

	A	B	C	D	E
1	<p>This list of services applies to <u>GHP Family (Medicaid)</u> line of business unless otherwise noted below. All drugs newly approved by the FDA should be considered to require prior authorization until such time as they are formally reviewed by the GHP Pharmacy & Therapeutics Committee. Final determinations to require prior authorization for specific drugs will be added to this list as they are made. The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL</p>				
2	Procedure/Service	Effective Date for providers	Comments	Most recent Communication to Providers	Associated Medical Policy #
3	Abilify Maintena®	01/01/20			Antipsychotics
4	J0401, Prior authorization is required for any member under 18 years of age.				
5	Actemra syringe and vial®	01/01/20			Cytokine and Cam Antagonists
6	J3262				
7	Actemra Actpen	01/01/20			Cytokine and Cam Antagonists
8	J3262				
9	Advate®	01/01/20			Antihemophilia Agents
10	J7192				
11	Adynovate®	01/01/20			Antihemophilia Agents
12	J7207				
13	Afstyla®	01/01/20			Antihemophilia Agents
14	J7210				
15	Akynzeo Vial®	01/01/20			Antiemetic/Antivertigo Agents
16	J1454				
17	Alphanate®	01/01/20			Antihemophilia Agents
18	J7186				
19	AlphaNine® SD	01/01/20			Antihemophilia Agents
20	J7193				

	A	B	C	D	E
21	Alprolix™	01/01/20			Antihemophilia Agents
22	J7201				
23	Aranesp syringe and vial®	01/01/20			Erythropoiesis Stimulating Proteins
24	J0881, J0882				
25	Aristada ER®	01/01/20			Antipsychotics
26	J1944, Prior authorization is required for any member under 18 years of age				
27	Aristada Initio®	01/01/20			Antipsychotics
28	J1943, Prior authorization is required for any member under 18 years of age				
29	Aveed®	01/01/20			Androgenic Agents
30	J3145				
31	Avsola™ (infliximab-axxq)	07/01/20			Cytokine and Cam Antagonists
32	Q5121				
33	Benefix®	01/01/20			Antihemophilia Agents
34	J7195				
35	Beovu®	4/15/2020			Macular Degeneration Agents
36	J0179				
37	Berinert®	01/01/20			Hereditary Angioedema Treatments
38	J0597				
39	Boniva vial, syringe®	01/01/20			Bone Density Regulators
40	J1740				
41	Botox®	01/01/20			Botulinum Toxins
42	J0585				
43	Cerezyme®	01/01/20			Enzyme Replacements, Gaucher Disease
44	J1786				
45	Cimzia IV®	01/01/20			Cytokine and Cam Antagonists
46	J0717				

	A	B	C	D	E
47	Cinqair®	01/01/20			Monoclonal Antibodies (MABs Anti-IL, Anti-IgE)
48	J2786				
49	Cinryze®	01/01/20			Hereditary Angioedema Treatments
50	J0598				
51	Depo-Provera syringe®	01/01/20			Contraceptives, Other
52	J1050, Prior authorization is only required for the following NDC number: 00009737611				
53	Depo-Provera vial®	01/01/20			Contraceptives, Other
54	J1050, Prior authorization is required for any of the following NDC numbers: 00009074630, 00009074635				
55	Depo-Testosterone vial®	01/01/20			Androgenic Agents
56	J1071				
57	Dexycu®	01/01/20			Ophthalmics, Anti-Inflammatories
58	J1095				
59	D.H.E. 45 Ampule®	01/01/20			Antimigraine Agents, Other
60	J1110				
61	Diazepam Syringe	01/01/20			Anxiolytics
62	J3360, Prior authorization is required for all members with any of the following NDC numbers only: 69339013632, 69339013602, 69374096502, 11704060001				
63	Diazepam Vial	01/01/20			Anxiolytics
64	J3360, Prior authorization is only required for members under 21 years of age with any of the following NDC numbers: 00409321312, 00409321310, 00409321309				
65	Dihydroergotamine Ampule	01/01/20			Antimigraine Agents, Other
66	J1110				
67	Dimenhydrinate Vial	01/01/20			Antiemetic/Antivertigo Agents
68	J1240				
69	Duopa™	01/01/20			Antiparkinson's Agents
70	J7340				

