UnitedHealthcare®

Medical Records Requirements for Pre-Service

Instructions:

This document lists medical records requirements for pre-service requests such as notification and prior authorization. These requirements are developed using published clinical evidence, physician advisory group recommendations and recognized national guidelines to help promote quality, safety and appropriate use of services. Covered services and services requiring prior authorization vary by state. Please review the requirements for notifications and prior authorization requests at **UHCprovider.com/priorauth**.

You may refer to this document or the UnitedHealthcare Administrative Guide at **UHCprovider.com/guides** for specific clinical information.

To decrease the need for repeated requests, improve turnaround time for medical records reviews and help improve the claims process, please prepare suggested materials in advance. You may receive communications from us to help support our current processes and we may ask for more information, as necessary.

The service categories and applicable CPT® codes listed in this guide are not inclusive of all service categories, but do include a majority of them. Medical record requirements for case review(s) may vary among various UnitedHealthcare Commercial, UnitedHealthcare Community Plan and UnitedHealthcare Medicare Advantage benefit plans. We'll let you know of any changes.

Service categories are listed alphabetically. You can search this document by using the keyboard command CTRL+F.

Thank you.

Service Categories:

Accidental Dental Services

Air Ambulance – Non-Emergency Transport

Aqueous Shunt to Extraocular Reservoir

Attended Sleep Study

Bariatric Surgery

Subsequent Bariatric Surgery Required

Behavioral Health Services

Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair

Breast Reconstruction, Non-Mastectomy

Breast Reduction, Non-Mastectomy Chiropractic Services

Clinical Trials

Cochlear Implants & Other Auditory Implants

Congenital Heart Disease (diagnostic/therapeutic services)

Cosmetic & Reconstructive

Decompression Unspecified Nerves

Deep Brain Stimulation for Idiopathic Parkinson's Disease, Essential Tremor and Primary Dystonia

DME – Automatic External Defibrillator

DME – Bone Growth Stimulator-Ultrasonic

DME – Bone Growth Stimulator - Electrical / Electromagnetic

DME – Continuous Glucose Monitoring (CGM)

DME – Cough Stimulating Device

DME – CPAP

DME – CPM for Knee Surgery

DME – Electrical Stimulation Device for Treatment of Wounds

DME – Enteral Nutrition/Tube Feedings

DME – External Insulin Pump

DME – External and Implantable Pump

DME – High Frequency Chest Wall Oscillation (HFCWO) Devices

DME – Hospital Beds

DME – Mechanical Stretching Devices (Dynamic and Static)

DME – Miscellaneous

DME – Negative Pressure Wound Therapy (Wound Vac)

DME – Neuromuscular Stimulators

DME – NMES

DME – Oral Appliances for the Treatment of Obstructive Sleep Apnea

DME – Member Lifts

DME – Percussor/Oscillatory Devices

DME – Pneumatic Compression Devices

DME – Power Mobility Devices (Scooters, Wheelchairs)

DME – Pressure Reducing Support Surface – Group 2

DME – Pressure Reducing Support Surface – Group 3

DME – PT INR Monitor

DME – Respiratory Assistive Device – BIPAP for OSA

DME – Respiratory Assistive Device – BIPAP for Diagnosis Other Than OSA

DME Seat Lifts

DME – TENS

DME – Ultraviolet Cabinet

DME – Ventilator

DME – Wheelchair – Manual

Extracorporeal Shock Wave Therapy for Plantar Fasciitis

Femoroacetabular Impingement Syndrome (FAI)

Functional Endoscopic Sinus Surgery (FESS)

Genetic and Molecular Pathology Testing including BRCA

Gender Dysphoria

Home Health Care Services

Hyperbaric Oxygen Treatment

Hysterectomy

IMRT

Injectable Medications – Enzyme Replacement Therapy for Gaucher's Disease

Injectable Medications – Luxterna

Injectable Medications – Radicava

Injectable Medications – Spinraza

Injectable Medications – Hemophilia

Injectable Medications – HP Acthar

Injectable Medications – Immune Globulin (IVIG) Initial

Injectable Medications – Immune Globulin (IVIG) Continuation

Injectable Medications – Immune Globulin (IVIG) for asthma

Injectable Medications – Immune Globulin (IVIG) for auto immune disease

Injectable Medications – Immune Globulin (IVIG) for demyelinating polyneuropathy

Injectable Medications – Immune Globulin (IVIG) for BMT

Injectable Medications – Immune Globulin (IVIG) for chronic lymphocytic leukemia (CLL)

Injectable Medications – Immune Globulin (IVIG) for dermatomyositis or polymyositis

Injectable Medications – Immune Globulin (IVIG) for fetomaternal alloimmune thrombocytopenia

Injectable Medications – Immune Globulin (IVIG) for Diabetes Mellitus

Injectable Medications – Immune Globulin (IVIG) for Guillian Barre

Injectable Medications – Immune Globulin (IVIG) for Pediatric HIV

Injectable Medications – Immune Globulin (IVIG) for Idiothrombocytic purpura (ITP)

Injectable Medications – Immune Globulin (IVIG) for Kawasaki disease Injectable

Medications – Immune Globulin (IVIG) for Lambert-Eaton Myasthenic Syndrome (LEMS)

Injectable Medications – Immune Globulin (IVIG) for Lennox Gastrate

Injectable Medications – Immune Globulin (IVIG) for multifocal motor neuropathy (MMN)

Injectable Medications – Immune Globulin (IVIG) for Multiple Sclerosis

Injectable Medications – Immune Globulin (IVIG) for Myasthenia Gravis

Injectable Medications – Immune Globulin (IVIG) for neuromyelitis optica

Injectable Medications – Immune Globulin (IVIG) for post transfusion purpura

Injectable Medications – Immune Globulin (IVIG) for Rasmussen syndrome

Injectable Medications – Immune Globulin (IVIG) for Primary Immunodeficit

Injectable Medications – Immune Globulin (IVIG) for Stiff person Syndrome

Injectable Medications – Immune Globulin (IVIG) for Thrombocytopenia secondary to HCV infection

Injectable Medications – Rituxan / Rituximab

Injectable Medications- Fulphila / pegfilgrastin

Injectable Medications- Nivestym

Injectable Medications- Hemlibra / emicizumab

Injectable Medications-Kymriah

Injectable Medications-Gamifant

Injectable Medications- Onpattro / patisiran

Injectable Medications- White Blood Cell Stimulators (Neupogen, Granix / tbofilgrastin, Leukine / sargramostim, Filgrastin)

Injectable Medication – Gelsyn

Injectable Medication – Durolane

Injectable Medication – Synvisc / Synvisc-One

Injectable Medication – Genvisc 850

Injectable Medication – Hyalgan / Supartz / Supartz FX / Visco-3

Injectable Medication – Hymovis

Injectable Medication – Euflexxa

Injectable Medication – Orthovisc

Injectable Medication – Gel-One

Injectable Medication – Monovisc

Injectable Medications- Kanuma

Injectable Medications – Naglazyme

Injectable Medications- Vimizim

Injectable Medications – Mepsevii

Injectable Medications – Aralast NP

Injectable Medications – Glassia

Injectable Medications- Zemaira

Injectable Medications – Benlysta

Injectable Medications – Aldurazyme

Injectable Medications- Fabrazyme

Injectable Medications –Adagen

Injectable Medications – Infliximab

Injectable Medications- Renflexis

Injectable Medications- Sublocade / Buprenorphine

Injectable Medications- Trogarzo / ibalizumab

Injectable Medications – Anti Neoplastic agents

Injectable Medications – Factor Products

Injectable Medications- Zinplava / bezlotoxumab

Injectable Medications – Prolia

Injectable Medications – Milrinone / milrione lactate

Injectable Medications – Tysabri / Natalizumab

Injectable Medications – TriVisc

Injectable Medication – Makena

Injectable Medication – Crysvita

Injectable Medication – Parsabiv

Injectable Medication – Trogarzo

Injectable Medications – Prolastin / alpha 1-proteinase inhibitor – human

Injectable Medications – Sandostatin / octreotide

Injectable Medications - Lumizyme / Myozyme / alglucosidase

Injectable Medications – Elaprase / idursulfase

Injectable Medications – Probuphine

Injectable Medications – Botox, Xeomin, Dysport, Myobloc

Injectable Medications – Botox, Dysport to treat achalasia

Injectable Medications – Botox, Dysport to treat Chr Anal fissures

Injectable Medications – Botox, Xeomin, Dysport, Myobloc to treat Cervical dystonia

Injectable Medications – Botox, Dysport, Myobloc to treat detrusor overactivity

Injectable Medication – Xeomin to treat Blepharospasm

Injectable Medications – Botox to treat migraine headaches

Injectable Medications – Botox to treat overactive bladder

Injectable Medications – Iloprost

Injectable Medications – Neulasta / pegfilgrastin

Injectable Medications – Herceptin / trastuzumab

Injectable Medications- Retacrit / Epoetin Alfa -EPBx

Injectable Medications – Ipilinumab

Injectable Medications – Alimta / pemetrexed

Injectable Medications – Velcade / bortezomib

Injectable Medications – Taxel / Onxal / paclitaxel

Injectable Medications – Xgeva / denosumab

Injectable Medications – Aranesp / darbepoetin alfa

Injectable Medications – Exondys 51

Injectable Medications – Procrit / Epogen / epoetin alfa

Injection Medications – Xolair for asthma

Injection Medications – Xolair for Uticaria

Injectable Medication – VPRIV

Injectable Medications – Brineuva Injection Anesthetic Agent Greater Occipital Nerve

Jaw Motion Rehabilitation System

Joint Replacement – Acetabuloplasty

Joint Replacement – Ankle Arthroplasty

Joint Replacement – Displaced Fracture of Femoral Neck, Hemiarthroplasty

Joint Replacement – Elbow Arthroplasty

Joint Replacement – Hip Arthroplasty

Joint Replacement – Knee Arthroplasty or Arthroplasty Revision

Joint Replacement – Knee Arthroscopy with Autologous implantation or Allograft

Joint Replacement – Shoulder Arthroplasty, Arthroplasty Revision

Joint Replacement – Shoulder Hemiarthroplasty

Magnetoencephalography

Mastectomy for Gynecomastia

Muscle Flap Procedures

Neuromuscular Stimulator for Scoliosis

Neuromuscular Stimulators

Neurostimulator Electrode Array, Peripheral Nerve

Non Invasive Fractional Flow Reserve (FFR)

Open Osteochondreal Autograft, Talus

Orthognathic and Jaw Surgery (including genioplasty)

Orthotics

Pacemaker insertion / replacement

Pacemaker replacement of leads / electrodes

Pacemaker replacement of batteries, generator

Radiopharmaceuticals

Stress Echocardiogram

Cardiac Catheterization with or without angiography

Panniculectomy and Body Contouring – Includes Lipectomy and Abdominoplasty

Pediatric Day Care MS, LA, TX

Percutaneous Lysis of Epidural Adhesions

Physical / Occupationl Therapy

Private Duty Nursing

Prosthetics – Breast

Prosthetics – Face

Prosthetics – Lower Limb

Prosthetics – Upper Limb

Prosthetics – Miscellaneous

Proton Beam Therapy

Radiation Therapy

Radiology Services (CT, MRI, MRA, PET, SPECT, Nuclear Medicine, MR – Ultrasounds, Thyroid / Parathyroid)

Request for Procedure or Service Not Already Listed in This Document

Rhinoplasty, Septoplasty, Repair of Vestibular Stenosis or Turbinate Resection

Self-Administered Drugs

Sinuplasty (Balloon Sinus Ostial Dilation)

Sleep Apnea Treatment and Surgeries

Sleep Study – Facility-Based

Speech Therapy AZ, NJ, OH, PA, MS

Spinal Stimulator for Pain Management

Spinal Surgery for pain and nerve /cord compression

Spinal Surgery – Scoliosis

Therapeutic Apheresis

Therapeutic Procedures

Therapeutic Embolization; Endometrial Ablation/Cryoablation

Thorascopy – Sympathectomy for Treatment of Hyperdidrosis

Transection or Avulsion of Greater Occipital Nerve

Transplant of Tissue or Organs

Upper Gastrointestinal Endoscopy with Delivery of Thermal Energy for Treatment of Gastroesophageal Reflux Disease

Vagus Nerve Stimulation Varicose Vein

Ventricular Assist Devices

Service Category	CPT Codes	Clinical Information Requested
Accidental Dental Services	All codes including CDT codes where applicable	1. Date of accident 2. Description of accident and identification of the tooth / teeth damaged 3. Date of initial contact with a Medical or Dental Professional 4. Detailed comprehensive treatment plan including submission of Pre and Post imaging studies and clinical photos, if taken 5. Anticipated date of completion 6. Certification from the DDS that the tooth was sound and natural prior to the accident
Acupuncture	97810 97811 97813 97814	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Imaging reports c. Previous treatments rendered, dates of treatments and response d. Treatment plan

Service Category	CPT Codes	Clinical Information Requested
Air Ambulance – Non-Emergency Transport	A0430 A0431 A0435 A0436 S9960 S9961	1. Date of Service 2. Ordering physician's name and phone# (if request is made to Air Ambulance provider) 3. Physician order and documentation by Physician explaining the reason for Air Ambulance transport 4. Any additional equipment or personnel needed for transport 5. Member's diagnosis and chief complaint 6. Physician notes evaluating members current condition (clinical summary) including a. Co-morbidities b. Current functional limitations c. Description of members inpatient (IP) stay and progress if applicable 7. Describe where member is traveling from (facility name & contact name/phone number) 8. Describe where member is traveling to (facility name & contact name/phone number) 9. Mileage (one-way) for transport including air mileage and land mileage for transport

Service Category	CPT Codes	Clinical Information Requested
Aqueous Shunt to Extraocular Reservoir	66180	Physician office notes including: 1. Condition/ diagnosis requiring procedure 2. History and physical by the attending/treating physician 3. History and duration of unsuccessful conservative therapy, when applicable 4. Previous related surgical procedures 5. Name of drainage device to be used
Abortion	59830, 59850, 59851, 59855, 59856, 59857, 59852	Physician office notes describing that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, and the life of the pregnant woman would be endangered if the fetus were carried to term OR that the pregnancy is the result of an act of rape or incest .
Bariatric Surgery	43633 43644 43645 43647 43648 43659 43770 43771 43772 43773 43774 43775 43842 43843 43845 43846 43847 43848 43860 43865 43886 43887 43888 43999 44799 0312T 0313T 0314T 0315T 0316T 0317T 64590 43881 43882 95980 95981 95982	1. Medical office notes which include: a. Height b. Weight c. Current and five year history of BMI (body mass index) 2. Diet history 3. Co-morbidities 4. Medical treatment tried and failed including diet and exercise. 5. Psychological evaluation 6. Nutritional consult 7. Name of the facility where the procedure will be performed

Service Category	CPT Codes	Clinical Information Requested
Subsequent Bariatric Surgery Required	Diagnosis codes: E66.09 E66.1 E66.8 E66.9 E66.01 E66.3 E66.2 Z98.84 Z68.1 Z68.20 Z68.21 Z68.22 Z68.23 Z68.24 Z68.25 Z68.26 Z68.27 Z68.28 Z68.29 Z68.30 Z68.31 Z68.32 Z68.33 Z68.34 Z68.35 Z68.36 Z68.37 Z68.38 Z68.39 Z68.41 Z68.42 Z68.43 Z68.44 Z68.45 Z68.51 Z68.52 Z68.53 Z68.54 AND Procedure codes: 43860 43865	1. Medical office notes which include: a. Height b. Weight c. BMI (body mass index) 2. Diet history 3. Co-morbidities 4. Previous unsuccessful medical treatment 5. Name of the facility where the procedure will be performed 6. Initial bariatric surgery performed and date and subsequent complications that require further surgical intervention
Behavioral Health Services	All codes	Provider should call the number on the member's identification (ID) card when referring for any mental health or substance abuse/substance use services.
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair	15820 15821 15822 15823 67900 67901 67902 67903 67904 67906 67908 67909	1. Goldman, manual or automated technique visual fields, taped and untaped 2. Marginal reflex distance (MRD-1) 3. Physician office notes describing visual complaints, functional impairments and ruling out other causes 4. High-quality photograph(s). All photos must be full face, labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s). Photos can't be faxed . Please use the Prior Authorization and Notification app on Link to send photos.

