Medical and Medication Prior Authorization and Notification List

After reading the applicability of the prior authorization requirements below, you can access information about our current list of services, codes and medication that need prior authorization by selecting the appropriate link:

CarePlus July 1, 2025, Medicare Advantage and Dual Medicare-Medicaid Plans Prior Authorization and Notification List

CarePlus July 1, 2025, provider-administered medication prior authorization list

Learn how to submit a prior authorization request for frequently requested services/procedures for your CarePlus-covered patients.

We have updated our CarePlus Health Plans Prior Authorization and Notification List and medication prior authorization list (PAL).

Please note the term "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 an approval or denial for notifications.

The list details services and medication (i.e., medications that are delivered in the physician's office, clinic, outpatient or home setting) that require prior authorization prior to being provided or administered. Services must be provided according to Medicare coverage guidelines established by the Centers for Medicare & Medicaid Services (CMS). According to the guidelines, all medical care, services, supplies and equipment must be medically necessary. You can review Medicare coverage guidelines here.

To view Humana's medical coverage policies, please visit Humana's Medical and Pharmacy Coverage Policies website.

Investigational and experimental procedures and devices usually are not covered benefits. Please consult the patient's Evidence of Coverage or contact CarePlus for confirmation of coverage.

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.

Important notes:

- CarePlus Medicare Advantage (MA) health maintenance organization (HMO): The full list of prior authorization requirements applies to your patients with CarePlus MA HMO coverage.
- For procedures or services that are investigational or experimental (or that may have limited benefit coverage), or for any service not on our PAL, you can request a predetermination on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.
    - Initiate a predetermination for medical services by submitting a fax or telephone request:
        - Submit by fax: 1-800-266-3022
            - When submitting a predetermination request by fax, please write "predetermination" on your request.
        - Submit by calling 1-800-201-4305, Monday – Friday, 8 a.m. to 5 p.m., Eastern time
            - When requesting a predetermination by phone, please advise CarePlus you're requesting a "predetermination."

Please note that urgent/emergent services do not require referrals or prior authorization.

Not obtaining prior authorization for a service could result in financial penalties for the practice and reduced benefits for the patient based on the healthcare provider's contract and the patient's Evidence of Coverage. Services or medication provided without prior authorization may be subject to retrospective medical necessity review. We recommend that an individual practitioner making a specific request for services or medication verify benefits and prior authorization requirements with CarePlus prior to providing services.

Information required for a prior authorization request or notification may include, but is not limited to, the following:

- Member's CarePlus ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes
- Date of proposed procedure (if applicable)
- Diagnosis codes (primary and secondary)
- Service location
- Inpatient (i.e., acute hospital, skilled nursing facility)
- Outpatient (e.g., telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center)
- Referral (e.g., office, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center)
- Tax Identification Number (TIN), National Provider Identifier (NPI) number of treatment facility where service is being rendered, and TIN and NPI number of the provider performing the service
- Requester's name/phone number

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- Attending physician's phone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will help expedite the determination. If additional clinical information is required, a CarePlus representative will contact the individual who submitted the prior authorization request and request the specific information needed to complete the authorization process.

How to request prior authorization:

Except where noted on links on the following pages, prior authorization requests for medical services may be initiated. Choose from the following options to submit a request for prior authorization:

- Submit the request on the Availity Essentials™ website.
- Complete the Health Services Prior Authorization Form and fax it (and a cover sheet) to the appropriate fax number:
    - Broward and Palm Beach counties: 1-866-832-2678
    - Miami-Dade County: 1-888-790-9999
    - All other counties: 1-888-634-3521
- Call the CarePlus Health Plans Utilization Management department at 1-800-201-4305, Monday – Friday, 8 a.m. to 5 p.m., Eastern time.

Please note: Online prior authorization requests are encouraged.

Except where noted on links on the CarePlus provider website, prior authorization for medication may be initiated:

- By faxing your request to CarePlus at 1-888-634-3521 or by calling the CarePlus Health Services department at 1-800-201-4305, Monday – Friday, 8 a.m. to 5 p.m., Eastern time, if the medication is billed, dispensed and administered by the physician's office, infusion clinic or outpatient facility.
- By faxing the CarePlus Health Plans Pharmacy at 1-800-310-9071, if the medication is billed and shipped from a retail pharmacy to the physician's office or facility (non-self-administered, infusible drug).

The CarePlus medication PAL is subject to change, and we will notify providers of these changes. We may update the list throughout the year for additions of new-to-market medication or step therapy requirements for medication without notification to providers.

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