Samaritan Health Plans

2019 PRIOR AUTHORIZATION LIST

SAMARITAN CHOICE PLANS

Coverage of certain medical services and surgical procedures require Samaritan Choice Plans' (SCP) written authorization before the services are performed. Your provider may request prior authorization by phone, fax, or mail. If for any reason your provider will not, or does not, request prior authorization for you, you must contact SCP yourself. This requirement applies to both in-network and out-of-network providers. **Failure to obtain a prior authorization may result in your claim being denied, either in whole or in part.** In some cases, SCP may require you to provide additional information or seek a second opinion before authorizing coverage.

Prior authorization by Samaritan Choice Plans is required for the following medical services and surgical procedures:

- Bariatric surgery (benefit is for in-network/designated facilities only)
- Capsule/wireless endoscopies and motility monitoring studies
- Durable Medical Equipment (DME) and supplies, prosthetics, and orthotics with billed amount greater than $1,000 for purchase. Rental items with rental fee greater than $1,000 per month or rental length greater than 3 months
- Elective termination of pregnancy
- Genetic testing
  - **Exception**: standard prenatal testing
- Hospitalization for dental procedures including Ambulatory Surgical Center (ASC)
- Hyperbaric oxygen therapy
- Infused/injected medications (see attached list)
- Inpatient hospital care (including mental health and substance use disorder) *
  - **Exception**: labor & delivery
  - **Exception**: newborn stays less than 5 days
- Inpatient rehabilitation care*
- Neck and back surgery (including those done as in-office procedures)
- Panniculectomy
- Potentially cosmetic, experimental or reconstructive surgery and services, including new and emerging technologies and clinical trials**
- Radiological services (for the following):
  - Magnetic Resonance Imaging (MRI)
  - Positron Emission Tomography (PET) scans
  - Virtual colonoscopy
- Residential services for mental health and substance use disorder
- Sclerotherapy
- Skilled Nursing Facility (SNF)
- Skin substitute – tissue engineered
- Transplants
  - **Exception**: corneal transplants
- Urine drug tests (prior authorization required after 12 units per year)
- Uvulopalatopharyngoplasty

* Emergency Services will not require prior authorization in accordance with Patient Protection and Affordability Care Act. We request notification of any emergency admissions or observation stays that exceed 48 hours in order to ensure that all of the member's care is appropriately coordinated.

** Cosmetic, experimental or reconstructive surgery and services, including new and emerging technologies and clinical trials, have the following requirements and considerations:

- Cosmetic and experimental services, which may include new or emerging technologies, often do not meet medical necessity and are generally not covered.
- Services which may be considered reconstructive will require prior authorization to demonstrate medical necessity regardless of dollar amounts or codes billed.
- Prior authorization for new or emerging technologies is required to ensure that the service meets current accepted standards of care.

Medically appropriate: health care services or supplies that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and

- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Samaritan Choice Plans reserves the right to review or otherwise deny services that are not found to be medically necessary. Prior authorization is not a guarantee of payment.

Prior authorization by Samaritan Choice Plans is required for the following drugs when paid under the medical plan. Any other brand name equivalents of the medications below also require prior authorization:

- Abatacept (Orencia)
- Abobotulinumtoxin A (Dysport)
- Adalimumab (Humira)
- Aflibercept (Eylea)
- Agalsidase Beta (Fabrazyme)
- Albiglutide (Tanzeum)
- Alemtuzumab (Campath, Lemtrada)
- Alglucosidase Alfa (Myozyme)
- Alpha-1 Proteinase Inhibitor (Aralast NP, Glassia, Prolastin-C, Zemaria)
- Antihemophilic Factor (Hemofil M, Koate, Monoclate-P)
- Belatacept (Nulojix)
- Belimumab (Benlysta)
- Bevacizumab (Avastin)
- Bortezomib (Velcade)
- C1 Esterase Inhibitor (Berinert, Cinryze, Haegarda, Ruconest)
- Certolizumab (Cimzia)
- Cetuximab (Erbitux)
- Coagulation Factor IX (Idelvion)
- Coagulation Factor VIIa (NovoSeven RT)
- Collagenase, Injectable (Xiaflex)
- Daratumumab (Darzalex)
- Denosumab (Prolia, Xgeva)
- Eculizumab (Soliris)
- Edetate (EDTA) Chelation
- Elotuzumab (Empliciti)
- Epoetin and Darbepoetin (Epogen, Procrit, Aranesp)
- Epoprostenol (Flolan, Veletri)
- Etanercept (Enbrel)
- Fulvestrant (Faslodex)
- Glatiramer Acetate (Copaxone, Glatopa)
- Golimumab (Simponi, Simponi Aria)
- Granulocyte Colony-Stimulating Factor (G-CSF) (filgrastim, Granix, Neupogen, Zarxio)
- Granulocyte-Macrophage Colony-Stimulating Factor (GM-CSF) (sargramostim, Leukine)
- Hyaluronic Acid, Intra-articular Injection (Durolane, Gel-One)
- Icatibant (Firazyr)
- Idursulfase (Elaprase)
- Imiglucerase
- Immune Globulin Intravenous (IVIG, Bivigam, Carimune, Cuvitru, Gammagard, Octagam, Privigen)
- Infliximab (Remicade, Inflectra, Renflexis)
- Interferon and Peginterferon (Intron A, Avonex, Betaseron, Extavia, Rebif, Pegasys)
- Ipilimumab (Yervoy)
- Lanreotide (Somatuline)
- Laronidase (Aldurazyme)
- Mecasermin (Increlex)
- Mepolizumab (Nucala)
- Natalizumab (Tysabri)
- Nivolumab (Opdivo)
- Octreotide (Sandostatin)
- Ocrelizumab (Ocrevus)
- Omalizumab (Xolair)
- OnabotulinumtoxinA (Botox)
- Oprelvekin (Neumega)
- Palifermin (Kepivance)
- Palivizumab (Synagis)
- Palonosetron (Aloxi)
- Panitumumab (Vectibix)
- Pasireotide (Signifor)
- Pegaptanib (Macugen)
- Pegloticase (Krystexxa)
- Pegvisomant (Somavert)
- Pembrolizumab (Keytruda)
- Pertuzumab (Perjeta)
- Ranibizumab (Lucentis)
- RimabotulinumtoxinB (Myobloc)
- Rituximab (Rituxan)
- Romiplostim (Nplate)
- Secukinumab (Cosentyx)
- Somatropin (Genotropin, Humatrope, Norditropin, Saizen, Omnitrope, Nutropin)
- Taliglucerase (Elelyso)
- Teduglutide (Gattex)
- Teriparatide (Forteo)
- Tocilizumab (Actemra)
- Trastuzumab (Herceptin)
- Ustekinumab (Stelara)
- Vedolizumab (Entyvio)
- Velaglucerase (Vpriv)

Contact us… Samaritan Choice Plans 541-768-4550 | 1-800-832-4580 | TTY 1-800-735-2900