Service Category	CPT Codes	Clinical Information Requested
Breast Reconstruction, Non-Mastectomy	19324 19325 19328 19330 19340 19342 19350 19355 19357 19361 19364 19366 19367 19368 19369 19370 19371 19380 19396 L8600	1. Physician office notes with the history of the medical condition(s) requiring treatment or surgical intervention 2. Chief complaint, history of the complaint and physical exam 3. Relevant medical-surgical history including dates 4. Define complications which necessitate the need for removal of the prosthetic, if applicable a. For capsular contractures, include Baker grade and functional impairment **Note:** If the request is related to gender dysphoria additional information will be required.
Breast Reduction, Non-Mastectomy	19316 19318	1. Physician office notes with the history of the medical condition(s) requiring treatment or surgical intervention and ALL of the following: a. Chief complaint, history of the complaint and physical exam b. Previous evaluations and diagnostic tests results used to rule out orthopedic, neurologic , rheumatologic, endocrine or metabolic causes c. Documentation of the member's bra size, height, weight d. Documentation that macromastia is the primary etiology of the member's functional impairment. With a diagnosis of macromastia include high quality color photograph(s). All photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s). e. Description of physiologic functional impairments (e.g. back pain, grooving from bras straps, skin breakdown, etc.) f. Previous conservative measures, response and duration g. Amount of breast tissue to be removed per breast
Chiropractic Services	98940 98941 98942 98943	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Imaging reports c. Previous treatments rendered, dates of treatments and response d. Treatment plan

Service Category	CPT Codes	Clinical Information Requested
Clinical Trials	All codes	Provider should call the number on the member's ID card when referring for any clinical trial.
Cochlear Implants & Other Auditory Implants	69714 69715 69717 69718 69799 69930 L8614 L8619 L8690 L8691 L8692 69710	Physician office notes which include: 1. Degree and frequencies of sensorineural hearing impairment 2. Effectiveness of hearing or vibrotactile aids previously tried 3. Documentation indicating: a. Absence from middle ear infection b. An accessible cochlear lumen that is structurally suited to implantation c. Freedom from lesions in the auditory nerve and acoustic areas of the central nervous system 4. Member's cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation 5. Proposed procedure(s) if any. Indicate whether this request is part of a staged procedure. 6. Indicate the type of cochlear implant or other auditory implant including the name of the device 7. For replacement of any components please indicate date of implant, model and reason for replacement.

Service Category	CPT Codes	Clinical Information Requested
Congenital Heart Disease (Diagnostic/ Therapeutic Services)	All codes	For any diagnostic/therapeutic services related to congenital heart disease, provider should call the number on the member's ID card when referring.
DME-Continuous Glucose Monitoring (CGM)	A9276, A9277, A9278	1. Provide the member's current lab work from the most recent three (3) months 2. Provide a current signed physician order **3.** Provide the member's office notes and treatment plan from the most recent three (3) months 4. Provide the type of Make and Model of the device requested 5. Provide the type of Diabetes – Type I DM, Type II DM or Gestational DM 6. If the request is to replace a device; Provide the reason(s) why does the current device need replacement.
Cosmetic & Reconstructive	0182T 11920 11960 11971 15876 15877 15878 15879 17106 17107 17108 17999 21137 21138 21139 21172 21175 21179 21180 21181 21182 21183 21184 21256 21230 21235 21260 21261 21263 21267 21268 21275 21280 21282 21295 67311 21740 21742 21743 28344 30520 30540 30545 30560 30620 67911 67912 67904 67906 67914 67915 67916 67917 67921 67922 67923 67924 67950 67961 67966 69090 69300 Q2026	1. Physician office notes with history of medical conditions requiring treatment or surgical invention which includes all of the following: a. To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment b. Recurrent or persistent functional impairment caused by the abnormality. 2. Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 3. High-quality color photograph(s). All photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s). 4. Physician plan of care with proposed procedures and whether this request is part of a staged procedure. Indicate how the procedure will improve and/or restore function.

Service Category	CPT Codes	Clinical Information Requested
Decompression Unspecified Nerves	64722	1. Physician office notes including: a. Condition requiring procedure b. History and physical by the attending/treating Physician c. Symptoms and functional impairment d. Pertinent imaging studies e. History and duration of unsuccessful conservative therapy, when applicable
Femoroacetabular Impingement Syndrome (FAI)	27299, 29916, 29914, 29999 29915 29916 31240 31253 31254 31255 31256 31276 31287 31288	1. Provide Radiographic reports 2. Provide Physician office note indicating: a. Condition requiring procedure b. Associated co-morbidities c. Medical/surgical therapies tried and failed d. Member's degree of pain and functional disability 3. Provide the proposed procedure
Functional Endoscopic Sinus Surgery (FESS)	31253, 31255, 31257, 31259, 31287 31240, 31256, 31288, 31267, 31254	1. Physician office notes indicating: a. Members history of chronic rhino sinusitis b. Complications of sinusitis c. Recurrent acute rhino sinusitis 2. Recent CT scan results 3. Medical therapies attempted a. Nasal lavage b. Antibiotic therapy c. Intranasal corticosteroids

Service Category	CPT Codes	Clinical Information Requested
Gender Dysphoria	55970, 55980, 11950, 11951 58260 11952, 11954, 11980, 14000, 14001 58262 14021, 31750, 14041, 14061, 45399, 45999, 58999, 64856, 64892, 64896, 69300, 31599, 90285, 96372, 14020, 14302, 15750, 15757, 15758, 15775, 15776, 21899, 15777, 15750, 15781, 15782, 15783, 15787, 15788, 15789, 15792, 15793, 15819, 19303, 21270, 15824, 15825, 15826, 15828, 15829, 15832, 15833, 15834, 15835, 15836, 15837, 19304, 21173, 15838, 15839, , 17380, 20926, 21083, 21087, 92508, 53410, 53420, 53425, 53430, 57292, 57426, 54125, 54400, 54401, 54405, 54408, 54520, 57295, 58661, 54660, 54690, 55175, 55180, 55866, 56625, 57296, 58720, 56800, 56805, 64896, 57106, 57110, 57291, 57335, 58940 58290 58291 64856 64892 55970 55980 15780 21120 21122 21172 21270 21899 31599	1. Physician office notes describing: a. The history of medical conditions requiring treatment or surgical intervention b. A well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment c. Recurrent or persistent functional deficit caused by the abnormality. 2. Clinical Studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 3. Color photos, where applicable, of the physical and/or physiological abnormality 4. Physician plan of care with proposed procedures and whether this request is part of a staged procedure. Indicate how the procedure will improve and/or restore function. **For 58260, 58262, 58290 and 58291** codes provide the additional information: 1. Physician office notes describing: a. The history of medical conditions requiring treatment or surgical intervention **2.** Physician plan of care with proposed procedures and whether this request is part of a staged procedure. 3. A written psychological assessment from at least two qualified behavioral health providers experienced in treating gender dysphoria, who have independently assessed the individual. The assessment should include <u>all</u> of the following: a. The member is capable to make a fully informed decision and to consent for treatment b. The member must be at least 18 years of age (age of majority) c. If significant medical or mental health concerns are present, they must be reasonably well controlled d. The member has completed at least 12 months of successful continuous full-time real-life experience in the desired gender e. The member has completed 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated). 4. A treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating gender dysphoria

Service Category	CPT Codes	Clinical Information Requested
DME – Automatic External Defibrillator	K0609 K0607 K0608 E0617	1. Current prescription from physician 2. Indicate whether this is an initial request, ongoing, replacement or purchase a. If ongoing request, provide data (downloaded report) indicating that member is wearing the equipment b. If replacement, provide reason 3. Clinical documentation that identifies risk for sudden death including but not limited to: a. History of cardiac arrest b. Ventricular fibrillation or ventricular tachyarrhythmia c. Familial or inherited conditions d. History of a prior implanted defibrillator e. History of myocardial infarction or dilated cardiomyopathy with a measured ventricular ejection fraction f. Coronary artery disease with a documented prior myocardial infarction g. History of a prior implanted defibrillator
DME – Bone Growth Stimulator – Ultrasonic	20979 E0760	1. Current physician prescription or order 2. Documentation to explain the reason the member will need a bone growth stimulator. 3. Member with an acute fracture include the following: a. Date and type of fracture b. Complete report of diagnostic imaging 4. Member with a non-union of the fracture include the following: a. Date and site of fracture b. All X-rays reports including: i. The initial X-ray ii. Follow-up X-ray(s) at least 90 days apart iii. Treatment of the fracture, including: 1. treatment already completed 2. treatment planned. 5. Member with a tibial osteotomy include the treatment plan.

Service Category	CPT Codes	Clinical Information Requested
DME Bone Growth Stimulator Electrical / Electromagnetic	E0747, E0748, E0749, 20974, 20975	1. Current physician prescription or order 2. Document the reason the member will need a bone growth stimulator. 3. Member with other issues such as diabetes, obesity, osteoporosis, or current tobacco use include supporting clinical. 4. Member has or will be having a spinal fusion include the following: a. Date of surgery, either past or future and number of vertebral levels fused; **or** b. Documentation of failed spinal fusion and date of reoperation of same site
DME – Cough Stimulating Device	E0482	1. Current prescription from physician 2. Diagnosis 3. Physician office notes with clinical documentation of history and the Member's current respiratory treatment program including frequency and duration of use for the requested items
DME – CPAP	E0601	**Initial Request** 1. Current (within the last year) prescription from physician 2. Physician office notes that include face-to-face clinical evaluation prior to the sleep test to assess for obstructive sleep apnea. 3. Sleep study that includes apneal hypopnea index (AHI) (using a 4% decline in oxygen saturation definition of hypopnea) and clinical symptoms noted during the study. 4. Documentation that appropriate instructions were provided on the use of the device. **Continuation Request** 1. Face-to-face clinical re-evaluation by the treating physician with documentation of the clinical response to PAP therapy treatment trial. 2. Objective evidence of adherence to use of the PAP device, reviewed by the treating physician. **To requalify for CPAP due to failed CPAP trial** 1. Date of failed CPAP trial period 2. Face-to-face clinical re-evaluation by the treating physician to

Service Category	CPT Codes	Clinical Information Requested
		determine the etiology of the failure to respond to PAP therapy. 3. For Medicare only: Repeat sleep test in a facility-based setting (Type 1 study).This may be a repeat diagnostic, titration or split-night study. **Replacement** 1. Age of the current device 2. Reason as to why the device needs to be replaced rather than repaired 3. If the device is five years or older, a face-to-face evaluation by the treating physician that documents that the member continues to use and benefit from the PAP device.
DME – CPM for Knee surgery	E0935	1. Current prescription from physician 2. Surgical date and procedure 3. Documentation that supports the service start date within two (2) days following surgery 4. Proposed duration of use
DME – Electrical Stimulation Device for Treatment of Wounds	E0761 E0769	1. Current prescription from physician 2. Diagnosis 3. Physician office notes with: a. Wound stage and size b. Prior treatment duration and response c. Plan of treatment
DME – Enteral Nutrition/Tube Feedings	B4102 B4103 B4104 B4149 B4150 B4152 B4153 B4155 B4158 B4159 B4160 B4161 B9004 B9006 B9000 B9002 B9998	1. Current prescription from physician 2. Office notes and clinical documentation that includes: a. The name of the formula b. The diagnosis for which the formula is being prescribed c. The member's current height and weight d. Copy of a nutritional evaluation e. Documentation of the member's daily dietary/calorie intake f. Documentation whether the formula is the member's sole source of nutrition g. Documentation that a feeding tube is in place and in use If a pump is ordered, include the following documentation: a. Justification as to why gravity feed is not

Service Category	CPT Codes	Clinical Information Requested
		satisfactory b. Rate of infusion

Service Category	CPT Codes	Clinical Information Requested
DME – External Insulin Pump	E0784 A9274 A9276 A9277 A9278	1. Current prescription from physician 2. Physician office notes with clinical documentation of: a. History of compliance with diabetic regimen b. Labs including recent A1C levels, C-Peptide with fasting blood sugar level (obtained at the same time) or beta cell autoantibody c. Number of daily finger sticks d. Current Insulin management regimen (e.g., number of injections, type of insulin) e. History of Emergency Room or hospitalization within the last six (6) months f. History of wide fluctuations in pre-prandial BG levels, hypoglycemia unawareness, nocturnal hypoglycemia, or dawn phenomenon g. A history of suboptimal glycemic control h. Completed comprehensive diabetes education program and is demonstration of ability to follow an aggressive self-testing regimen **Is this for a replacement device?** If yes, include: a. Indicate age and make and model of current device, reason for replacement rather than repair and warranty status b. Make and model of the device being requested c. Recent A1C levels
DME – External and Implantable Pump	E0779 E0780 E0781 E0782 E0783 E0785 E0786 E0791 K0455	1. Physician office notes indicating condition requiring treatment. 2. Prescription, which includes name of drug, dosage, duration and frequency of infusion 3. State if the infusion will be intermittent or continuous a. If intermittent, state how many hours for infusion of each dose 4. Reason for replacement, if applicable
DME – High Frequency Chest Wall Oscillation (HFCWO) Devices	E0483 A7025	1. Current prescription from physician 2. Documentation of failed standard treatments to adequately mobilize retained secretions 3. Diagnosis

Service Category	CPT Codes	Clinical Information Requested
		4. CT scan report confirming diagnosis of bronchiectasis if applicable 5. Frequency of exacerbations requiring antibiotic therapy 6. Duration and frequency of productive cough
DME – Hospital Beds	Fixed Hgt: E0328, E0250, E0251, E0290, E0291 E0270 Variable Hgt: E0255, E0256, E0292, E0293 Semi Electric: E0329, E0260, E0261, E0294, E0295 Total Electric: E0297, E0265, E0266, E0296 Heavy Duty: E0301, E0302, E0303, E0304 Pediatric: E0300	**Fixed Height/Heavy Duty/Pediatric** 1. Current prescription from physician 2. Office notes with clinical documentation identifying: a. The need for positioning of the body in ways not feasible with an ordinary bed; and/or b. The need for positioning of the body in ways not feasible with an ordinary bed to alleviate pain; and/or c. The need for the head of bed elevated more than 30 degrees and why; and/or d. The need for traction equipment e. Member Weight **Variable Height –** 1. Current prescription from physician 2. Office notes with clinical documentation identifying: a. The need for positioning of the body in ways not feasible with an ordinary bed; and/or b. The need for positioning of the body in ways not feasible with an ordinary bed to alleviate pain; and/or c. The need for the head of bed elevated more than 30 degrees and why; and/or d. The need for traction equipment e. Member weight 3. Explanation of requirement for height difference (to permit transfers to chair, wheelchair or standing position) 4. Current transfer and bed mobility skills 5. Current functional limitations with regards to activities of daily living

Service Category	CPT Codes	Clinical Information Requested
		Semi-Electric – 1. Current prescription from physician 2. Office notes with clinical documentation identifying: a. The need for positioning of the body in ways not feasible with an ordinary bed; and/or b. The need for positioning of the body in ways not feasible with an ordinary bed to alleviate pain; and/or c. The need for the head of bed elevated more than 30 degrees and why; and/or d. The need for traction equipment e. Member weight 3. Rationale for requirement for frequent or immediate changes in body position 4. Susceptibility to ulcers, identify reasons
DME – Mechanical Stretching Devices (Dynamic and Static)	E1800 E1801 E1802 E1805 E1806 E1810 E1811 E1812 E1815 E1816 E1818 E1820 E1825 E1830 E1821	1. Current prescription from physician 2. Physician office notes that indicate all of the following: a. The affected joint b. The date of injury/surgery c. Previous treatments attempted d. Treatment plan, including proposed duration of use
DME – Miscellaneous	E1399	1. Current prescription from physician 2. Equipment price quote with full description of item 3. Relevant physician office notes 4. Letter of Medical Necessity

