.com/coverage-claims/prior-authorizations/prior-authorization-lists](https://Provider.Humana.com/coverage-claims/prior-authorizations/prior-authorization-lists). Humana updates its lists when new prior authorization or notification requirements are added and when new medications or technology enter the market. To request a copy of any of these lists, please call the customer service number on the back of the Humana member ID card (TTY: 711).

To prevent disruption of care, Humana does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to enrollment. Humana may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment. To ensure appropriate claim payment please include the modifier based on Humana's Medicare Advantage Payment Policy (CP2023011), found on Humana.com or include medical records with evidence that the member is in an active course of treatment.

#### Notice of changes to prior authorization or notification requirements for medical services

| New prior authorization requirements effective Jan. 1, 2027, managed by Humana |                |                                      |                   |
|--------------------------------------------------------------------------------|----------------|--------------------------------------|-------------------|
| Medical services                                                               | Affected plans | Prior authorization request reviewer | Procedure code(s) |
| Bilevel positive airway pressure devices                                       | MA and D-SNPs  | Humana                               | E0470, E0471      |

| Procedure codes added to existing categories effective Jan. 1, 2027                                      |                                  |                                                          |                                           |
|----------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------|-------------------------------------------|
| Procedure codes                                                                                          | Existing category                | Affected plans                                           | Prior authorization requests reviewed by: |
| 0108U                                                                                                    | Molecular and diagnostic testing | MA and D-SNPs                                            | Humana                                    |
| 37255, 37257, 37259, 37261, 37264, 37266, 37268, 37270, 37272, 37274, 37276, 37278, 37281, 37283, 37285, | Peripheral Revascularization     | Medicare, IL D-SNP, MI D-SNP, SC D-SNP and VA D-SNP ONLY | Cohere                                    |

\* Affected MA plans (e.g., health maintenance organization [HMO], point of service [POS] and preferred provider organization [PPO]) and D-SNPs

Prior authorization is not required for MA private fee-for-service plans, but notification is requested as it helps coordinate care for your patients.

**Physicians and healthcare providers contracted through an independent practice association:** These updates do not affect any contractual relationship you may have with a contracted independent practice association (IPA). These updates solely pertain to your participation with Humana under your direct contract with Humana (if any).

**IPAs delegated for utilization management:** These updates do not affect your contractual relationship with Humana and only apply to the extent identified in your contract or Delegation of Services Agreement with Humana.

|                                                 |                                                             |                                             |        |
|-------------------------------------------------|-------------------------------------------------------------|---------------------------------------------|--------|
| 37287, 37289, 37291, 37293, 37295, 37297, 37299 |                                                             |                                             |        |
| 0402T, 0686T, 0888T, 1037T                      | Emerging technology/new indications for existing technology | MA and D-SNPs                               | Humana |
| 90867, 90868, 90869                             | Behavioral health services                                  | Humana PathWays Dual Care Indiana plan ONLY | Humana |

| Effective Jan. 1, 2027, the following Behavioral health service codes will now be managed by Humana. |                |                                      |                                                  |
|------------------------------------------------------------------------------------------------------|----------------|--------------------------------------|--------------------------------------------------|
| Medical services                                                                                     | Affected plans | Prior authorization request reviewer | Procedure codes                                  |
| Behavioral health services                                                                           | IL DSNP ONLY   | Humana                               | 900, 904, 910, 912, 913, 914, 915, 916, 918, 942 |

**Please have the following clinical information available when requesting prior authorization:**

- Member ID number, name, date of birth and date of actual service or hospital admission
- Procedure codes (up to a maximum of 10 per request) and diagnosis codes (primary and secondary) (up to a maximum of six per request)
- Service location
- Inpatient (acute hospital, skilled nursing, hospice) and outpatient (telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center [ASC])
- Referral (office, off-campus outpatient hospital, on-campus outpatient hospital, ASC, other)
- Tax Identification Number (TIN), National Provider Identifier (NPI) number of treatment facility (where service is rendered), and TIN and NPI number of the provider performing the service
- Caller/requester's name, email and telephone number and the attending physician's telephone number
- Relevant clinical information and discharge plans

**NOTICE OF CHANGES TO PRIOR AUTHORIZATION REQUIREMENTS FOR MEDICATIONS DELIVERED  
IN THE PROVIDER'S OFFICE, CLINIC, OUTPATIENT OR HOME SETTING**