	A	B	C	D	E
71	Durolane®	01/01/20			Intra-Articular Hyaluronates
72	J7318				
73	Dysport®	01/01/20			Botulinum Toxins
74	J0586				
75	ElELYso®	01/01/20			Enzyme Replacements, Gaucher Disease
76	J3060				
77	Eligard®	01/01/20			Pituitary Suppressive Agents, LHRH
78	J9217				
79	Eloctate™	01/01/20			Antihemophilia Agents
80	J7205				
81	Emend Vial®	01/01/20			Antiemetic/Antivertigo Agents
82	J1453				
83	Entyvio®	01/01/20			Cytokine and Cam Antagonists
84	J3380				
85	Epogen®	01/01/20			Erythropoiesis Stimulating Proteins
86	Q4081,J0885				
87	Esperoct®	07/01/20			Antihemophilia Agents
88	J7204				
89	Eylea®	01/01/20			Macular Degeneration Agents
90	J0178				
91	Euflexxa®	01/01/20			Intra-Articular Hyaluronates
92	J7323				
93	Fasenra Syringe®	01/01/20			MONOCLONAL ANTIBODIES (MABS) ANTI-IL, Anti-IgE)
94	J0517				
95	Feiba NF®	01/01/20			Antihemophilia Agents
96	J7198				

	A	B	C	D	E
97	Feraheme®	01/01/20			Iron, Parenteral
98	Q0139				
99	Fluphenazine Decanoate Injection	01/01/20			Antipsychotics
100	J2680, Prior authorization is required for any member under 18 years of age				
101	Fluphenazine Vial	01/01/20			Antipsychotics
102	Currently there is no specific code for this service.				
103	Fulphila®	01/01/20			Colony Stimulating Factors
104	Q5108				
105	Gel-One®	01/01/20			Intra-Articular Hyaluronates
106	J7326				
107	Gelsyn™	01/01/20			Intra-Articular Hyaluronates
108	J7328				
109	Genvisc®	01/01/20			Intra-Articular Hyaluronates
110	J7320				
111	Geodon Vial®	01/01/20			Antipsychotics
112	J3486				
113	Granix®	01/01/20			Colony Stimulating Factors
114	J1447				
115	Haldol ampule®	01/01/20			Antipsychotics
116	J1630, Prior authorization is required for any member under 18 years of age				
117	Haldol Decanoate ampule®	01/01/20			Antipsychotics
118	J1631, <u>Prior authorization is only required for members with the following NDC numbers:</u> 50458025414, 50458025303.				
119	Haloperidol Decanoate ampule	01/01/20			Antipsychotics
120	J1631, <u>Prior authorization is only required for members under 18 years of age with any of the following NDC numbers:</u> 70069003105, 10147092205, 70069003101, 70069003001, 10147092103, 70069003003				

	A	B	C	D	E
121	Haloperidol Decanoate vial	01/01/20			Antipsychotics
122	J1631, Prior authorization is only required for members under 18 years of age with any of the following NDC numbers: 25021083301, 00703702301, 00703702103, 67457040913, 67457038158, 67457040900, 00703702101, 67457038100, 63323047141, 63323047105, 63323047101, 00703701103, 00703701101, 63323046901, 63323046905, 67457041013, 25021083101, 00703701301, 67457041000				
123	Haloperidol Lactate Ampule (Syringe or Vial)	01/01/20			Antipsychotics
124	J1630, Prior authorization is required for any member under 18 years of age				
125	Helixate FS®	01/01/20			Antihemophilia Agents
126	J7192				
127	Hemlibra®	01/01/20			Antihemophilia Agents
128	J7170				
129	Hemofil-M	01/01/20			Antihemophilia Agents
130	J7190				
131	Humate-P®	01/01/20			Antihemophilia Agents
132	J7187				
133	Hyalgan®	01/01/20			Intra-Articular Hyaluronates
134	J7321				
135	Hydroxyprogesterone Caproate	01/01/20			Progestational Agents
136	J1726, J1729				
137	Hymovis®	01/01/20			Intra-Articular Hyaluronates
138	J7322				
139	Ibandronate vial, syringe	01/01/20			Bone Density Regulators
140	J1740				
141	Idelvion™	01/01/20			Antihemophilia Agents
142	J7202				
143	Ilaris®	01/01/20			Cytokine and Cam Antagonists
144	J0638				