Service Category	CPT Codes	Clinical Information Requested
DME – Negative Pressure Wound Therapy (NPWT) (Wound Vac)	E2402	1. Current prescription from physician 2. Wound size / location / measurements Wound type (post-surgical, venous stasis, decubitus ulcer, diabetic neuropathic ulcer) 3. Date(s) of surgery including debridement 4. The date the NPWT was started 5. Physician notes that Wound VAC has been used previously on the same type of wound 6. Physician notes indicating that a moist wound environment has been maintained with dressings, evaluation of nutritional status and incontinence is managed. 7. Physician notes that support the member is free of necrotic tissue, no osteomyelitis, no cancer of the wound and no open fistula to an organ or body cavity within the vicinity of the wound. 8. Physician notes documenting if member is diabetic, the member is maintained on a diabetic management program. 9. Physician notes documenting that the member is turned and repositioned with the presence of a Stage III or IV pressure ulcer.
DME – Neuromuscular Stimulators	E0745 E0764 E0770	1. Current prescription from physician 2. Diagnoses for the condition(s) needing treatment 3. Physician office notes with clinical documentation that indicate: a. The device is being used to treat the diagnosis of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy b. Intact lower motor units both muscle and peripheral nerve c. Muscle and joint stability for weight bearing and the ability to support upright posture independently d. Muscle contractions and sensory perception response to electrical stimulation e. Transfer ability and independent standing tolerance f. Hand and finger dexterity

Service Category	CPT Codes	Clinical Information Requested
		g. Date of spinal cord injury and restorative surgery h. Pertinent medical/surgical history i. If spinal cord injury present, documentation of completion of a training program which consists of at least 32 physical therapy sessions with the device over a period of three months and is directly performed by the physical therapist as part of a one-on-one training program

Service Category	CPT Codes	Clinical Information Requested
DME – NMES	E0762	1. Indicate if the request is for the trial or permanent use of the stimulator 2. Current prescription from physician 3. Documentation that the item is approved by FDA 4. Physician office notes indicating the reason for the unit as opposed to conventional delivery 5. For **Muscle Atrophy:** a. Diagnosis/condition causing the muscle atrophy b. Documentation of intact nerve supply to the affected muscle 6. For **Spinal Cord Injury:** a. Physician office notes indicating: i. Co-morbidities ii. Intact lower motor units (L1 and below) (both muscle and peripheral nerve iii. Muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently iv. Brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction v. Member possesses high motivation, commitment and cognitive ability to use such devices for walking; vi. Member can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes vii. Member has hand and finger function to manipulate controls viii. Date of spinal cord injury and restorative surgery ix. Absence of hip and knee degenerative disease and no history of long bone

Service Category	CPT Codes	Clinical Information Requested
		fracture secondary to osteoporosis x. Member demonstrates willingness to use the device long-term xi. Goal for use of the stimulator 7. **Post-trial:** a. Documentation of the success of trial treatment period b. Documentation of completion of training program including length of program and number of physical therapy sessions c. Description of the treatment for which the unit will be used
DME – Oral Appliances for the Treatment of Obstructive Sleep Apnea (OSA)	E0485 E0486	Physician office notes including: 1. Face-to-face clinical evaluation by the treating Physician prior to the sleep test to assess need for obstructive sleep apnea testing 2. Prescription or referral from the treating physician for oral appliance therapy 3. Sleep study with clinical documentation of severity of the OSA with AHI/RDI values and the compliance and effectiveness of CPAP or BIPAP therapy. **4.** Does the member have an AHI higher than 5? **a.** If yes, include required Sleep Study. **b.** If no, please explain why appliance is needed.
DME – Member Lifts	E0621 E0625 E0630 E0635 E0636 E0639 E0640 E1035 E1036	1. Current prescription from physician 2. Office notes with clinical information including: a. Diagnosis b. That addresses the inability to safely make transfers between bed and a chair, wheelchair, or commode without the use of a lift c. That addresses a requirement for supine positioning for transfers and rationale
DME – Percussor/ Oscillatory Devices	E0480 E0484	1. Current prescription from physician 2. Physician office notes that indicate respiratory condition and clinical documentation supporting inability to mobilize secretions

Service Category	CPT Codes	Clinical Information Requested
		3. Documentation indicating that the member/caregiver or therapist has received appropriate training to use the device
DME – Pneumatic Compression Devices	E0650 E0651 E0652 E0655 E0656 E0666 E0667 E0668 E0669 E0671 E0672 E0673 E0675 E0676 E0660 E0657 E0665 E0670	1. Current prescription from physician 2. Physician office notes that address: a. Member symptoms b. Clinical documentation that supports the diagnoses of Lymphedema or Chronic Venous Insufficiency with Venous Stasis Ulcers c. Previous conservative treatments attempted d. Evidence of regular Physician visits for the treatment of venous stasis ulcer during the past six (6) months e. Date of trial and clinical response including objective effectiveness of treatment, pre- and post-treatment measurements and member compliance 3. For **E0652** the following additional information is required: a. Treatment plan including the pressure in each chamber, frequency and duration of each treatment b. Documentation as to whether a segmented compressor without calibrated gradient pressure, (E0651, or a non-segmented compressor, E0650, with a segmented appliance, E0671-E0673) had been tried and the results c. Why the features of the device are needed d. Name, model number and manufacturer of the device
DME – Power Mobility Devices (Scooters, Wheelchairs)	K0010 K0011 K0012 K0014 K0800 K0801 K0802 K0806 K0807 K0808 K0812 K0813 K0814 K0815 K0816 K0820 K0821 K0822 K0823 K0824 K0825 K0826 K0827 K0828 K0829 K0830 K0831 K0835	**Initial request for device** 1. Seven Element Order 2. Current Documentation that supports medical need for a power mobility device instead of alternate equipment for home mobility (e.g., manual wheelchair, walker, cane, scooter) 3. Specific Health Care Common Procedure Coding System (HCPCS) codes for each accessories requested including

Service Category	CPT Codes	Clinical Information Requested
	K0836 K0837 K0838 K0839 K0840 K0841 K0842 K0843 K0848 K0849 K0850 K0851 K0852 K0853 K0854 K0855 K0856 K0857 K0858 K0859 K0860 K0861 K0862 K0863 K0864 K0868 K0869 K0870 K0871 K0877 K0878 K0879 K0880 K0884 K0885 K0886 K0890 K0891 K0898 K0899 E0983 E0984 E0986 E1002 E1003 E1004 E1005 E1006 E1007 E1008 E1009 E1010 E1016 E1018 E1030 E1230 E1239 E2300 E2310 E2311 E2321 K0005 K0008 K0013 K0108 E2321 E2301 E2322 E2325 E2327 E2329 E2331 E2351 E2373	make, model and price quotation 4. For Power Operated Vehicles (POVs) include the following: a. The ability to transfer safely to and from the POV device b. The ability to operate the tiller steering system \ c. The ability to maintain postural stability and positon while operating the POV 5. Physician's face-to-face evaluation record, which must be from office notes. A check off or pre-prepared form cannot be accepted. The information must include the following: a. Current ambulation status including current mobility equipment being used and why it is no longer effective b. Limitation of physical mobility that impacts mobility-related activities of daily living (MRADLs) c. Estimated duration of use d. Measurement of: i. Strength ii. Ability to move and distance moved with assistive equipment iii. Coordination deficits iv. Pain level e. Documentation of missing or disabled legs or arms f. History of falls 6. Primary setting of power mobility device use (e.g., home, community) 7. Documentation of ability/inability to operate a manual wheelchair 8. Documentation of ability/inability to safely operste a power wheelchair or POV. 9. Documentation of Specialty Evaluation of power wheelchairs with special features that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or Physician

Service Category	CPT Codes	Clinical Information Requested
		who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT, OT or Physician may have no financial relationship with the supplier. 10. For member transitioning from other insurance, please submit the information included with the original / initial evaluation including the date the member received the Power Mobility Device. **For Replacement – same Power Mobility group** 1. Current prescription from physician 2. Date acquired the chair and model 3. Detailed equipment repair quote 4. If stolen, include police report **For Replacement – different Power Mobility group** 1. Date the current chair was acquired, 2. Make and model of current chair 3. All requirements listed for initial request **For Repair:** 1. Date acquired the chair 2. Detailed equipment repair quote including complete description, serial number, repair estimate and reason for repair

Service Category	CPT Codes	Clinical Information Requested
DME – Pressure Reducing Support Surface – Group 2	E0193 E0277 E0373	1. Prescription from physician tied to current plan of care 2. Clinical documentation supporting: a. Decubitus ulcers with measurements, staging, measurements, location and description b. Prior ulcer treatment program, duration and response to treatment c. Current plan of care including wound program, nutritional status and expected length of need d. Frequency of wound assessment by healthcare professional e. Prior use of a Group 1 support surface 3. For recent flap or skin graft include date of surgery and flap location
DME – Pressure Reducing Support Surface – Group 3	E0194	1. Prescription from physician tied to current plan of care 2. Clinical documentations supporting: a. Mobility limitations b. Wound ulcers with measurements, staging, measurements, location and description c. Prior ulcer treatment program, duration and response to treatment, including type of support surface currently used d. Physician supervised current plan of care including wound program, nutritional status and expected length of need e. Home assessment of structural support of floor and electrical system
DME – PT INR Monitor	G0248 G0249	1. Current prescription from physician 2. Equipment quote 3. Physician office notes with: a. Clinical documentation of diagnosis b. The most recent PT/INR results c. Face to face educational program d. Length of time the member has been on anticoagulation e. Frequency of self-testing
DME – Respiratory	E0470 E0471 E0472	1. Current prescription from physician **For initial three (3) month trial of therapy**

Service Category	CPT Codes	Clinical Information Requested
Assistive Device – BIPAP for Diagnosis of OSA and Other Diagnoses		2. Physician office notes indicating clinical condition and the following additional details For **Obstructive Sleep Apnea (OSA) diagnosis code of G 47.**33 include: a. Face-to-face evaluation prior to sleep test to assess for OSA b. Sleep test report scoring using 4% definition of hypopnea c. Documentation of a trial of E0601 (CPAP) including clinical response. For **Restrictive Thoracic Disorders** include: a. Specific neuromuscular disease or thoracic cage abnormality and respiratory co-morbidities, **AND** b. Arterial blood gas PaCo2 while awake and on prescribed FIO2, **OR** c. Sleep oximetry study saturation results with minimum of 2 hour nocturnal recording while on prescribed FIO2, **OR** d. (For Neuromuscular disease only) Maximal inspiratory pressure or forced vital capacity For **Severe COPD** include: a. Arterial blood gas PaCo2 while awake and on prescribed FIO2 b. Sleep oximetry study saturation results with minimum of 2 hour nocturnal recording while on prescribed FIO2, c. Documented evaluation of OSA and treatment with CPAP has been considered and ruled out For **Central Sleep Apnea or Complex Sleep apnea** include: a. A complete facility-based, attended polysomnogram that confirms CSA or CompSA, **AND** b. Documents degree of improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the member's prescribed FIO2. For **Hypoventilation Syndrome** include: a. Arterial blood gas PaCo2 while awake and on prescribed FIO2, **AND** b. FEV1/FVC spirometry results, **AND**

Service Category	CPT Codes	Clinical Information Requested
		c. Arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the member's prescribed FIO2, or a facility-based polysomnogram of nocturnal recording time (minimum recording time of two (2) hours) For **continued rent to purchase of device** a. Documentation in the member's medical record about the progress of relevant symptoms and member usage of the device up to that time b. A signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the member is compliantly using the device (# of hours per 24 hour period) and that the member is benefiting from its use. For **Replacement** submit the following information: a. Age and type of the current PAP therapy device b. Reason as to why the device needs to be replaced c. A recent face-to-face evaluation by the treating physician that documents continued compliance with benefit from the current PAP therapy

Service Category	CPT Codes	Clinical Information Requested
DME Seat Lifts	E0172 E0627 E0628 E0629	1. Current prescription from physician 2. Physician office notes with clinical information documenting: a. Diagnosis b. Whether the member is completely incapable of standing up from a regular armchair or any chair in his/her home c. Whether the member has the ability to ambulate once standing d. Whether all appropriate therapeutic modalities to enable the member to transfer from a chair to a standing position (e.g., medication, physical therapy) have been tried and failed 3. Make, model, and type of lift 4. Price quote
DME – TENS	E0720 E0730 E0731	1. Current prescription from physician 2. Physician office notes that address the member's condition 3. **For acute post-operative pain** include: a. Date of surgery b. Nature of the surgery c. Location and severity of the pain 4. **For chronic pain** include: a. Location of the pain b. Severity of the pain c. Duration of time the member has had the pain d. Presumed etiology of the pain e. Prior treatment and results of that treatment f. Re-evaluation of the member at the end of the trial period, must indicate: i. How often the member used the TENS unit ii. Typical duration of use each time iii. Results/effectiveness of therapy 5. **For chronic lower back pain** include the name of clinical study in which the member is enrolled. 6. **For E0731** include the following: a. Area and sites to be stimulated; and b. Reason that conventional electrodes cannot be used; or c. Medical condition that precludes the application of conventional electrodes.

Service Category	CPT Codes	Clinical Information Requested
DME – Ultraviolet Cabinet	E0692 E0693 E0694 E0691	1. Current prescription from physician 2. Physician office notes with clinical documentation that includes: a. Presence of generalized intractable psoriasis b. Dates of prior conservative treatments with objective clinical outcomes; **and** c. Factors that justify treatment at home rather than at alternative outpatient sites
DME – Ventilator	E0466	1. Current prescription from physician including ventilator settings and hours of use per day 2. Face – to – face evaluation which includes a. Medical history and respiratory condition supporting the need for a ventilator versus CPAP or BIPAP b. Other therapies with settings trialed, failed or ruled out and clinical justification of failure 3. Additional testing to support need for ventilator vs. CPAP or BiPAP a. ABGs b. PFTs c. Overnight Oximetry d. Sleep Study 4. Physician Office Notes that include the following: a. Plan of Care to include the use as intermittent or continuous b. Member compliance with the current treatment plan, including compliance report c. Prognosis
DME – Wheelchair – Manual	E1037 E1050 E1070 E1084 E1085 E1086 E1087 E1089 E1100 E1110 E1161 E1172 E1180 E1190 E1195 E1200 E1222 E1223 E1224 E1227 E1228 E1229 E1231 E1232 E1233 E1234 E1235 E1236 E1237 E1238 E1250 E1270 E1280 E1285 E1290 E1295	**For an Initial Request** 1. Current prescription from physician 2. Specific HCPCS codes for each item requested including make, model and price quotation 3. Member's weight 4. Physician office notes that supporting medical need for a manual wheelchair for home mobility: a. Current ambulation b. Transfer status c. Functional limitations as related to ADLs

Service Category	CPT Codes	Clinical Information Requested
	E1093 E2227 E2228 E2230 E2626	d. Estimated duration of use e. Documentation of sufficient upper extremity function and other physical and mental capabilities to safely self-propel the wheelchair 5. Primary setting of wheelchair use (e.g., home, community) 6. Description of member's ability to operate a manual wheelchair 7. Description of member's capability to safely operate the control of the equipment 8. Mobility assistance devices currently used 9. Home/safety evaluation assessment **For Replacement – same type/group** 1. Current Prescription 2. Date the member acquired the chair and original payer 3. Make, model, configuration and serial number of the existing chair 4. Detailed equipment repair quote 5. If stolen, include police report **For Replacement – different type / group** 1. Date the member acquired the chair and model 2. Plus all requirements listed for initial request **For Repair:** 1. Date the member acquired the chair and original payer 2. Make, model , configuration and serial number of the existing chair 3. Detailed equipment repair quote including: a. Repair estimate (including diagnostic codes) and reason for repair b. For repairs over $1000, include replacement cost

