



Dear physician or administrator:

Effective Jan. 1, 2027, we will update our prior authorization and notification lists (PALs) for our Medicare Advantage (MA) and Dual Eligible Special Needs Plans (D-SNP). You can view the PALs and find information about the changes to these lists by visiting the CarePlus provider website at **CarePlusHealthPlans.com/PAL**. CarePlus updates its lists when new prior authorization requirements are added and when new prescription drugs or technology enter the market.

To request a copy of any of these lists, please call the CarePlus Provider Operations inquiry line at **866-220-5448**, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

To prevent disruption of care, CarePlus 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 the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

Notice of changes to prior authorization requirements for medical services

New prior authorization requirements effective Jan. 1, 2027

Medical services	Affected plans	Prior authorization request reviewer	Procedure code(s)
Bilevel positive airway pressure devices	Medicare Advantage and D-SNPs	CarePlus	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	Medicare Advantage and D-SNPs	CarePlus
0402T, 0686T, 0888T, 1037T	Emerging technology/new indications for existing technology	Medicare Advantage and D-SNPs	CarePlus

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

- Member ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes (up to a maximum of 10 per request)
- Diagnosis codes (primary and secondary) (up to a maximum of six per request)
- Service location
- Inpatient (acute hospital, skilled nursing, hospice)
- 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) and National Provider Identifier (NPI) number of treatment facility (where service is rendered)
- TIN and NPI number of the provider performing the service
- Caller/requester's name/email/telephone number
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Notice of changes to prior authorization requirements for medications delivered in the physician's office, clinic, outpatient or home setting

New step therapy requirements for provider administered drugs:

New step therapy REQUIREMENTS effective Jan. 1, 2027			
Drug class	Affected plans	Non-preferred drugs (step is required)	Preferred drugs
Immunologic drugs – autoimmune disorders (e.g. arthritis, psoriasis, inflammatory bowel disease)	Medicare Advantage and D-SNPs	Inflectra (Q5103), Stelara (J3358), Ustekinumab IV (J3358), Actemra IV (J3262), Avtozma IV (Q5156), Cimzia (J0717), Cosentyx IV (J3247), Entyvio (J3380), Ilumya (J3245), Imuldosa IV (Q5098), Omvoh IV (J2267), Orencia IV (J0129), Pyzchiva IV (Q9997), Renflexis (Q5104), Riabni (Q5123), Rituxan IV (J9312), Ruxience (Q5119), Selarsdi IV (Q9998), Starjemza IV (Q5164), Steqeyma IV (Q5099), Tofidence (Q5133), Truxima (Q5115), Tysabri (J2323), Wezlana IV (Q5138)	Avsola (Q5121), Tylene (Q5135), Infliximab (J1745), Remicade (J1745), Simponi Aria (J1602), Tremfya IV (J1628), Otulfi IV (Q9999), Yesintek IV (Q5100) <i>Preferred products in this class will not require prior authorization, effective 1/1/2027.</i>

For a complete list of prior authorization requirements for provider administered drugs, please visit [CarePlusHealthPlans.com/PAL](https://www.CarePlusHealthPlans.com/PAL).

Additional information related to step therapy for Medicare Part B-covered drugs:

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- The CarePlus Part B Step Therapy Preferred Drug List, which includes background information about the program and a comprehensive list of preferred and nonpreferred prescription drugs, is available at [CarePlusHealthPlans.com/PAL](https://www.CarePlusHealthPlans.com/PAL).
- Some step therapy strategies for MA prescription drug plans may require a trial of a preferred prescription drug across different benefits, such as Medicare Part B and Part D. The details regarding these cross-benefit strategies can be found in the CarePlus Part B Step Therapy Preferred Drug List, which is available at **CarePlusHealthPlans.com/PAL**.
- The CarePlus Part B Step Therapy Preferred Drug List should be reviewed in conjunction with CarePlus coverage policies, which are accessible at **Humana.com/CoveragePolicies**.
- If providers do not stock a preferred prescription drug, they may be able to obtain it from a pharmacy (i.e., a pharmacy can ship the medication to the office).

National Drug Code billing requirement:

- For certain Healthcare Common Procedure Coding System (HCPCS) drug codes, Humana requires providers to submit a charge with the valid and corresponding National Drug Code (NDC). Humana's prior authorization and notification lists identify each prescription drug for which Humana requires an NDC. Humana may reject a charge for a shared prescription drug code or a not otherwise classified drug code if it is submitted without an NDC. A rejected charge for a prescription 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 and corresponding NDC.

Submit prior authorization requests reviewed by the CarePlus Pharmacy Utilization Management Unit via:

- **CoverMyMeds (preferred):** Requests can be submitted at **CoverMyMeds.health**.
- Fax: **800-310-9071** (Request forms are available at **CarePlusHealthPlans.com/providers/pharmacy-resources**.)
- Phone: **866-315-7587**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time

An oncology vendor may review prior authorization requests for chemotherapy agents, supportive drugs and symptom management drugs. Refer to the prior authorization lists at **CarePlusHealthPlans.com/PAL** for submission instructions.

Other announcements

- Online prior authorization requests are encouraged. For certain PAL services requested via Availity Essentials™, 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" (prior authorization, 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 CarePlus of the intent to provide an item or service. CarePlus requests notification, as it helps coordinate care for CarePlus-covered patients. This process is distinguished from prior authorization. CarePlus does not issue approvals or denials for notifications.
- For additional information, refer to **CarePlusHealthPlans.com/PAL**. Providers can access Humana's latest medical coverage policies at **Provider.Humana.com/coverage-claims/claims-payment-policies**.

If you have questions about this information, please call the CarePlus Provider Operations inquiry line at **866-220-5448**, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

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

Sincerely,

CarePlus Clinical Operations