	A	B	C	D	E
145	Ilumya	01/01/20			Cytokine and Cam Antagonists
146	J3245				
147	Iluvien Implant®	01/01/20			Ophthalmics, Anti-Inflammatories
148	J7313				
149	Inflectra	01/01/20			Cytokine and Cam Antagonists
150	Q5103				
151	Injectafer®	01/01/20			Iron, Parenteral
152	J1439				
153	Invega Sustenna®	01/01/20			Antipsychotics
154	J2426, Prior authorization required for all members under 18 years of age				
155	Invega Trinza®	01/01/20			Antipsychotics
156	J2426, Prior authorization required for all members under 18 years of age				
157	Ixinity®	01/01/20			Antihemophilia Agents
158	J7195				
159	Jivi®	01/01/20			Antihemophilia Agents
160	J7208				
161	Kalbitor®	01/01/20			Hereditary Angioedema Treatments
162	J1290				
163	Koate®	01/01/20			Antihemophilia Agents
164	J7190				
165	Kogenate FS®	01/01/20			Antihemophilia Agents
166	J7192				
167	Kovaltry®	01/01/20			Antihemophilia Agents
168	J7211				
169	Krystexxa®	01/01/20			Antihyperuricemics
170	J2507				

	A	B	C	D	E
171	Lemtrada®	01/01/20			Multiple Sclerosis Agents
172	J0202				
173	Leukine®	01/01/20			Colony Stimulating Factors
174	J2820				
175	Leuprolide	01/01/20			Pituitary Suppressive Agents, LHRH
176	J9218				
177	Levothyroxone Vial	01/01/20			Thyroid Hormones
178	Currently this drug is billed with and unlisted procedure code				
179	Liothyronine Vial	01/01/20			Thyroid Hormones
180	Currently this drug is billed with and unlisted procedure code				
181	Lucentis®	01/01/20			Macular Degeneration Agents
182	J2778				
183	Lupron Depot®	01/01/20			Pituitary Suppressive Agents, LHRH
184	J1950, J9217				
185	Lupron Depot-Ped®	01/01/20			Pituitary Suppressive Agents, LHRH
186	J1950, J9217				
187	Macugen®	01/01/20			Macular Degeneration Agents
188	J2503				
189	Makena vial, autoinjector®	01/01/20			Progestational Agents
190	J1726				
191	Midazolam syringe	01/01/20			Sedative Hypnotics
192	Currently this drug is billed with and unlisted procedure code				
193	Mircera®	01/01/20			Erythropoiesis Stimulating Proteins
194	J0887, J0888				
195	Monoclate-P®	01/01/20			Antihemophilia Agents
196	J7190				

	A	B	C	D	E
197	Monoferric® (ferric derisomaltose)	10/01/20			Iron, Parental
198	J1437				
199	Mononine®	01/01/20			Antihemophilia Agents
200	J7193				
201	Monovisc®	01/01/20			Intra-Articular Hyaluronates
202	J7327				
203	Myobloc®	01/01/20			Botulinum Toxins
204	J0587				
205	Neulasta Onpro®	01/01/20			Colony Stimulating Factors
206	J2505				
207	Neulasta Syringe®	01/01/20			Colony Stimulating Factors
208	J2505				
209	Neupogen®	01/01/20			Colony Stimulating Factors
210	J1442				
211	Nivestym®	01/01/20			Colony Stimulating Factors
212	Q5110				
213	Novoseven RT®	01/01/20			Antihemophilia Agents
214	J7189				
215	Novoeight®	01/01/20			Antihemophilia Agents
216	J7182				
217	Nplate®	01/01/20			Thrombopoietics
218	J2796				
219	Nucala Vial®	01/01/20			Monoclonal Antibodies (mAbs Anti-IL-5, Anti-IgE)
220	J2182				
221	Nuwiq®	01/01/20			Antihemophilia Agents
222	J7209				