Service Category	CPT Codes	Clinical Information Requested
Extracorporeal Shock Wave Therapy for Plantar Fasciitis	28890	1. Physician office notes describing : a. Length of time the member has been symptomatic b. Member response to conservative measures for at least the last two months, including: i. Rest ii. Physical therapy iii. Anti-inflammatory medications iv. Local corticosteroid injections v. Heel orthotics or forearm sleeve as applicable 2. Documentation that the member is not a candidate for surgical treatment
Genetics and Molecular Pathology Testing (Including BRCA)	0001U,0018U, 0019U, 0023U, 0022U, 0026U, 0027U, 0028U, 0029U, 0030U, 0031U, 0032U, 0033U, 0034U, 0004M, 0006M, 0007M, , 0009M, 0011M, 81105, 81106, 81107, 81108, 81109, 81110, 81111, 81120, 81121, 81161, 81162, 81170, 81175, 81176, 81200, 81201, 81202, 81203, 81205, 81206, 81207, 81208, 81209, 81210, 81211, 81212, 81213, 81214, 81215, 81216, 81217, 81218, 81219, 81220, 81221, 81222, 81223, 81224, 81225, 81226, 81227, 81228, 81229, 81230, 81231, 81232, 81235, 81238, 81240, 81241, 81242, 81243, 81244, 81245, 81246, 81247, 81248, 81249, 81250, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81258, 81259, 81260, 81261, 81262, 81263, 81264, 81265, 81266, 81267, 81268, 81269, 81270, 81272, 81273, 81275, 81276, 81283, 81287, 81288, 81290, 81291, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81302, 81303, 81304, 81310, 81311, 81313, 81314, 81315, 81316, 81317, 81318, 81319, 81321, 81322, 81323, 81324, 81325, 81326, 81327, 81328, 81330, 81331, 81332,81334, 81335, 81340, 81341, 81342, 81346, 81350, 81355, 81361, 81362, 81363,	For all testing please include the name of the lab test being requested (e.g., BRCA 1 Targeted Analysis or Ovarian Tumor Profile). **For inherited conditions:** 1. Personal history of the condition, if applicable, including age at diagnosis 2. Complete family history (usually three-generation pedigree) relevant to condition being tested 3. Genetic testing results of family member, if applicable, and reason for testing 4. Ethnicity/ancestry (e.g. Ashkenazi Jewish), if reason for testing 5. Any prior genetic testing results 6. How clinical management will be impacted based on results of genetic testing 7. Genetic counseling (if available) **To guide cancer treatment:** 1. Cancer type and stage including, if applicable, tumor size and nodal status 2. Results of other biomarker testing (e.g. estrogen receptor, HER-2 neu), if applicable 3. Proposed treatment based on results of genetic testing (if available) **For Fetal Aneuploidy Testing:** 1. Maternal age 2. History of prior pregnancy with a trisomy, if applicable 3. History of parental balanced Robertsonian translocation 4. Abnormal first- or second-trimester screening test result

Service Category	CPT Codes	Clinical Information Requested
	81364, 81370, 81371, 81372, 81373, 81374, 81375, 81376, 81377, 81378, 81379, 81380, 81381, 81382, 81383, 81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81410, 81411, 81412, 81413, 81414, 81415, 81416, 81417, 81420, 81425, 81426, 81427, 81430, 81431, 81432, 81433, 81434, 81435, 81436, 81437, 81438, 81439, 81440, 81442, 81445, 81448, 81450, 81455, 81460, 81465, 81470, 81471, 81479, 81507, 81519, 81520, 81521 81545, 81595, 81599	

Service Category	CPT Codes	Clinical Information Requested
Home Health Care Services	G0151, G0152, G0153, G0154 G0157, G0158, G0159, G0163 G0164, G0156, G0300, G0493 G0495, G0496 S9123 S9124 S9122, S9128, S9129, S9131. 99503, S9127, G0155, S9474 T1012 T1030 T1031	**Documentation required for the initial and subsequent requests:** 1. Must include services requested (SN, PT/OT/ST, HHA, SW), number of visits and weekly frequency, diagnosis codes, CPT codes, start date of care 2. Indicate the number of hours per visit for skilled nursing and home health aide services. **Documentation required for the initial episode**: 1. Physician order and completed 485 Plan of Care for certification period being requested 2. Current Skilled Nurse Assessment and or initial visit summary; therapy (PT,OT, ST) notes if applicable **Documentation required for subsequent episodes:** 1. Current 485 (may be unsigned) or 485 draft 2. Signed 485 from the previous episode. **This must be signed by physician**. **Note:** The 485 is required if unable to provide at this time then submit the following 3. 60 day Skilled Nurse Summary to include the following: a. Nursing summary needs to be current and related to ALL stated diagnoses. b. PT, OT, ST, SW evaluations and notes if applicable. c. Home Health Aide duties d. Vital Signs ranges, 02 Sats, glucose levels, PT/INR levels, HCT/HGB if receiving B12 injections e. Medication changes, wound care with wound measurements, edema with description, weight gain/weight loss f. Member's functional mobility. g. Caregiver must be identified. I. Does caregiver participate in care of the member? II. Who lives with the member? Name and relationship III. Who administers medications? h. Recent inpatient or ER visits with dates and diagnosis. i. Discharge Plan

Service Category	CPT Codes	Clinical Information Requested
Home Health Care Applies to KS	99600 99601 99602 G0156 G0299 S0315 G0300 S0316 S5181 S9128 S9129 S9131 S9460 T1004 T1021 T1023 T1030 T1031 T1502 T1002 T1003	**A Face to Face evaluation is required.** Please include the Members full name, Date of Birth and Member ID number on the Face to Face evaluation. The document **must** include the Face to Face evaluation date and the ordering physician signature. Please provide a brief narrative describing the member's clinical condition during the face to face visit to support that the member is homebound and the need for skilled services within 90 days before the start of the service.
Hyperbaric Oxygen Treatment	99183 C1300	1. An initial assessment and medical history detailing the condition requiring Hyperbaric Oxygen Treatment (HBO) therapy and a physical exam. 2. Medical history should list prior treatments including antibiotic therapy and surgical interventions. 3. Documentation of current adjunctive treatment should include type of treatment, and the effectiveness of same. 4. Physician progress notes and any communication between Physicians detailing past or future proposed treatments. 5. Established goals and Plan of Care for HBO therapy. 6. Condition specific information such as: a. Documentation that the member has **Type I** or **Type II** diabetes and a lower extremity wound due to diabetes i. Wagner grade classification ii. Failed response to an adequate course of standard therapy. iii. Documentation showing there has been no measurable signs of healing for at least 30 days of treatment with standard wound therapy b. Definitive radiographic findings or positive bone culture with sensitivity studies to confirm the diagnosis of **osteomyelitis**, and documentation of failed antibiotic therapy and surgical management. c. History of radiation therapy, including date and anatomical site of radiation therapy, with documentation of fracture or resorption of bone, and radiographic studies, if available, to confirm the diagnosis of **osteoradionecrosis**; d. History of radiation therapy and clinical photographs of the necrotic site will help support the medical necessity of HBO services for soft tissue **radionecrosis**;

Service Category	CPT Codes	Clinical Information Requested
		e. Documentation of radiographic and laboratory tests (e.g., positive gram-stain smear or culture) that confirm the diagnosis of **gas gangrene** is required; f. Documentation supporting a threatened loss of function, limb, or life; g. Surgical and pathology reports for treatment of **necrotizing fasciitis**.

Service Category	CPT Codes	Clinical Information Requested
Hysterectomy	ABD Hyst: 58150, 58152, 58180 Lap Hyst: 58541, 58542, 58543, 58544, 58570, 58571, 58572, 58573 Vag Hyst: 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58290, 58291, 58292, 58293, 58294 Lap Asst Vag Hyst: 58550, 58552, 58553, 58554	1. Primary indication for the hysterectomy 2. Physician office notes which includes the following: a. Complete history including OB/GYN, surgical and co-morbid medical condition(s) b. Symptoms attributable to pelvic disease i. Duration ii. Severity iii. Relation to menstrual cycle c. Reports of all relevant diagnostic evaluations i. Laboratory ii. Pathology iii. Imaging includes Ultrasound, MRI, CT etc. iv. Prior procedure/operative reports d. Reports of all attempted treatments (offered, attempted or declined) , including dates and clinical response. e. Investigational procedures (e.g. endometrial sampling, PAP, laboratory studies, hysteroscopy or D&C within ACOG guidelines)
IMRT	77385 77386 G6015 G6016	1.Indicate whether this is an initial or continuation of IMRT a. For initial, indicate number of planned treatments and date range of request b. For continuation, indicate when IMRT was initiated and the number of treatments delivered, and how many IMRT treatments in total are planned. 2. Physician office notes with the following a. Specific condition and target volume requiring IMRT b. Prior treatments related to diagnosis (previous surgery, Chemo and Radiation – specific history of prior radiation therapy. Information to include sites of delivery, total dose and dose per fraction c. A statement documenting the special need for performing IMRT vs Conventional or 3-Dimensional radiation treatment. If failure of dose constraints, please cite the specific constraint, including protocol number, if applicable. Please note, only Quantec or RTOG dose constraints are applicable.

Service Category	CPT Codes	Clinical Information Requested
		d. For hypofractionated radiation therapy provide the prescribed total dose and dose per fraction e. For delivery of a prescribed radiation therapy course with standard fractionation, submit the dose prescription along with documentation in the form of a clearly labeled, color comparative 3D and IMRT dose volume histogram and dose table, in absolute doses. When citing an RTOG dose constraint, provide the RTOG protocol number. f. Include noting that sparing of the surrounding normal tissue cannot be achieved with 3D technique, per generally accepted Quantec or RTOG dose constraints g. An immediately adjacent area has been previously irradiated and abutting portals must be established with high precision. h. Physicians treatment plan including any combined therapies 3. IMRT used for Breast Cancer provide all the above and one of the additional clinical: a. If the patient is to be treated in the supine position, provide the patient separation measurement of 25.5 cm or more in the intra-thoracic distance from the midpoint of the posterior light field border of the medial tangential field to the midpoint of the posterior light field of the lateral tangential field. b. The prescribed total dose and dose per fraction **Note:** The color comparative 3D and IMRT dose volume histogram and dose table must be submitted by the portal or emailed **not faxed**. Submit the images thru the portal, Link, Prior Authorization And Notification application at www.uhcprovider.come/paan or email the information to the following: **For Commercial members –** CCR@uhc.com **For Medicare members -** medicareccr@uhc.com **For C&S Medicaid**: MedicaidCCR@UHC.COM **For C&S Hawaii**: hi_ccr@uhc.com

Service Category	CPT Codes	Clinical Information Requested
Infertility	58321 58322 58323 58970 58974 S4015 S4016 S4023 S4035 58752 58760 58976 79648 89250 89251 89253 89254 89255 89257 89258 89259 89260 89261 89264 89268 89272 89280 89281 89290 89291 89335 89337 89342 89343 89344 89346 89352 89353 89354 89356 0058T 0357T S4011 S4013 S4014 S4022 S4025 S4026 S4028 S4030 S4031 S4037	1. Physician office notes with the following: a. Initial history and physical b. All clinical notes including rationale for proposed treatment plan c. All ovarian stimulation sheets for timed intercourse, IUI and/or IVF cycles d. All embryology reports e. All operative reports f. Laboratory reports – FSH, AMH, estradiol and any other pertinent information g. Ultrasound reports – antral follicle count and any other pertinent information h. HSG report i. Semen analysis
Injectable Medication – Gelsyn	J7328	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Durolane	J3490 C9465	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Synvisc, Synvisc One	J7325	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Genvisc 850	J7320	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Hyalgan / Supartz / Supartz FX / Visco-3	J7321	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan
Injectable Medication – Hymovis	J7322	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Euflexxa	J7323	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan
Injectable Medication – Orthovisc	J7324	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Gel-One	J7326	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan
Injectable Medications – Fulphila / pegfilgrastin	Q5108	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation c. Documentation that injectable was prescribed by or in consultation with an hematologist oncologist d. ANC laboratory results e. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse)

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Nivestym	Q5110	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation c. Documentation that injectable was prescribed by or in consultation with an hematologist oncologist d. ANC laboratory results e. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse)
Injectable Medications – Hemlibra / emicizumab	Q9995	1. Current Prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include the following: a. Physician's orders with drug dosage and frequency. b. History of the medical condition requiring treatment including clinical indications. c. Physicians treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Onpattro / patisiran	C9399 J3490 J3590	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of hereditary transthyretin amyloidosis (hATTR) amyloidosis with polyneuropathy b. Laboratory results for transthyretin (TTR) mutation c. Results of polyneuropathy disability (PND) score d. Results of familial amyloid polyneuropathy (FAP) stage 1 or 2 e. Documentation of signs and symptoms f. List of all medications currently being used for this disease g. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – WBC Stimulators Neupogen Granix / tbofilgrastin Leukine / sargramostim Filgrastin	J1442 J1447 J2820 Q5101	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation c. Documentation that injectable was prescribed by or in consultation with an hematologist oncologist d. ANC laboratory results e. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse)
Injectable Medication – Monovisc	J7327	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-TriVisc	J3490	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis of OA of the knee, or TMJ b. Reason for treatment, including positive response to previous treatments c. Documentation of signs and symptoms, including morning stiffness or crepitus d. Pain that interferes with functional activities e. X-ray, CT, or MRI reports of the knee(s) or TMJ(s) for initial requests f. Previous treatment provided including the name of the drug, course of treatment and response. g. Conservative treatment of at least 3 months, including therapy and medications tried, failed, or contraindicated h. Dose, frequency, interval since previous treatment, and the physician treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications- Crysvita / burosumab Initial request	J3490 J3590 C9399	**Please provide the following for an initial request:** 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis and age b. Genetic testing or Laboratory results of serum fibroblast growth factor 23 (FGF23), and serum phosphorus. c. Documentation of signs and symptoms d. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications- Crysvita / burosumab Continued request	J3490 J3590 C9399	**Request to continue administration provide the following:** 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Documentation with member's response to therapy, including recent fracture history or reduced bone pain. c. Growth curve d. Laboratory results including updated serum phosphorus e. Documentation of signs and symptoms f. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, se lf-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Zinplava / bezlotoxumab	J0565	Please provide the following for the **initial** administration 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Prolia / denosumab	J0897	Please provide the following for the **initial** administration 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: d. Documentation with member's response to therapy e. Dose, frequency including the physician treatment plan f. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Anti Neoplasic agents	J0640 J0641 J9000 J9015 J9017 J9019 J9020 J9025 J9027 J9031 J9032 J9033 J9034 J9035 J9039 J9040 J9041 J9042 J9043 J9045 J9047 J9050 J9055 J9060 J9065 J9070 J9098 J9100 J9120 J9130 J9145 J9150 J9151 J9155 J9160 J9165 J9171 J9175 J9176 J9178 J9179 J9181 J9185 J9190 J9200 J9201 J9202 J9205 J9206 J9207 J9208 J9209 J9211 J9212 J9213 J9214 J9215 J9216 J9217 J9218 J9219 J9225 J9226 J9230 J9245 J9250 J9260 J9261 J9262 J9263 J9266 J9268 J9270 J9271 J9280 J9293 J9295 J9299 J9301 J9302 J9303 J9305 J9306 J9307 J9308 J9315 J9320 J9325 J9328 J9330 J9340 J9351 J9352 J9354 J9355 J9357 J9360 J9370 J9371 J9390 J9395 J9400 J9600 J9999 Q2017 Q2049 Q2050 J9022 J9023 J9203 J9285	Request for an initial start 1. Current Prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including the treatment plan. b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the patient is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the patient (e.g., supplied by office/facility, obtained by patient from either a pharmacy or OptumRx Specialty Pharmacy Program). NOTE: For members with Medicare, If drug is obtain by the patient prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications- Sublocade / Buprenophine	Q9991 Q9992 J3490	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to faciltate claim processing 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Provide the date and doasge the patient started oral, sublingual, or transmucosal buprenorphine. d. Provide the DATA 2000 requirements that are met to support the medication request. i.e. X waiver DEA e. Dose and frequency being requested including the treatment plan. f. Provide list of medications that will be used to treat this condition g. Documentation that the patient has a had a negative drug screen within 90 days of starting Sublocade. 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the patient, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications- Trogarzo / ibalizumab	J3490 J3590	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Renflexis / Infliximab ABDA continuation	Q5104	Please provide the clinical for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dose and frequency being requested e. List medications patient will be taking to treat the condition f. Date the therapy was started g. Patient response to therapy with the requested medication h. Follow-up patient assessments pertinent to this request 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the patient, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Renflexis / Infliximab ABDA Initial	Q5104	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dates of previous trial, length of time of Remicade and outcome e. Dose and frequency being requested and treatment plan. Include the rationale supporting the use of Renflexis as the drug of choice over Remicade f. List medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the patient, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Kymriah	Q2040 Q2042	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Patient diagnosis b. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation c. Dose and frequency being requested and treatment plan. d. List medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse)
Injectable Medications- Gamifant	J3490 J3590 C9399	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Patient diagnosis b. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation c. Dose and frequency being requested and treatment plan. d. List medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse)