**New step therapy requirements for physician administered drugs:**

| New step therapy REQUIREMENTS effective Jan. 1, 2027                                             |                                                         |                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Drug class                                                                                       | Affected plans                                          | Non-preferred drugs (step is required)                                                                                                                                                                                                                                                        | Preferred drugs (* step is required)                                                                                                                                                                                                                                                 |
| Immunologic drugs – autoimmune disorders (e.g. arthritis, psoriasis, inflammatory bowel disease) | Medicare and Dual Eligible Special Needs Plans (D-SNPs) | Inflectra (Q5103),<br>Stelara (J3358),<br>Ustekinumab IV (J3358),<br>Actemra IV (J3262),<br>Avtozma IV (Q5156),<br>Cimzia (J0717),<br>Cosentyx IV (J3247),<br>Entyvio (J3380),<br>Ilumya (J3245),<br>Imuldosa IV (Q5098),<br>Omvoh IV (J2267),<br>Orencia IV (J0129),<br>Pyzchiva IV (Q9997), | Avsola (Q5121),<br>Tyenne (Q5135),<br>Infliximab (J1745),<br>Remicade (J1745),<br>Simponi Aria (J1602),<br>Tremfya IV (J1628),<br>Otulfi IV (Q9999),<br>Yesintek IV (Q5100)<br><br><i>Preferred products in this class will not require prior authorization, effective 1/1/2027.</i> |

|  |  |                                                                                                                                                                                                                                                |  |
|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|  |  | Renflexis (Q5104),<br>Riabni (Q5123),<br>Rituxan IV (J9312),<br>Ruxience (Q5119),<br>Selarsdi IV (Q9998),<br>Starjemza IV (Q5164),<br>Steqeyma IV (Q5099),<br>Tofidence (Q5133),<br>Truxima (Q5115),<br>Tysabri (J2323),<br>Wezlana IV (Q5138) |  |
|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

For a complete list of prior authorization requirements for physician administered drugs, please visit **Humana.com/PAL**.

**Additional information related to step therapy for Part B drugs:**

- Humana’s Part B Step Therapy Preferred Drug List, which includes background information about the program and a comprehensive list of preferred and nonpreferred drugs, is available at **Humana.com/PAL**.
- Some step therapy strategies for MAPD plans may require trial of a preferred drug across different benefits, such as Part B and Part D. Details regarding these cross-benefit strategies can be found in Humana’s Part B Step Therapy Preferred Drug List, available at **Humana.com/PAL**.
- Humana’s Part B Step Therapy Preferred Drug List should be reviewed in conjunction with Humana’s coverage policies, which are accessible at **Humana.com/CoveragePolicies**.
- The designation of preferred status does not guarantee exemption from step therapy requirements. Please refer to the specific criteria contained in our coverage criteria policies, which will be available at **Humana.com/CoveragePolicies**. Affected drugs are noted with a step therapy indicator on the Medicare prior authorization list at **Humana.com/PAL**.
- If providers do not stock a preferred drug, they may be able to obtain the preferred drug from a pharmacy (i.e., a pharmacy can ship the medication to the office). Visit our list of specialty and mail-order pharmacies at **Humana.com/mail-order** to select a pharmacy that can provide the drug. A full list of pharmacies also is available via the Pharmacy Finder Tool at **Humana.com/finder/pharmacy/**. If you have questions, please call us at **800-457-4708 (TTY: 711)**. You can call us seven days a week, from 8 a.m. – 8 p.m., Eastern time. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 to Sept. 30. Please leave your name and telephone number, and we’ll call you back by the end of the next business day. For 24-hour service, visit **Humana.com**.

**National Drug Code (NDC) billing requirement:**

- For certain Healthcare Common Procedure Coding System (HCPCS) drug codes, Humana requires providers to submit a charge with the valid, corresponding National Drug Code (NDC). Humana’s prior authorization and notification lists identify each drug for which Humana requires an NDC. Humana may reject a charge for a shared drug code or a not-otherwise-classified (NOC) drug code if it is submitted without an NDC. A rejected charge for a drug code that requires an NDC can be resubmitted with an NDC, within timely filing guidelines, for reconsideration of payment. For all other HCPCS drug codes, Humana requests a provider to submit a charge with the valid, corresponding NDC.

