Cancer Guidance Program: Continuity of Care

Clinical Guidelines

Effective Date: 07/23/2026

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Summary

To outline Optum's process for addressing preservice requests for members with continuity of care situations beyond what is covered outside of Transition of Care period (90 days).

Audience

Cancer Specialty Guidance Program (CSGP) Nurse, Cancer Specialty Guidance Program (CSGP) Leader

Explanation of Rationale

- To provide clinical benefits for members who are currently receiving a regimen that is not supported by NCCN or is non-preferred, where denying treatment can result in negative treatment outcomes including increased morbidity and mortality.
- This does not apply to any other services approved for new members in an active course of treatment for the duration of the authorization.

Statement

Upon client implementation of Optum's Cancer Guidance Program (CGP) or when members enroll into a health plan with CGP, Optum may encounter situations in which a provider wishes to receive authorization for services currently in place for a member.

Continuity of Care (COC)

Services Continuity

The event in which a provider makes a preservice request for a member in which services are currently/recently in place. Services may or may not have required prior authorization in the past. Services may or may not have a current prior authorization in place by the previous or current healthcare payer.

Any continuity of care criteria outlined in a drug policy should be applied prior to using this Optum Continuity of Care Policy. For Medicare Advantage plans, refer to UHC Medicare Advantage Policy - Part B Step Therapy unless it is an exempt H plan.

Background

As part of an effort to ensure quality of care and reduce treatment delays, in partnership with our clients, Optum's CGP has implemented a Continuity of Care (COC) policy.

Servicing COC event: Consideration for COC events often occur at the point of new client implementation, when specific drugs are newly added to a client's prior authorization list or when a member is new to a health plan or medical group with Optum CGP. A member may be receiving services that now require prior authorization. Evaluation of these services should occur with considerations given to the member's current/recent response to the ongoing treatment, alignment of services to client policies or applicable clinical guidelines, state or federal regulatory requirements, program accreditation and the impact to the member in the event of a required change in service authorization status.

How COC Evaluation Works

When a provider, or operations user on behalf of a provider, submits a prior authorization request to Optum's Cancer Guidance Program (CGP), CGP's authorization platform will determine if a case can be approved against client's policy / applicable clinical guidelines based on responses to clinical assessment questions. In the event a request cannot be system approved, the request will pend for clinical review.

If the request pends to clinical review, the clinician will evaluate and consider any available clinical treatment notes received by the provider and content within the member's health record in the authorization platform such as responses to clinical assessment questions or historical prior authorization information. If a COC event is identified, the clinician will approve the request as allowed by this policy.

Guidelines for Continuity of Care Allowances

Members undergoing active treatment prior to a health plan's implementation of CGP, prior to a plan's requirement for prior authorization services or prior to a member's enrollment in the health plan with a prior authorization requirement Or an auth previously approved by CGP has now expired (and the provider is seeking a new authorization), can be approved by CGP even if it is not supported by the applicable hierarchy, clinical guidelines or client policy, including off pathways regimens and non-preferred drugs if applicable if it meets All of the following requirements:

- The member has been under treatment with requested drug Or regimen within the **90-day look-back** period (unless otherwise specific by client). An addition or change of any drug (except for preferred in same drug class) within the treatment regimen will disqualify the request for COC. The request should be the same drug or a preferred product of the same drug classification. i.e., original request was Neulasta, new request is for Udenyca – both are current UHC preferred GCSF in the same classification and can be approved. If same classification of drug, but non- preferred, this would not fall under COC.
- The member has demonstrated clinical improvement or stabilization of their condition during treatment with the requested drug/regimen.
- Discontinuing the requested drug/regimen would be expected to compromise the member's treatment outcome.
- Acknowledgement by the provider of prior treatment as evident within the provider's submitted clinical notes.

Exceptions

- If continuation of care provisions are available in an applicable UHC Drug Policy, then Optum COC Policy will not apply.
- If Chemotherapy regimens and associated supportive drugs started in an in-patient setting do not meet NCCN guidelines, FDA approvals and/or UHC policies referencing Preferred Products, then Optum COC Policy will not apply.

When all the above parameters are met, Optum will approve the member for COC allowing for standard service date duration.

Exceptions or changes to these COC allowances will be allowed by the client to align with their plan or drug policies contingent on Optum's assurance that changes will not interfere in compliance with state, federal, or accreditation standards. Such adjustments might include consideration to preferred or step therapies, or adjustments to allowed service durations to allow for member transition. Client's changes to this policy will require joint legal and compliance approval between Client and Optum.

Approval and Revision History

Version	Date and Description
1.0	**07/23/2026**: New template. Approved by Luciana Gay. C. Lim