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Adagen	J2504	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results to support defecicency of adenosine deaminase c. Documentation that member is not a candidate or failed hematopoietic cell transplantation (HCT) d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Kanuma	J2840	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results or genetic testing to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Naglazyme	J1458	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results or genetic testing to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Vimizim	J1322	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results or genetic testing to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Mepsevii	J3590	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results or genetic testing to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Aralast NP	J0256	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results of alpha1-antitrypsin (AAT) level and genetic testing to confirm diagnosis c. Current Pulmonary function test results d. Documentation of signs and symptoms e. List of medications being taken for this condition f. Documentation that member is a nonsmoker, g. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy d.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Glassia	J0257	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results of alpha1-antitrypsin (AAT) level and genetic testing to confirm diagnosis c. Current Pulmonary function test results d. Documentation of signs and symptoms e. List of medications being taken for this condition f. Documentation that member is a nonsmoker, g. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Zemaira	J0256	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results of alpha1-antitrypsin (AAT) level and genetic testing to confirm diagnosis c. Current Pulmonary function test results d. Documentation of signs and symptoms e. List of medications being taken for this condition f. Documentation that member is a nonsmoker, g. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Benlysta	J0490	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results or genetic testing to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Aldurazyme	J1931	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to faciolitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Documentation of signs and symptoms c. Laboratory results to support defeciency or absence of fibroblast or leukocyte enzyme activity of alpha-L-iduronidase enzyme activity d. Laboratory result to support Molecular genetic confirmation of mutations in the alpha-L-iduronidase gene; Hurler variance e. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Fabrazyme	J0180	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Laboratory results or genetic testing to confirm diagnosis c. Documentation of signs and symptoms d. Dose, frequency including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy Request to **continue** administration provide the following 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation with member's response to therapy b. Dose, frequency including the physician treatment plan c. Laboratory results to support the positive response to therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Probuphine continued request	J0570	Please provide the clinical for a **continuation** request 1. New prescription 2. Physician office notes that include: a. Member weight b. Provide the DATA 2000 requirements that are met to support the medication request. c. Dose and frequency being requested including the treatment plan d. List the medication the member will be taking to treat the condition e. Documentation that the member has a viable site for implant include that there is no evidence of tamper and or removal of previous Probuphine implant f. Documentation that the member has not had a positive drug screen since starting Probuphine. g. Date the therapy was started 3. Name and tax ID number of the servicing provider/facility to facilitate claim processing

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Probuphine initial request	J0570	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Provide the date and dosage the member started oral, sublingual, or transmucosal buprenorphine. Include documentation to support that the member has been stable for six months or longer. d. Provide the DATA 2000 requirements that are met to support the medication request. i.e. X waiver DEA e. Dose and frequency being requested including the treatment plan. f. Documentation that the member has a viable site for implant. g. Documentation that the servicing provider has completed a live training program for probuphine insertion h. Provide list of medications that will be used to treat this condition i. Documentation that the member has a had a negative drug screen within 90 days of insertion 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Elelyso / taliglucerase continued request	J3060	Request for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member response to therapy with the requested medication. b. Date the therapy was started c. Dose and frequency being requested, including the treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Elelyso / taliglucerase Initial request	J3060	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as Type 1 Gaucher disease b. Describe clinical signs and symptoms c. Medication treatment tried and failed, contraindications, intolerance to medication named VPRIV d. Dose and frequency being requested, including the treatment plan e. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Initial Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin IVIG, human HyQvia / hyaluronidase	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555 J1459 J1575 90283	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Dose and frequency being requested e. List of medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the member is clinically unstable iii. Documentation that the member has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the member has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the member when administration is in the home or office setting v. Treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Thrombocytopenia secondary to HCV infection Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis include if the patient is receving concurrent antiviral therapy. c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Platelet count results drawn inthe last 30 days. e. Documentation of medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) stiff person syndrome Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan including the taper plan. 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Rasmussen Syndrome Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for all requests 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Describe why IVIG therapy is the choice of treatment versus surgical intervention f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Primary Immunodefeciency Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis including history of recurrent infections c. Documentation describing the failure to produce antibodies to specifc antigens. d. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan including the titration plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Post Transfusion Purpura Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for all request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Neuromyelitis Optica Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of two disease modifying medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Myathenia Gravis Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Documentation describing severity of symptoms experienced, progression and duration d. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Multiple Sclerosis Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Documentation describing the symptoms and progression of the patients clinical status. d. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. e. Documentation of at least two or more disease modifying medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Multifocal Motor Neuropathy (MMN) Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Documentation describing severity of symptoms being experience and duration. Include asymmetric involvement and the number of nerves impacted. d. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment and taper plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Lennox Gastrate Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of treatments tried, failed, contraindicated include trials with seizure medicine. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan including the taper plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Lambert-Eaton Myasthenic Syndrome (LEMS) Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan include the taper plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Kawasaki Disease Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of mediction treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) ITP Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of medication or surgical treatments tried, failed, contraindicated. Include the trial of systemic corticosteroids with the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Pediatric HIV Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight and age b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Lab results to support the functional antibody deficit with specific antibody titers or recurrent bacterial infections. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Guillian Barre Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Documentation describing the date of the onset of neuropathic symptoms and functional limitations. d. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan including the taper plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for fetomaternal alloimmune thrombocytopenia Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis including a previous affected pregnancy, family history and / or platelet alloantibodies found on screening. c. If the service is for a newborn include documentation that the patient has received a platelet transfusion. d. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for Diabetes Mellitus Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Provide the date patient diagnosed as IDDM and documentation that the patient is not a candidate or refractory to insulin therapy. d. Documentation of medication treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for dermatomyositis or polymyositis Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of treatments tried, failed, contraindicated or intolerance to. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan that includes the titration plan. f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for chronic lymphocytic leukemia (CLL); Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Provide history of bacterial infections associated with B-cell CLL e. Documentation of medication treatments tried, failed, contraindicated. Include the trial of systemic corticosteroids with the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for demyelinating polyneuropathy Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Provide results of Electrophysiologic testing, include the number of motor nerves impacted. d. Documentation describing severity of symptoms being experience and duration e. Documentation of medication treatments tried, failed, contraindicated. Include the trial of systemic corticosteroids with the date range the medication was used and reason for discontinuation. f. Dose and frequency being requested and treatment plan g. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for Bone Marrow Transplant (BMT) Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Provide date of the Allogeneic Bone Marrow transplant e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for auto immune disease Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Dose and frequency being requested and treatment plan f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) for asthma Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for an initial request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Patient weight b. Patient diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Dose and frequency being requested and treatment plan including titration plan e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. f. List of medications patient will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is an initial infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the patient is clinically unstable iii. Documentation that the patient has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the patient has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the patient when administration is in the home or office setting v. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Immune Globulin (IVIG) Continuation Gammagard Hizentra Gammunex Gamunex-C Gammaked Privigen Octogam Bivigam Carimune Cuvitru Gammaplex Flebogamma Flebogamma Dif Vivaglobin	J1569 J1559 J1561 J1459 J1568 J1556 J1599 J1566 J1557 J1572 J1562 J1555	Please provide the following for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Lab results to define immunoglobulin A (IgA) deficiency with anti-IgA antibodies including IgG levels. d. Dose and frequency being requested e. Member response to therapy with the requested medication f. Date the therapy was started 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the drug will be administered in a facility include physician office notes with the following: i. Documentation that the service is a continuation of infusion of immune globulin, or re-initiation of therapy after more than 6 months off of immune globulin ii. The service is a change of immune globulin products and the member is clinically unstable iii. Documentation that the member has a history of severe adverse events to immune globulin (including but not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) iv. Documentation that the member has episodes of moderate to severe adverse events that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other therapy pre-medications, thereby increasing risk to the member when administration is in the home or office setting v. Treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Botox, Myobloc, Dysport, Xeomin to treat cervical dystonia	J0585, J0586, J0587, J0588	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as cervical dystonia b. Documentation of the relevant symptoms, please include the following i. Sustained head tilt or abnormal posturing resulting in pain or functional impairment ii. Recurrent involuntary contraction of one or more muscles of the neck c. Dose and frequency being requested, treatment plan
Injectable Medications – Botox, Dysport, to treat chronic anal fissure	J0585, J0586	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as chronic anal fissures b. Medications tried and failed, contraindications, intolerance previously c. Documentation of relevant symptoms experienced and length of time. Please include information about pain and bleeding. d. Dose and frequency being requested, treatment plan Request for a **continuation** start 1. New prescription 2. Physician office notes that include: a. Dose and frequency being requested b. Member response to therapy with the requested medication c. Date the therapy was started 3. Physicians treatment plan 4. Name and tax ID number of the servicing provider/facility if different from the initial request

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Botox, Dysport, to Treat Achalasia	J0585, J0586	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed by esophageal manometry testing b. List of medications tried and failed, contraindications, and intolerance c. Explanation why member is not a candidate for pneumatic dilation or myotomy d. Results of Upper GI endoscopy to rule out cause of dysphagia e. Dose and frequency being requested, treatment plan f. List medications member will be taking to treat the condition Request for an **continuation** 1. New prescription 2. Physician office notes that include: a. Dose and frequency being requested b. Member response to therapy with the requested medication c. Date the therapy was started 3. Physicians treatment plan
Injectable Medications - Botox, Dysport, Myobloc to Treat Detrusor Overactivity	J0585, J0586, J0587	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as detrusor overactivity or detrusor-sphincter dysynergia due to spinal cord injury or disease; b. Medications tried and failed, contraindications, intolerance for this diagnosis c. Dose and frequency being requested, including the treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Xeomin to Treat Blepharospasm	J0588	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. History and physical documenting severity of condition b. Related laboratory testing and imaging c. Dose and frequency being requested, treatment plan d. List medications member has tried and failed, contraindications, intolerance to. Request for **continuation** therapy 1. New prescription 2. Physician office notes that include: a. Dose and frequency being requested b. Member response to therapy with the requested medication c. Date the therapy was started 3. Physician's treatment plan
Injectable Medications – Botox to Treat Migraine Headaches	J0585	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as chronic migraines. Provide the number of occurrences per month and length of time for each headache. b. Medications tried and failed, contraindications, intolerance to the following therapeutic classes, include the length of time tried with any of the classes: - Antidepressant - Antiepileptic - Beta blocker c. Dose and frequency being requested, including the treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Botox to Treat Overactive Bladder	J0585	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as overactive bladder b. Symptoms including the length of time experienced c. Medications tried and failed, contraindications, intolerance d. Dose and frequency being requested, including the treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Exondys 51	J1428	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. The drug is being prescribed by or in consultation with a neurologist with expertise in diagnosis of Duchenne Muscular Dystrophy (DMD) b. Documentation and severity of symptoms being experience c. Results of 6-Minute Walk Time (6MWT) d. Provide results of genetic testing to confirm mutation of DMD gene that is amenable to exon 51 skipping e. Dose and frequency being requested 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Exondys 51	J1428	Request for **continuation** therapy 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. The drug is being prescribed by or in consultation with a neurologist with expertise in diagnosis of Duchenne Muscular Dystrophy (DMD) b. Results of 6-Minute Walk Time (6MWT) c. Dose and frequency being requested d. Member response to therapy with the requested medication 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications Botox, Myobloc, Dysport, Xeomin	J0585, J0586, J0587, J0588	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. History and physical documenting severity of condition b. Related laboratory testing and imaging c. Dose and frequency being requested, including treatment plan d. List medications member has tried and failed, contraindications, intolerance to Request for **continuation** therapy 1. New prescription 2. Physician office notes that include: a. Dose and frequency being requested b. Member response to therapy with the requested medication c. Date the therapy was started 3. Physicians treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Nucala	J2182	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as Severe Asthma b. Provide results of the Asthma Control Questionnaire (ACO) or Asthma Control Test (ACT) if available c. Provide blood eosinophil level and date drawn (within the last 6 weeks) d. Provide results of the Forced Expiratory Volume (FEV1) e. The drug is being prescribed by or in consultation with a pulmonologist or allergist/immunologist f. Asthma related emergency treatment describe the treatment provided and number of occurrences over the last 6 months g. Treatment tried, including any episodes of trying systemic corticosteroids over the last 12 months. h. Medication treatment failed, contraindicated or intolerance to i. Dose and frequency being requested, including the treatment plan j. List medications member will be taking to treat the condition
Injectable Medications – Nucala Continuation Request	J2182	Request for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member response to therapy with the requested medication b. Date the therapy was started c. Provide Forced Expiratory Volume (FEV1) results prior to initial treatment and results with the continued therapy d. The drug is being prescribed by or in consultation with a pulmonologist or allergist/immunologist e. Asthma related emergency treatment describe the treatment provided and number of occurrences over the last 6 months f. Dose and frequency being requested, including the treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications-Cinqair -- initial request	J2786	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as Severe Asthma b. Provide results of the Asthma Control Questionnaire (ACO) or Asthma Control Test (ACT) if available c. Provide blood eosinophil level and date drawn (within the last 4 weeks) d. Provide result Forced Expiratory Volume (FEV1) e. The drug is being prescribed by or in consultation with a pulmonologist or allergist/immunologist f. Asthma related emergency treatment describe the treatment provided and number of occurrences over the last 6 months g. Treatment tried, including any episodes of trying systemic corticosteroids over the last 12 months. h. Medication treatment failed, contraindicated or intolerance to i. Dose and frequency being requested, including the treatment plan j. List medications member will be taking to treat the condition
Injectable Medications – Cinqair Continuation request	J2786	Request for an **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member response to therapy with the requested medication. b. Date the therapy was started c. Provide Forced Expiratory Volume (FEV1) results prior to initial treatment and results with the continued therapy d. The drug is being prescribed by or in consultation with a pulmonologist or allergist/immunologist e. Asthma related emergency treatment describe the treatment provided and number of occurrences over the last 6 months f. Dose and frequency being requested, including the treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Eylea/Aflibercept	J0178	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Physician's orders with drug dosage and frequency. b. History of the medical condition requiring treatment, clinical indications including results of optical coherence tomography or fluorescein angiography where appropriate. c. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.
Injectable Medications - Velcade/bortezomib bortezomib	J9041	Request for an **initial** start 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan. b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRX Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Taxel/Onxal/ paclitaxel	J9264 J9267	Request for an **initial** start 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Xgeva/denosumab	J0897	Request for an **initial** start 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Herceptin / trastuzumab	J9355	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Ipilinumab	J9228	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Alimta/pemetrexed	J9305	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Rituxan/Rituximab	J9310	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Milrinone/milrione lactate	J2260	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Tysabri/ Natalizumab	J2323	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Prolastin/alpha 1-proteinase inhibitor – human	J0256	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicinas treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Sandostatin/ octreotide	J2353	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Lumizyme/ Myozyme/ alglucosidase	J0221	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits
Radiopharmaceuticals	A9699 A9606 C9031	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Imaging reports demonstrating advancing disease c. Previous treatments rendered and response d. Requested dose, frequency, and interval