	A	B	C	D	E
223	Obizur®	01/01/20			Antihemophilia Agents
224	J7199				
225	Ocrevus®	01/01/20			Multiple Sclerosis Agents
226	J2350				
227	Olanzapine vial	01/01/20			Antipsychotics
228	S0166				
229	Orencia vial®	01/01/20			Cytokine and Cam Antagonists
230	J0129				
231	Orthovisc®	01/01/20			Intra-Articular Hyaluronates
232	J7324				
233	Ozurdex Implant®	01/01/20			Ophthalmics, Anti-Inflammatories
234	J7312				
235	Perseris ER®	01/01/20			Antipsychotics
236	J2798, Prior authorization required for all members under 18 years of age				
237	Phenergan Ampule	01/01/20			Antiemetic/Antivertigo Agents
238	J2550, <u>Prior authorization is only required for members with the following NDC numbers:</u> 00641608225, 00641608201, 00641608301, 00641608325				
239	Phenergan Vial	01/01/20			Antiemetic/Antivertigo Agents
240	J2550, <u>Prior authorization is only required for members with the following NDC numbers:</u> 00641608425, 00641608401, 00641608525, 00641608501				
241	Premarin Vial®	01/01/20			Estrogens
242	J1410				
243	Probuphine Implant®	01/01/20			Opioid Dependence Treatments
244	J0570				
245	Procrit®	01/01/20			Erythropoiesis Stimulating Proteins
246	J0885, Q4081				
247	Profilnine®	01/01/20			Antihemophilia Agents
248	J7194				

	A	B	C	D	E
249	Prolia®	01/01/20			Bone Density Regulators
250	J0897				
251	Promethazine Ampules	01/01/20			Antiemetic/Antivertigo Agents
252	J2550, Prior authorization is only required for members under 6 years of age with the following NDC numbers: 39822552502, 00641149535, 00641094831, 39822552503, 00641149531, 00641094835, 39822555006, 00641094935, 00641149635, 00641094931, 39822555005, 00641149631				
253	Promethazine Vial	01/01/20			Antiemetic/Antivertigo Agents
254	J2550, Prior authorization is only required for members under 6 years of age with the following NDC numbers: 00641092821, 00641095521, 00703219104, 00641620825, 00641095525, 00641092825, 00641620801, 00641095621, 00703220104, 00641092921, 6641092925, 00641095625				
255	Rapivab Vial®	01/01/20			Hepatitis B Agents
256	J2547				
257	Rebinyn®	01/01/20			Antihemophilia Agents
258	J7203				
259	Reclast®	01/01/20			Bone Density Regulators
260	J3489, Prior authorization is only required for members with the following NDC number: 00078043561				
261	Recombinate™	01/01/20			Antihemophilia Agents
262	J7192				
263	Remicade®	01/01/20			Cytokine and Cam Antagonists
264	J1745				
265	Renflexis®	01/01/20			Cytokine and Cam Antagonists
266	Q5104				
267	Retacrit™	01/01/20			Erythropoiesis Stimulating Proteins
268	Q5105, Q5106				
269	Retisert Implant®	01/01/20			Ophthalmics, Anti-Inflammatories
270	J7313				
271	Risperdal Consta®	01/01/20			Antipsychotics
272	J2794, Prior authorization required for all members under 18 years of age				

	A	B	C	D	E
273	Rixubis®	01/01/20			Antihemophilia Agents
274	J7195				
275	Ruconest®	01/01/20			Hereditary Angioedema Treatments
276	J0596				
277	Simponi Aria®	01/01/20			Cytokine and Cam Antagonists
278	J1602				
279	Sinuva™	01/01/20			Intranasal Rhinitis Agents
280	J7401				
281	Spravato™	01/01/20			Antidepressants, Other
282	G2082, G2083				
283	Stelara Syringe or Vial®	01/01/20			Cytokine and Cam Antagonists
284	J3357				
285	Stelara Vial®	01/01/20			Cytokine and Cam Antagonists
286	J3358				
287	Supartz FX®	01/01/20			Intra-Articular Hyaluronates
288	J7329				
289	Supprelin LA®	01/01/20			Pituitary Suppressive Agents, LHRH
290	J9226				
291	Sustol®	01/01/20			Antiemetic/Antivertigo Agents
292	J1627, Prior authorization is only required for members with the following NDC number: 47426010106				
293	Synvisc®	01/01/20			Intra-Articular Hyaluronates
294	J7325				
295	Synvisc-One®	01/01/20			Intra-Articular Hyaluronates
296	J7325				
297	Testopel Implant Pellet®	01/01/20			Androgenic Agents
298	S0189				