**Submit prior authorization requests reviewed by the Humana Clinical Pharmacy Review (HCPR) Medical team via:**

- CoverMyMeds (preferred): Requests can be submitted at **covermymeds.com**.
- Fax: **888-447-3430** (request forms are available at **Humana.com/medpa**)
- Phone: **866-461-7273** (available Monday – Friday, 8 a.m. – 11 p.m., Eastern time)

**Prior authorization requests for chemotherapy agents, supportive drugs and symptom management drugs** may be reviewed by an oncology vendor. Refer to the prior authorization lists at **Humana.com/PAL** for submission instructions.

### Other announcements

- Online prior authorization requests are encouraged. For certain PAL services requested via Availity Essentials™/Cohere Health, healthcare providers have the option to complete a questionnaire. Answers to the questionnaire could lead to real-time approval. If approval is not provided immediately, the information on the questionnaire will help expedite the review.

### Important notes

- Urgent/emergent services do not require a referral or prior authorization.
- Please note that the term *prior authorization* (preauthorization, precertification, preadmission), when used in this communication, is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item or service will be covered.
- *Notification* refers to the process by which the physician or other healthcare provider notifies Humana of the intent to provide an item or service. Humana requires notification, as it helps coordinate care for Humana-covered patients. This process is distinguished from prior authorization. Humana does not issue approval or denial for notifications.
- Healthcare providers who participate in an IPA or other risk network with delegated services are subject to the prior authorization list. They should refer to their IPA or risk network for guidance on processing their requests.
- For additional information, refer to **[Provider.Humana.com/coverage-claims/prior-authorizations/prior-authorization-lists](https://provider.humana.com/coverage-claims/prior-authorizations/prior-authorization-lists)**.
- Providers can access Humana's latest medical coverage policies at **[Humana.com/CoveragePolicies](https://Humana.com/CoveragePolicies)**

### Code-editing software and policy updates for medical claims

As part of Humana's ongoing effort to improve our claim adjudication process, we update our claim payment system to better align with correct-coding initiatives, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards. We post notifications about upcoming updates the first Friday of each month. To view these changes and to find additional information regarding claim policy updates and submitting code-editing questions, visit **[Provider.Humana.com/coverage-claims/processing-edits](https://Provider.Humana.com/coverage-claims/processing-edits)**.

If you have questions about this information, please call **800-4HUMANA (448-6262) (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

Thank you for your continued care of your Humana-covered patients.

Sincerely,

Humana Clinical Operations



Dear physician or administrator:

As part of Humana's ongoing claims process improvement efforts, we continue to update our claims payment systems to better align with correct-coding initiatives, Centers for Medicare & Medicaid Services (CMS) guidelines, national benchmarks and industry standards. **These changes occur throughout the year, with updates posted the first Friday of each month.** Each item notified will indicate the item's implementation date.

To view these changes, visit <https://provider.humana.com/coverage-claims/processing-edits> and select "Search processing edits." General reminders and special announcements can be viewed by selecting "General coding reminders and special announcements" under the "Additional resources" sidebar on the page above.

We update our claim payment systems—primarily claims submitted on a CMS-1500—to better align with American Medical Association (AMA) Current Procedural Terminology (CPT®) code sets, Healthcare Common Procedure Coding System (HCPCS) code sets, International Classification of Diseases (ICD) code sets and CMS guidelines.

You can submit specific questions about code editing through the code-editing questions tool. To access the code-editing questions tool, you must be registered on Humana's website or through Availity Essentials™.

To submit a code editing question on **Humana.com**:

1. If you are not registered for the **Humana.com** secure portal, go to **Humana.com** and choose "Sign in or Register" or contact your primary access administrator.
2. Once signed in, select the "Claims Tools" tab at the top of the page.
3. Select "Code Edit Questions" to access the tool.

To submit a code-editing question on Availity Essentials:

1. If you are not registered for Availity Essentials, please visit [www.availity.com](http://www.availity.com) and select "REGISTER" to sign up.
2. Once signed in, select "Claims Management" from the links on the left.
3. Select "Research Procedure Code Edits" to access the tool.

If you do not have access to the web and you have questions about this information, or if you require a printed copy of the claims payment changes, please call a Humana Customer Care representative at **800-4HUMANA (448-6262)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Thank you for your continued care of your Humana-covered patients

Sincerely,

Medicare  
Humana Claims Team