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Elaprase/ idursulfase	J1743	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Iloprost	Q4074	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including the physicians treatment plan . b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Makena	J1726 J1729 J2675	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis b. Relevant obstetrical member history, including current singleton pregnancy c. Documentation of signs and symptoms d. Current gestational age e. Dose, frequency, duration, including the physician treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility, provide office notes for at least one of the following: i. Medically unstable based on submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Neulasta/ pegfilgrastin	J2505	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physician's treatment plan. b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Ilumya Initial	C9399 J3490 J3590	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis b. Attestation that member is unable to self-administer and that there is no competent caregiver to administer the drug that includes explanation c. List of other medications that this member is currently using for this diagnosis d. For plaque psoriasis, percent of body surface involvement including description of areas involved e. List of other medications that this member has tried for this diagnosis. Include dates of therapy and outcome of treatment. f. Dose and frequency being requested including the physicians treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Ilumya Continuation	C9399 J3490 J3590	Please provide the following for a continuation request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Documentation of response to Ilumya therapy b. Attestation that member is unable to self-administer and that there is no competent caregiver to administer the drug that includes explanation c. List of other medications that this member is currently using to treat this diagnosis

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Parsabiv / etelcalcetide initial	J0606	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis b. Documentation that member is currently on dialysis c. List of medications that were tried prior to Parsibiv d. List of other medications that the member is currently using to treat this diagnosis e. Documentation that this is being prescribed by or in consultation with and endocrinologist or nephrologist. f. Dose and frequency being requested including the physicians treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medication – Parsabiv continuation	J0606	Please provide the following for a continuation request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. List of medications that the member is currently taking for this diagnosis. b. Documentation that this is being prescribed by or in consultation with and endocrinologist or nephrologist. c. Documentation of a reduction in serum calcium from baseline
Injectable Medications - Lucentis/ Ranibizumab	J2778	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physician's treatment plan. b. History of the medical condition requiring treatment, clinical indications including results of optical coherence tomography or fluorescein angiography where appropriate. c. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.
Injectable Medications - Factor –Products	J7175 J7178 J7179 J7180 J7181 J7182 J7183 J7185 J7186 J7187 J7188 J7189 J7190 J7191 J7192 J7193 J7194 J7195 J7198 J7199 J7200 J7201 J7202 J7205 J7207 J7210 J7211	1. Current Prescription 2. Physician office notes that include the following: a. Physician's orders with drug dosage and frequency. b. History of the medical condition requiring treatment including clinical indications. c. Physicians treatment plan

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Provenge / Sipuleucel-T	Q2043	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physician's treatment plan. b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Erbitux / cefuximab	J9055	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physician's treatment plan. b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE**: If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Aranesp/ darbepoetin alfa	J0881	1. Current prescription 2. Physician office notes that support documentation of: a. Drug dosage, route of administration and frequency including physician's treatment plan. b. History of the medical condition requiring treatment including clinical indications and the most recent hgb/hct, serum erythropoietin level and other pertinent labs such as iron studies. c. Previous treatment provided including the name of the drug, course of treatment and response d. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). NOTE: If drug is obtain by the member prior authorization may be required through the member's Part D benefits

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Procrit/Epogen / epoetin alfa	J0885	1. Current prescription 2. Physician office notes that support documentation of: a. Drug dosage, route of administration and frequency including physician's treatment plan. b. History of the medical condition requiring treatment including clinical indications and the most recent hgb/hct, serum erythropoietin level and other pertinent labs such as iron studies. c. Previous treatment provided including the name of the drug, course of treatment and response d. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. e. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Soliris (eculizumab)	J1300	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Labs to support the diagnosis of Atypical hemolytic uremic syndrome (aHUS)1. Please include CBC with differential, laboratory evidence of hemolysis, evidence of uremia, verification of the diagnosis, verification of exclusion of diagnoses of STEC-HUS and TTP with ADAMTS13. d. Labs to support the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) and Hemoglobin and Hematocrit e. Current symptoms experienced f. Dose and frequency being requested 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Soliris (eculizumab)	J1300	Please provide the clinical for a **continuation** request 1. New prescription 2. Physician office notes that include: a. Member weight b. Member diagnosis c. Date the therapy was started d. Member response to therapy with the requested medication e. Labs to support the diagnosis of Atypical hemolytic uremic syndrome (aHUS)1. Please include CBC with differential, laboratory evidence of hemolysis, evidence of uremia, verification of the diagnosis, verification of exclusion of diagnoses of STEC-HUS and TTP with ADAMTS13. f. Labs to support the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) and Hemoglobin and Hematocrit or documentation of reduced transfusion. g. Dose and frequency being requested h. Member response to therapy with the requested medication 3. Name and tax ID number of the servicing provider/facility 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – VPRIV initial request	J3385	Request for an **initial** start 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Diagnosis confirmed as Type 1 Gaucher disease b. Describe the clinical signs and symptoms c. Dose and frequency being requested, including the treatment plan d. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – VPRIV continued request	J3385	Request for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member response to therapy with the requested medication. b. Date the therapy was started c. Dose and frequency being requested, including the treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Cerezyme (Imiglucerase)	J1786	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis (type 1 or type 3 of Gaucher's disease) c. Documentation of severity of symptoms d. Documentation of treatments tried, failed, contraindicated or intolerant to VPRIV e. Dose and frequency being requested, including the treatment plan 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) Please provide the clinical for a **continuation** request 1. New prescription 2. Physician office notes that include:- a. Member weight b. Member diagnosis (type 1 or type 3 of Gaucher's disease) c. Documentation and severity of symptoms being experience d. Dose and frequency being requested e. Member response to therapy with the requested medication f. Follow-up member assessments pertinent to this request 3. Date the therapy was started 4. Name and tax ID number of the servicing provider/facility to facilitate claim processing

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Lemtrada (Alemtuzumab) initial request	J0202	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation and severity of symptoms being experience d. Documentation of treatments tried, failed, contraindicated Include the date range the medication was used and reason for discontinuation. e. Documentation of past treatments with the drug being requested f. Dose and frequency being requested include if the member will be receiving the drug in combination with another disease modifying agent 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired AND no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Lemtrada (Alemtuzumab) continuation request	J0202	Please provide the clinical information for a **continuation** request 1. New prescription 2. Physician office notes that include: a. Member weight b. Member diagnosis c. Dose and frequency being requested, include if the member will be receiving the drug in combination with another disease modifying agent d. Date the therapy was started 3. Name and tax ID number of the servicing provider/facility to facilitate claim processing

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Ocrevus (Ocrelizumab) **initial request**	J2350	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to assist with claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis which includes the relapsing form of MS c. Documentation and severity of symptoms being experience d. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. e. Documentation of past treatments with the drug being requested f. Dose and frequency being requested. Include if the member will be receiving the drug in combination with: i. Another disease modifying agent ii. B Cell Targeted Therapy iii. Lymphocyte trafficking blockers g. Include if the member will be receiving the drug in combination with any other drug. 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Ocrevus (Ocrelizumab) **Continuation request**	J2350	Please provide the clinical for a **continuation** request 1. New prescription 2. Physician office notes that include: a. Member weight b. Member diagnosis c. Dose and frequency being requested. Include if the member will be receiving the drug in combination with any other medication d. Member response to therapy with the requested medication e. Date the therapy was started 3. Name and tax ID number of the servicing provider/facility to facilitate claim processing 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - HP Acthar (Corticotropin)	J0800	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis and age c. Dose and frequency including taper plan being requested d. List medications member will be taking to treat the condition 4. Physicians treatment plan 5. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) Please provide the clinical for a **continuation** request 1. New prescription 2. Physician office notes that include: a. Member weight b. Dose and frequency including taper plan being requested c. Member response to therapy with the requested medication d. Date the therapy was started 3. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse)

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Inflectra / Infliximab DYYB **Initial request**	Q5103	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Medication treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dates of previous trial, length of time of Remicade and outcome e. Dose and frequency being requested and treatment plan. Include the rationale supporting the use of Inflectra as the drug of choice over Remicade f. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications – Inflectra / Infliximab DYYB **Continued request**	Q5103	Please provide the clinical for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dose and frequency being requested including the treatment plan e. List medications member will be taking to treat the condition f. Date the therapy was started g. Member response to therapy with the requested medication h. Follow-up member assessments pertinent to this request 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.

Service Category	CPT Codes	Clinical Information Requested
Injectable Medications - Ilaris (Canakinumab) **Initial request**	J0638	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Member consult with a rheumatologist or immunologist d. Dose and frequency being requested including the treatment plan e. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy. a.
Injectable Medications - Ilaris (Canakinumab) **Continued request**	J0638	Please provide the clinical for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Member consult with a rheumatologist or immunologist d. Dose and frequency being requested including a treatment plan

Service Category	CPT Codes	Clinical Information Requested
		e. List medications member will be taking to treat the condition f. Date the therapy was started g. Member response to therapy with the requested medication h. Follow-up member assessments pertinent to this request 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications - Actemra (Tocilizumab)	J3262	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility 3. Physician office notes that include: a. Member weight b. Member diagnosis Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation c. Dose and frequency being requested d. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse. a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy

Service Category	CPT Codes	Clinical Information Requested
		iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications - Orencia / abatacept	J0129	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. d. Dose and frequency being requested including treatment plan e. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the <u>location is in a facility</u> provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments

Service Category	CPT Codes	Clinical Information Requested
		v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications – Retacrit / Epoetin Alfa -EPBx	Q5106	1. Current prescription 2. Physician office notes that support documentation of: a. Drug dosage, route of administration and frequency including physician's treatment plan. b. History of the medical condition requiring treatment including clinical indications and the most recent hgb/hct, serum erythropoietin level and other pertinent labs such as iron studies. c. Previous treatment provided including the name of the drug, course of treatment and response d. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. e. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.
Injectable Medications - Remicade / Infliximab	J1745	Please provide the following: 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation

Service Category	CPT Codes	Clinical Information Requested
		d. Dose and frequency being requested including treatment plan e. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications - Simponi Aria / golimumab	J1602	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dose and frequency being requested including treatment plan e. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history

Service Category	CPT Codes	Clinical Information Requested
		ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications - Entyvio (Vedolizumab) **Initial request**	J3380	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dose and frequency being requested including treatment plan e. List medications member will be taking to treat the condition 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure

Service Category	CPT Codes	Clinical Information Requested
		iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications - Entyvio (Vedolizumab) **continuation request**	J3380	Please provide the clinical for a **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation d. Dose and frequency being requested including treatment plan e. List medications member will be taking to treat the condition f. Date the therapy was started g. Member response to therapy with the requested medication h. Follow-up member assessments pertinent to this request 4. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate

Service Category	CPT Codes	Clinical Information Requested
		adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications – Luxterna	J3490 J3590 C9399 C9032	1. Current Prescription 2. Physician office notes to support the treatment of Inherited Retinal Dystrophies (IRD) must include whether: a. The member has previously been treated with RPE65 gene therapy in the intended eye b. The member has sufficient retinal cells determined by the optical coherence tomography (OCT) c. The treatment will be administered by an ophthalmologist or retinal surgeon experienced in providing sub-retinal injections d. Provide documentation of member diagnosis of Leber's congenital amaurosis or Retinitis pigmentosa. e. Provide documentation of genetic testing documenting biallectic mutation of RPE65 gene.
Injectable Medications – Fasenra / benralizumab	J3490 J3590 C9399 C9466	Please include the following: 1. Current prescription 2. Physician office notes that include the following: a. Drug dosage and frequency including physician's treatment plan. b. Associated orders for an infusion pump or a nebulizer needed to administer the drug. c. History of the medical condition requiring treatment including clinical indications. d. If dose and/or frequency are different from the FDA approved package insert, provide literature support for the specific schedule chosen. e. If the member is receiving this drug as part of a clinical trial, please provide information about the clinical trial, including the clinical trial identifier. 3. Documentation of how the drug will be supplied and who will administer the drug to the member (e.g., supplied by office/facility, obtained by

Service Category	CPT Codes	Clinical Information Requested
		member from either a pharmacy or OptumRx Specialty Pharmacy Program). **NOTE:** If drug is obtain by the member prior authorization may be required through the member's Part D benefits.
Injectable Medications - Xolair for treating Asthma – initial request	J2357	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation of the severity of symptoms includes frequency of exacerbations, provide the rescue medications and systemic corticosteroids utilized during the exacerbation(s). d. Provide results of the Asthma Control Questionnaire (ACO) or Asthma Control Test (ACT) if available e. Baseline plasma immunoglobulin E (IgE) level prior to therapy start date f. Provide results of skin testing or in vitro reactivity to a perineal aero allergen g. Provide result Forced Expiratory Volume (FEV1) h. The drug is being prescribed by or in consultation with a pulmonologist or allergist/immunologist i. Asthma related emergency treatment describe the treatment provided and number of occurrences over the last 6 months j. Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation k. Dose and frequency being requested including the treatment plan l. List medications member will be taking to treat the condition. Include if the member will be taking Xolair in combination with Cinqair, Fasenra or Nucala.
Injectable Medications - Xolair for treating Asthma continued request	J2357	Please provide the following for an **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight

Service Category	CPT Codes	Clinical Information Requested
		b. Member response to therapy with the requested medication c. Date the initial therapy was started d. Provide Forced Expiratory Volume (FEV1) results prior to initial treatment and results with the continued therapy e. Dose and frequency being requested include the treatment plan f. List medications member will be taking to treat the condition. Include is the member will be taking Xolair in combination with Cinqair, Fasenra or Nucala.
Injectable Medications - Xolair for treating Uticaria initial request	J2357	Please provide the following for an **initial** request 1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member diagnosis c. Documentation describing the symptoms d. If the drug is being prescribed by or in consultation with an allergist/ immunologist or dermatologist. e. Documentation of treatments tried, failed, contraindicated. Include the date range the medication was used and reason for discontinuation. g. Dose and frequency being requested include the treatment plan
Injectable Medications - Xolair for treating Uticaria continued request	J2357	Please provide the following for an **continuation** request 1. New prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member weight b. Member response to therapy with the requested medication c. Date the initial therapy was started d. Dose and frequency being requested include the treatment plan
Injectable Medications – Radicava	J3490 J3590 C9399 C9493	Please provide the following: 1. Current prescription 2. Physician office notes should include: a. If the drug is being prescribed by or in consultation with a neurologist. b. Radicava dosing for ALS is in accordance with the U.S. Food and Drug Administration (FDA)-approved labeling c. EL Escorial and Airlie House diagnostic criteria results that indicate a diagnosis of a definite or probable Amyotrophic Lateral Sclerosis

Service Category	CPT Codes	Clinical Information Requested
		(AML). d. ALS Functional Rating Scale-Revised (ALSFRS-R) results prior to treatment. e. Forced Vital Capacity (FVC) % at the start of treatment. f. Physicians treatment plan 3. Location where the drug will be administered (e.g., infusion center, physician office, self-administered, home health nurse) a. If the location is in a facility provide office notes for at least one of the following: i. Medically unstable based upon submitted clinical history ii. Initial medication infusion of or re-initiation after more than 6 months following discontinuation of therapy iii. Previous experience of a severe adverse event following infusion. Examples include but are not limited to anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure iv. Continuing experience of adverse events that cannot be mitigated by pre-medications or infusion rate adjustments v. Physically and/or cognitively impaired and no home caregiver available vi. Difficulty establishing and maintaining patent vascular access vii. Homecare or infusion provider has deemed that the member, home caregiver, or home environment is not suitable for home infusion therapy.
Injectable Medications – Spinraza initial request	J2326	Please provide the following for **initial** request: 1. Current prescription 2. Physician office notes supporting the diagnosis and Type (I, II, or III) of Spinal Muscular Atrophy (SMA) including: a. Documentation with laboratory values describing the type of mutation or deletion of genes in Chromosome 5q. b. Documentation that member has 2 copies of SMN2. c. Documentation that member is dependent on an invasive ventilation/ tracheostomy or a noninvasive ventilation beyond use for naps and nighttime sleep. d. The drug is being prescribed by or in consultation with a neurologist with expertise in diagnosis of SMA. e. Dosing of Spinraza for SMA is in accordance with the FDA-approved labeling (maximum dosing of 12mg). f. Spinraza administered intrathecally by, or under the direction of,