	A	B	C	D	E
299	Testosterone Cypionate Vial	01/01/20			Androgenic Agents
300	J1071				
301	Testosterone Enanthate Injection	01/01/20			Androgenic Agents
302	J3130				
303	Tigan Vial®	01/01/20			Antiemetics/Antivertigo Agents
304	J3250				
305	Tysabri®	01/01/20			Multiple Sclerosis Agents
306	J2323				
307	Trelstar Vial®	01/01/20			Pituitary Suppressive Agents, LHRH
308	J3315				
309	Triesence®	01/01/20			Ophthalmics, Anti-Inflammatories
310	J3300				
311	Triostat Vial®	01/01/20			Thyroid Hormones
312	Currently this drug is billed with and unlisted procedure code				
313	Triptodur	01/01/20			Pituitary Suppressive Agents, LHRH
314	J3316				
315	Trivisc™	01/01/20			Intra-Articular Hyaluronates
316	J7329				
317	Trogarzo™	01/01/20			HIV/AIDS Antiretrovirals
318	J1746				
319	Udenyca®	01/01/20			Colony Stimulating Factors
320	Q5111				
321	Visco-3®	01/01/20			Intra-Articular Hyaluronates
322	J7321, J7333				
323	Visudyne®	01/01/20			Macular Degeneration Agents
324	J3396				

	A	B	C	D	E
325	Vpriv®	01/01/20			Enzyme Replacements, Gaucher Disease
326	J3385				
327	Vonvendi®	01/01/20			Antihemophilia Agents
328	J7179				
329	Vyepti™	07/01/20			Antimigraine Agents, Other
330	J3032				
331	Wilate	01/01/20			Antihemophilia Agents
332	J7183				
333	Xeomin®	01/01/20			Botulinum Toxins
334	J0588				
335	Xgeva®	01/01/20			Bone Density Regulators
336	J0897				
337	Xolair Syringe or Vial®	01/01/20			Monoclonal Antibodies (mAbs) Anti-IL4, Anti-IgE)
338	J2357				
339	Xyntha®	01/01/20			Antihemophilia Agents
340	J7185				
341	Xyntha Solofuse®	01/01/20			Antihemophilia Agents
342	J7185				
343	Yutiq Implant™	01/01/20			Ophthalmics, Anti-Inflammatories
344	J7313				
345	Zantac vial®	01/01/20			Histamine 2 Receptor Blockers
346	J2780, Prior authorization is only required for members with the following NDC numbers; 52565009601, 52565010201, 52565010110				
347	Zarxio®	01/01/20			Colony Stimulating Factors
348	Q5101				
349	Zemplar®	01/01/20			Vitamin D Analogs
350	J2501, Prior authorization is only required for members with the following NDC numbers; 00074165805, 00074463701, 00074165801				

	A	B	C	D	E
351	Ziextenzo® (pegfilgrastime-bmez)	04/01/20			Colony Stimulating Factors
352	Q5120				
353	Zinplava™	01/01/20			Antibiotics, GI an related agents
354	J0565				
355	Zoladex Implant®	01/01/20			Pituitary Suppressive Agents, LHRH
356	J9202				
357	Zometa Injection®	01/01/20			Bone Density Regulators
358	J3489, Prior authorization is only required for members with the following NDC number: 00078059061				
359	Zometa Vial®	01/01/20			Bone Density Regulators
360	J3489, Prior authorization is only required for members with the following NDC number: 00078038725				
361	Zyprexa Relprevv®	01/01/20			Antipsychotics
362	J2358, Prior authorization required for all members under 18 years of age				
363	Zyprexa Vial®	01/01/20			Antipsychotics
364	S0166				