Service Category	CPT Codes	Clinical Information Requested
		healthcare professionals experienced in performing lumbar punctures. 3. Provide medical records (e.g., chart notes, laboratory values) of the baseline exam of at least **one** of the following exams (based on member age and motor ability) to establish baseline motor ability: a. Hammersmith Infant Neurological Exam (HINE),infant to early childhood b. Hammersmith Functional Motor Scale Expanded (HFMSE) c. Upper Limb Module (ULM) Test, non-ambulatory d. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
Injectable Medications – Spinraza continued request	J2336	Please provide the following for a **continuation** request 1. New prescription 2. Diagnosis and Type (I, II, or III) of Spinal Muscular Atrophy (SMA) including: a. Documentation with laboratory values describing the type of mutation or deletion of genes in Chromosome 5q. b. Documentation that member has 2 copies of SMN2. c. Documentation that member has any dependencies on invasive ventilation/ tracheostomy or a noninvasive ventilation beyond use for naps and nighttime sleep. d. The drug is being prescribed by or in consultation with a neurologist. e. Dose being requested and frequency including treatment plan 2. Medical records (e.g., chart notes, laboratory values) with the most recent results (< 1 month prior to request) documenting a positive clinical response from pretreatment baseline status to Spinraza therapy as demonstrated any of the following: a. Follow up HINE milestones b. Follow up HFMSE c. Follow up ULM d. Follow up CHOP INTEND
Injectable Medications – Hemophilia	J7178 J7180 J7183 J7185 J7186 J7187 J7189 J7193 J7194 J7195 J7198 J7199	On UHCprovider.com, refer to Clotting Factors and Coagulation Blood Products Drug Policy

Service Category	CPT Codes	Clinical Information Requested
Injection Anesthetic Agent Greater Occipital Nerve	64405	1. Physician office notes including: a. History and physical findings b. Identification of the problem including diagnosis, precipitating events c. Frequency, duration and intensity of pain d. Previous response to therapies e. Laboratory and other tests relevant to the service request
Cardiac Catheterization with or without angiography	93452 93453 93454 93455 93456 93457 93458 93459 93460 93461	1. Current prescription 2. Physician office notes that include: a. Diagnosis, including suspected diagnosis, the necessity to evaluate a condition and treatment planning. b. Relevant history & physical, including history of cardiac trauma c. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG/ECG) d. Documentation of signs and symptoms; including onset, duration, and frequency
Stress Echocardiogram	93350 93351	1. Current prescription 2. Physician office notes that include: a. An electrical STRESS test alone is not useful or effective, and a STRESS echocardiogram is needed. Include results old electrical STRESS test. b. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG/ECG) c. Documentation of signs and symptoms; including onset, duration, and frequency d. The member has significant valvular heart disease or high risk for CAD e. Provide the significance or the extent of myocardial ischemia (or scar), or to assess myocardial viability f. Relevant history & physical, including any planned surgery. g. Documentation that the service is requires to aid in diagnosis of hypertrophic or dilated cardiomyopathy or differentiate ischemic from non-ischemic cardiomyopathy h. List of medication(s) and treatment plan

Service Category	CPT Codes	Clinical Information Requested
Non Invasive Fractional Flow Reserve (FFR)	0051T 0052T 0053T 0054T	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis related to the FFR service being requested b. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) c. Documentation of signs and symptoms; with onset, duration, and frequency d. Relevant medication(s) taken
Pacemaker replacement of batteries, generator	33212 33213 33221 33227 33228 33229 33230 33231 33240 33262 33263 33264	1. Current prescription 2. Physician office notes that include: a. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction b. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block c. Relevant history & physical d. Relevant medication(s) taken e. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) f. Documentation of signs and symptoms; with onset, duration, and frequency
Pacemaker replacement of lead electrodes	33224 33225	1. Physician office notes that include: a. Relevant history & physical, including history of initial pacemaker placement b. Relevant medication(s) taken c. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) d. Documentation of signs and symptoms; with onset, duration, and frequency
Pacemaker insertion / replacement	33206 33207 33208 33249 33270	1. Current prescription 2. Indicate whether this is an initial request, or replacement. 3. Physician office notes that include:

Service Category	CPT Codes	Clinical Information Requested
		a. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction b. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block c. Relevant history & physical d. Relevant medication(s) taken e. Reports of all recent imaging studies and applicable diagnostics (i.e. EKG) f. Documentation of signs and symptoms; with onset, duration, and frequency
Jaw Motion Rehabilitation System	E1700 E1701 E1702	1. Physician office notes containing: a. Member history b. Previous treatments tried and results
Arthroscopy-Knee	29870 29873 29874 29875 29876 29877 29879 29880 29881 29882 29883 29884 29885 29886 29887 29888 29889 27488	1. Current physician office notes indicating: a. Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Co-morbid medical condition(s) d. Pertinent physical examination of the knee or relevant joint, with history of present illness and joint pathology. e. Physician's treatment plan including pre-op discussion f. Therapies tried and failed of the following, including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgery v. Other pain management procedures g. Conservative measures tried and failed h. Laboratory results (such as ESR, Rheumatoid Factor, or other pertinent labs) 2. Complete report(s) of diagnostic imaging (MRI, CT Scan, and X-rays)
Joint Replacement – Acetabuloplasty	27120 27122	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Current physician office notes indicating: a. Condition requiring procedure

Service Category	CPT Codes	Clinical Information Requested
		b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Co-morbid medical condition(s) d. Pertinent physical examination the relevant joint e. Physician's treatment plan including pre-op discussion f. Therapies tried and failed of the following including dates: i. Orthotics ii. Medications/injections iii. Physical Therapy iv. Surgery v. Other pain management procedures
Joint Replacement – Ankle Arthroplasty	27700 27702 27703	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Current physician office notes indicating: a. Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Co-morbid medical condition(s) d. Pertinent physical examination of the relevant joint e. Physician's treatment plan including pre-op discussion f. Therapies tried and failed of the following including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgery **v.** Other pain management procedures
Joint Replacement – Displaced Fracture of Femoral Neck, Hemi-arthroplasty	27125	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Physician office notes indicating: a. Condition requiring procedure b. Physician's treatment plan including pre-op

Service Category	CPT Codes	Clinical Information Requested
		discussion c. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) Co-morbid medical condition(s) d. Pertinent physical examination of the relevant joint e. Therapies tried and failed of the following including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgery v. Other pain management procedures
Joint Replacement – Elbow Arthroplasty	24360 24361 24362 24363 24370 24371	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Current physician office notes indicating: a. Condition requiring procedure b. Co-morbid medical conditions (Rheumatoid Arthritis, Osteoarthritis, Degenerative Joint Disease, Post-traumatic Arthritis, Severe Fractures) c. Pertinent physical examination of the relevant joint d. Physician's treatment plan including pre-op discussion e. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) f. Therapies tried and failed of the following including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgery v. Other pain management procedures 3. For arthroplasty due to rheumatoid arthritis, include documentation of: a. Documentation of member's symptoms, pain,

Service Category	CPT Codes	Clinical Information Requested
		location, and severity including functional impairment that is interfering with activities of daily living (preparing meals, walking, getting dressed, driving) 4. For **revision surgery**, include documentation of the complication and complete (staged) surgical plan. .

Service Category	CPT Codes	Clinical Information Requested
Joint Replacement – Hip Arthroplasty	27130 27132 27134 27137 27138 29914 29915 29916	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Current physician office note indicating: a. Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Physician's treatment plan including pre-op discussion d. Pertinent physical examination of the relevant joint e. Co-morbid medical conditions (cardiovascular diseases, hypertension, diabetes, cancer, pulmonary diseases, neurodegenerative diseases) f. Therapies tried and failed of the following including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgical v. Other pain management procedures 3. Documentation that more conservative measures have been considered. (e.g., osteotomy, hemiarthroplasty) 4. Documentation that member has failed or is not a candidate for more conservative measure (e.g., osteotomy, hemiarthroplasty) 5. Date of failed previous hip fracture fixation, if applicable For **revision surgery** includes documentation of the complication and complete (staged) surgical plan.
Joint Replacement – Knee Arthroplasty or Arthroplasty Revision	27445 27446 27447 27486 27487	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Current physician office note indicating: a. Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking)

Service Category	CPT Codes	Clinical Information Requested
		c. Physician's treatment plan including pre-op discussion d. Pertinent physical examination of the relevant joint e. Co-morbid medical condition(s) f. Therapies tried and failed of the following including dates : i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgical v. Other pain management procedures 3. Date of failed previous surgery to the same joint (proximal tibial or distal femoral osteotomy, if applicable) For **revision surgery** includes documentation of the complication and the complete (staged) surgical plan.
Joint Replacement – Knee Arthroscopy with Autologous Implantation or Allograft	27412 J7330 29866 29867 29868 S2112	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) Note: For pediatric age, indicate status of growth plates. 2. Current physician office note indicating: a. Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Physician's treatment plan including pre-op discussion d. Pertinent physical examination of the relevant joint e. Co-morbid medical condition(s) f. Therapies tried and failed for the following including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgical v. Other pain management procedures

Service Category	CPT Codes	Clinical Information Requested
		3. For **27412**, **J7330** and **S2112** include the following: a. Size and location of defect b. Cause of defect: acute or repetitive trauma 4. For **29866, 29867 and 29868** include the following documentation: a. Degree of degenerative changes in surrounding– Outerbridge Grade b. Why total knee replacement is not planned.
Joint Replacement – Shoulder Arthroplasty, Arthroplasty Revision	23472 23473 23474	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) 2. Current physician office notes with documentation of: a. Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Physician's treatment plan including pre-op discussion d. Pertinent physical examination of the relevant joint e. Co-morbid medical condition(s) f. Therapies tried and failed for the following including dates : i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgical v. Other pain management procedures For **revision surgery** includes documentation of the complication and complete (staged) surgical plan.

Service Category	CPT Codes	Clinical Information Requested
Joint Replacement – Shoulder Hemi-arthroplasty	23470	1. Complete report(s) of diagnostic imaging (MRI, CT Scan, Xrays and Bone Scan) a. Location and number of fractures; or 2. Current physician's office notes including if applicable: a. Co-morbid medical condition(s) Condition requiring procedure b. Severity of pain and details of functional disability(ies) interfering with activities of daily living (preparing meals, dressing, driving, walking) c. Physician's treatment plan including pre-op discussion d. Pertinent physical examination of the relevant joint e. Therapies tried and failed for the following including dates: i. Orthotics ii. Medications/injections iii. Physical therapy iv. Surgery v. Other pain management procedures 3. Document the member has the ability to participate in post-surgical rehab
Magneto-encephalography	95965	Physician office notes including: 1. Condition requiring procedure 2. History and physical by the attending/treating physician 3. Symptoms and functional impairment 4. History and duration of unsuccessful conservative therapy, when applicable
Mastectomy for Gynecomastia	19300	1. Physician office notes with the history of the medical condition 2. Frontal and lateral colored photos of the including expected outcome torso 3. Treatment Plan for proposed surgery 4. Clinical studies that address the physical and/or physiological abnormality 5. Functional deficits and associated conditions and complications

Service Category	CPT Codes	Clinical Information Requested
		6. Pertinent medication history and laboratory results
Muscle Flap Procedures	15732 15734 15736 15738	1. Physician office notes with history of medical conditions requiring treatment or surgical intervention which includes all of the following: a. A well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment b. Recurrent or persistent functional deficit caused by the abnormality. 2. Clinical Studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment 3. Color photos, where applicable, of the physical and/or physiological abnormality 4. Physician plan of care with proposed procedures including expected outcome
Neuromuscular Stimulator for Scoliosis	E0744 E0745	This procedure is considered unproven. To request a review please submit: 1. Current prescription from physician 2. Physician office notes that relate to treatment of the condition
Neurostimulator Electrode Array, Peripheral Nerve	64555	Physician office notes describing: 1. Frequency, duration and intensity of pain 2. Previous response to therapies 3. Documentation of pain relief from temporarily implanted electrode

Service Category	CPT Codes	Clinical Information Requested
Pediatric Day Care MS, LA, TX	T1025, T1026, T2002	Please provide the following information: 1. Current Physician order that is within 30 days of personally examining the member 2. Physician office notes that include: a. Member diagnosis, age, and letter of medical necessity b. Documentation of ongoing need for skilled nursing care and supervision, therapeutic interventions, or skillful observations c. Status as medically dependent or technologically dependent d. Documentation of member stability for outpatient services and risk status towards other persons e. Address whether delayed skilled intervention is expected to result in the following: i. Deterioration of a chronic condition; ii. Loss of function; iii. Imminent risk to health status due to medical fragility iv. Risk of death. f. Documentation of current residence, including whether living with responsible adult or in any 24-hour care setting g. Relevant member history h. Treatment plan, including visit frequency and duration
Physical / Occupational Therapy	97799 97161 97162 97163 97164 97165 97166 97167 97168	1. Current prescription by Physician 2. Indicate whether this is an initial request, or extended/continued therapy. 3. Specific diagnosis/condition, with description of the Physical or Occupational therapy needed 4. Goals of therapy 5. Therapy plan of care by an occupational or physical therapist 6. Physician office notes that include: a. History & physical, including history of condition and limitations b. Medical and surgical history, including any planned procedures or treatment c. Reports from any applicable imaging studies or diagnostic testing 7. For extended/continued therapy, please also provide the following: a. Functional progress during initial therapy b. Generalization and carryover of targeted skills into natural environment c. Goals of therapy are not yet met d. Member is actively participating in treatment

Service Category	CPT Codes	Clinical Information Requested
Speech Therapy in AZ, NJ, OH, PA, MS	92507 92508 92521 92522 92523 92524 92526 92609 92610 92597	1. Current prescription by Physician 2. Indicate whether this is an initial request, or extended/continued therapy. 3. Specific diagnosis/condition, with description of the speech, hearing or language disorder 4. Goals of therapy 5. Speech therapy plan of care, by a speech pathologist, therapist or audiologist 6. Physician office notes that include: a. History & physical, including history of condition and limitations b. Medical and surgical history, including any planned procedures or treatment c. Reports from any applicable imaging studies or diagnostic testing d. As applicable, documented member/family/caregiver support, is functionally able to use device, and desires to use device. e. As age appropriate, member is able to communicate via pictures/words 7. For extended/continued therapy, please also provide the following: a. Functional progress during initial therapy b. Generalization and carryover of targeted skills into natural environment c. Goals of therapy are not yet met d. Member is actively participating in treatment

Service Category	CPT Codes	Clinical Information Requested
PT / OT Therapy	97799 97161 97162 97163 97164 97165 97166 97167 97168	1. Current prescription by Physician 2. Indicate whether this is an initial request, or extended/continued therapy. 3. Specific diagnosis/condition, with description of the Physical or Occupational therapy needed 4. Goals of therapy 5. Therapy plan of care by an occupational or physical therapist 6. Physician office notes that include: a. History & physical, including history of condition and limitations b. Medical and surgical history, including any planned procedures or treatment c. Reports from any applicable imaging studies or diagnostic testing 7. For extended/continued therapy, please also provide the following: a. Functional progress during initial therapy b. Generalization and carryover of targeted skills into natural environment c. Goals of therapy are not yet met d. Member is actively participating in treatment
Open Osteochondral Autograft, Talus	28446	Physician office notes including: 1. Symptoms 2. Imaging studies 3. Previously failed treatment 4. Planned procedure and plan of care
Orthognathic and Jaw Surgery (Including Genioplasty)	21120 21121 21122 21123 21125 21127 21141 21142 21143 21145 21146 21147 21150 21151 21154 21155 21159 21160 21188 21193 21194 21195 21196 21198 21199 21206 21208 21209 21210 21215 21244 21245 21246 21247 21248 21249 21255 21296 21299 21242 21240 22867 22869	1. Comprehensive physician office notes identifying with the history of the medical condition(s) requiring treatment or surgical intervention. This documentation must include all of the following: a. A well-defined physical and/or physiological abnormality (e.g., congenital abnormality, functional or skeletal impairments) resulting in a medical condition that has required or requires treatment; b. The physical and/or physiological abnormality has resulted in a functional deficit; and c. The functional deficit is recurrent or persistent in nature 2. Appropriate clinical studies/tests including cephalometric

Service Category	CPT Codes	Clinical Information Requested
		tracings and analysis addressing the physical and/or physiological abnormality that confirm its presence and the degree to which it is causing impairment, with appropriate measurements, when applicable Radiologic film interpretations including lateral cephalometric radiograph, AP radiograph and panoramic radiograph. 3. Clinical photographs of the member's occlusion Diagnostic Polysomnography for obstructive sleep apnea surgery 4. Treating physician's plan of care including surgical treatment objectives, which must include the expected outcome for the improvement of the functional deficit 5. History of previous non-surgical and surgical treatment (e.g. such as with obstructive sleep apnea)
Orthotics	L0112 L0140 L0150 L0170 L0200 L0220 L0452 L0462 L0464 L0466 L0468 L0480 L0482 L0484 L0486 L0622 L0623 L0624 L0629 L0631 L0632 L0634 L0636 L0638 L0700 L0710 L0810 L0820 L0830 L0859 L0999 L1000 L1001 L1005 L1200 L1300 L1310 L1499 L1630 L1640 L1680 L1685 L1700 L1710 L1720 L1730 L1755 L1834 L1844 L1904 L1920 L2000 L2005 L2010 L2020 L2030 L2034 L2036 L2037 L2038 L2040 L2050 L2060 L2070 L2080 L2090 L2126 L2128 L2136 L2232 L2320 L2387 L2520 L2525 L2526 L2627 L2628 L2800 L2861 L3160 L3201 L3202 L3203 L3204 L3206 L3207 L3208 L3209 L3211 L3212 L3213 L3214	1. Current prescription from physician 2. Equipment quote with billing codes and cost 3. What is the reason for custom orthotic needed? 4. Physician office notes documenting the following: a. Diagnosis b. Medical necessity for orthotic **c.** Functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) 5. Date and type of injury/surgery, if applicable 6. For **Knee Orthotics (KO)** include: a. Documentation of deformity of the leg or knee b. Size of thigh and calf c. Sufficiency of muscle mass d. Documentation that pediatric orthotics for small limbs or straps with additional length for large limbs have been ruled out 7. For **Ankle-Foot Orthoses (AFO)** and **Knee-Ankle-Foot Orthoses (KAFO)** include: a. Duration the condition is expected to persist b. Member's ambulatory status c. Physician office notes indicating a neurological, circulatory or orthopedic condition that supports the need for a custom orthotic

Service Category	CPT Codes	Clinical Information Requested
	L3215 L3250 L3251 L3252 L3253 L3254 L3255 L3257 L3265 L3320 L3485 L3649 L3674 L3720 L3764 L3765 L3766 L3891 L3900 L3901 L3904 L3921 L3956 L3961 L3967 L3971 L3973 L3975 L3976 L3977 L3978 L4000 L4030 L4040 L4045 L4050 L4055 L4631 L1810 L1832 L1843 L1932 L1951 L1960 L2280 L2999 L3000 L3010 L3010 L3020 L3216 L3221 L3960 L5611	8. **If a replacement:** Please provide age of current orthotic and reason for replacement.

Service Category	CPT Codes	Clinical Information Requested
Panniculectomy and Body Contouring – Includes Lipectomy and Abdominoplasty	15830 15847	1. Physician office notes describing: a. Primary complaint, history of complaint and physical exam b. Intertriginous rashes or other skin problems with documentation of treatment and response c. Documentation of functional limitations due to pannus 2. High-quality color photographs of a full frontal view of the hanging pannus, a full frontal view of pannus elevated that allows any skin damage can be evaluated, and a full lateral view of the hanging pannus. All photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s).
Percutaneous Lysis of Epidural Adhesions	62263 62264	Physician office notes describing: 1. The nature of the cervical, lumbar or thoracic pain including the location, intensity and duration 2. Prior conservative treatment regimens tried and response (e.g., medications, injections, traction) 3. If procedure previously performed, provide dates

Service Category	CPT Codes	Clinical Information Requested
Private Duty Nursing	T1000 T1002 T1003 S9122 S9123 S9124	**Initial Request**: 1. Signed order and/or Letter of Medical Necessity 2. Recent hospitalization documentation, if applicable 3. Recent clinical documentation from Primary Care Physician and/or specialist, if applicable 4. Recent home health agency notes if currently receiving services 5. Summary of Case Manager assessment and/or notes **Recertification of Services**: 1. Current 485 (**must be signed**) 2. Current Letter of Medical Necessity and/or order (must renew annually) 3. Note last time member was seen by Primary Care Physician (must see Primary Care Physician annually) 4. 60 Day Skilled Nurse Summary including: a. Nursing Summary needs to be current and related to ALL stated diagnosis b. Vital Signs ranges, O2 Sats, glucose levels, PT/INR levels, HCT/HGB if receiving B12 injections c. Medication changes, wound care with wound measurements, edema with description, weight gain/weight loss d. Member's functional mobility e. **Caregiver must be identified**. Does caregiver participate in care of the member? Who lives with the member? Who administers medications? f. Recent inpatient or ER visits with dates and diagnosis g. Summary of most current Case Management notes.
Prosthetics – Breast	L8000 L8001 L8002 L8010 L8015 L8020 L8030 L8031 L8032 L8035 L8039	1. Current prescription from physician 2. Diagnosis 3. Indicate if initial or replacement 4. Reason for replacement, if applicable 5. Date received initial prosthetic, if applicable

Service Category	CPT Codes	Clinical Information Requested
Prosthetics – Face	L8040 L8041 L8042 L8043 L8044 L8045 L8046 L8047 L8048 L8049	1. Current prescription from physician 2. Equipment quote with billing codes 3. Physician office notes with clinical information documenting: a. Medical history b. Cause of facial defect
Prosthetics – Lower Limb	L5010 L5020 L5050 L5060 L5100 L5105 L5150 L5160 L5200 L5210 L5220 L5230 L5250 L5270 L5280 L5301 L5311 L5312 L5321 L5331 L5400 L5410 L5420 L5430 L5460 L5500 L5505 L5510 L5520 L5530 L5535 L5540 L5560 L5570 L5580 L5585 L5590 L5595 L5600 L5640 L5613 L5614 L5616 L5617 L5618 L5620 L5624 L5626 L5628 L5629 L5630 L5631 L5632 L5634 L5636 L5639 L5640 L5642 L5643 L5644 L5645 L5646 L5647 L5648 L5649 L5651 L5652 L5653 L5654 L5655 L5656 L5658 L5661 L5666 L5676 L5677 L5678 L5680 L5681 L5682 L5683 L5684 L5686 L5688 L5690 L5692 L5694 L5696 L5697 L5698 L5699 L5700 L5701 L5702 L5703 L5706 L5710 L5711 L5712 L5714	1. Current prescription from physician 2. Equipment quote with billing codes: for miscellaneous codes include make, model, part number and explanation as to why the item is needed 3. Physician office notes with clinical information documenting: a. Medical history b. Specify amputated limb and date c. Document the K level and describe current functional level including employment and recreational activities d. Surfaces normally traversed e. Condition of contralateral limb 4. Prosthesis fitting notes, if applicable 5. Specify if the prosthetic is new for the member OR is it a replacement? Is it temporary or permanent? **If it is a replacement prosthetic, include the following documentation:** 1. Age of current prosthetic and reason for replacement or upgrade 2. Documented changes in limb 3. Comparative residual limb measurements 4. Comparative sock-ply and liner thickness 5. Member's current functional level

Service Category	CPT Codes				Clinical Information Requested
	L5716	L5718	L5722	L5724	
	L5726	L5728	L5780	L5650	
	L5782	L5785	L5790	L5795	
	L5810	L5811	L5812	L5714	
	L5816	L5818	L5822	L5824	
	L5826	L5828	L5830	L5840	
	L5845	L5848	L5850	L5855	
	L5856	L5857	L5858	L5910	
	L5920	L5925	L5930	L5960	
	L5961	L5966	L5968	L5970	
	L5971	L5972	L5973	L5975	
	L5976	L5978	L5979	L5980	
	L5981	L5985	L5987	L5988	
	L5990	L5000	L5668	L5671	
	L5673	L5679	L5705	L5962	
	L5964	L5984	L5986	L5999	
	L5673	L5679	L5685	L5671	
	L5704	L5705	L5707	L5940	
	L5962	L5986	L8420		

Service Category	CPT Codes				Clinical Information Requested
Prosthetics – Upper Limb	L6000	L6010	L6020	L6025	1. Current prescription from physician 2. Equipment quote with billing codes: for miscellaneous codes include make, model, part number and explanation as to why the item is needed 3. Physician office notes with clinical information documenting: a. Member's medical history b. Specify amputated limb and date 4. Specify whether the prosthetic is an initial or replacement 5. Prosthesis fitting notes a. Condition of residual limb b. How is each feature associated with an ADL c. Motivation to use device d. If **powered**, why a body powered device is not sufficient e. If **myoelectric**, include: i. Microvolt threshold and outcome of test ii. Environment in which the device will be used
	L6050	L6055	L6100	L6110	
	L6120	L6130	L6200	L6205	
	L6250	L6300	L6310	L6320	
	L6350	L6360	L6370	L6380	
	L6382	L6384	L6386	L6388	
	L6400	L6450	L6500	L6550	
	L6570	L6580	L6582	L6584	
	L6586	L6588	L6590	L6600	
	L6605	L6610	L6611	L6615	
	L6616	L6620	L6621	L6623	
	L6624	L6625	L6628	L6629	
	L6630	L6632	L6635	L6637	
	L6638	L6639	L6640	L6641	
	L6642	L6645	L6646	L6647	
	L6648	L6650	L6655	L6660	
	L6665	L6670	L6675	L6676	
	L6677	L6684	L6687	L6688	
	L6689	L6690	L6691	L6692	
	L6693	L6695	L6696	L6697	
	L6698	L6703	L6704	L6706	
	L6707	L6708	L6709	L6711	
	L6712	L6713	L6714	L6715	
	L6721	L6722	L6805	L6810	
	L6880	L6881	L6882	L6883	
	L6884	L6885	L6895	L6900	
	L6905	L6910	L6915	L6920	
	L6925	L6930	L6935	L6940	
	L6945	L6950	L6955	L6960	
	L6965	L6970	L6975	L7007	
	L7008	L7009	L7040	L7045	

Service Category	CPT Codes	Clinical Information Requested
	L7170 L7180 L7181 L7185 L7186 L7190 L7191 L7400 L7401 L7402 L7403 L7404 L7405 L7499 L7500 L7600 L7260 L7261 L7266 L7272 L7274	
Prosthetics – Miscellaneous	L5637 L5638 L6680 L6682 L7362 L7364 L7366 L7367 L8310 L8320 L8330 L8410 L8415 L8435 L8465 L8480 L8485 L8499 L8505 L8507 L8511 L8512 L8514 L8515 L8603 L8604 L8609 L8610 L8612 L8613 L8629 L8630 L8631 L8641 L8642 L8658 L8659 L8670 L8684 L8695 L8699 L8500	**Refer to anatomic site for detailed instructions (e.g., breast, face, upper/lower limb). For any prosthetic that does not fit into breast, face, upper/lower limb categories please submit the following:** 1. Current prescription from physician 2. Equipment quote with billing codes: for miscellaneous codes include make, model, part number and explanation as to why the item is needed 3. Physician office notes with clinical information documenting: a. Medical history b. Reason for prosthetic

Service Category	CPT Codes	Clinical Information Requested
Proton Beam Therapy	77520 77522 77523 77525	1. Physician office notes with include the following: a. History of medical condition requiring treatment b. Documentation that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques c. Evaluation includes a comparison of treatment plans for PBT, IMRT, and stereotactic body radiation therapy (SBRT). d. *For Hypofractionated radiation* provide the prescribed total dose and dose per fraction, e. *For delivery of radiation therapy course with standard fractionation*, provide the dose prescription along with documentation in the form of a clearly labeled, color comparative Proton, and IMRT dose volume histogram and dose table, in absolute doses noting that sparing of the surrounding normal tissue cannot be achieved with IMRT techniques. Note: If citing an RTOG dose constraint, please provide the RTOG protocol number f. Physicians treatment plan **Note:** The color comparative Proton and IMRT dose volume histogram and dose table must be submitted by the portal or emailed **not faxed**. Submit the images thru the portal, Link, Prior Authorization And Notification application at www.uhcprovider.come/paan or email the information to the following: **For Commercial members –** CCR@uhc.com **For Medicare members -** medicareccr@uhc.com **For C&S Medicaid:** MedicaidCCR@UHC.COM **For C&S Hawaii: hi_ccr@uhc.com**
Radiation Therapy	77371 77372 77373 77385 77386 G0173 G0251 G0339 G0340 G6015 G6016	1. Physician office notes with include the following: a. History of medical condition requiring treatment b. Physicians treatment plan

Service Category	CPT Codes	Clinical Information Requested
Radiology Services (CT, MRI, MRA, PET, SPECT, Nuclear Medicine, MR – Ultrasounds)	CT Abd/Pelvis: 72192, 74160, 74178, 72193, 74170, 75635, 72194, 74176, 74150, 74177 CT Colon: 74261, 74262, 75263 CT Head: 70450, 70481, 70488, 70460, 70482, 70490, 70470, 70486, 70491, 70480, 70487, 70492 MRI Head: 70551, 70554, 70558, 70552, 70555, 70559, 70553, 70557 MRI Joint LE: 73721, 73722, 73723 MRI Joint UE: 73221, 73222, 73223 MRI Spine: 72141, 72147, 72156, 72142, 72148, 72157, 72146, 72149, 72158 MRI Spine/ Pelvis: 72195, 72196, 72197 PET: 78459, 78811, 78816, 78491, 78812, G0219, 78492, 78813, G0235, G0252, 78608, 78814, S8085, 78609, 78815, 58085, A9515, A9526, A9552, A9580, A9587, A9588 SPECT: 78205, 78453, 78710, 78206, 78454, 78803, 78320, 78494, 78803, 78451, 78607, 78807, 78452, 78647 Thyroid and Parathyroid: 78011, 78071, 78072	Provider should call the number on the member's ID card when referring for radiology services. 1. Recent history & physical with documentation of medical necessity 2. Reports of all recent imaging studies and applicable diagnostics 3. Relevant medication(s) taken 4. Documentation of pain; with scale, onset, duration, frequency, and location

Service Category	CPT Codes	Clinical Information Requested
Rhinoplasty, Septoplasty, Repair of Vestibular Stenosis or Turbinate Resection	30400 30410 30420 30430 30435 30450 30460 30462 30465 30520	Office notes that support documentation of: 1. Obstructive Sleep Apnea confirmed by polysomnogram/sleep study 2. What is the chief complaint? Detailed history of nasal symptoms 3. Supply evidence of chronic sinusitis with treatment, response and duration 4. CT report of maxilla-facial /nasal sinus area (and/or full face photos in cases of post-traumatic nasal deformity) 5. Internal exam of the nose 6. Treating physician's plan of care For Rhinoplasty for Nasal Vestibular Stenosis or Alar Collapse include: a. Endoscopic evaluation and photographs confirming nasal valve compromise or dynamic collapse of the external nasal valve or upper lateral cartilage b. High-quality color photograph(s). For services related to **traumatic injury**: high-quality color photo showing the severe lateral displacement of the nose is required. All photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s).
Self-Administered Drugs	A9270 C9399 J0135 J0270 J0275 J0364 J0630 J0718 J0800 J0945 J1324 J1438 J1595 J1675 J1744 J1815 J1830 J2170 J2212 J2354 J2440 J2760 J2940 J2941 J3030 J3110 J3355 J3357	Current physician office notes which include: 1. Medical Necessity for the use of a self-administered drug 2. History of medical condition requiring treatment

Service Category	CPT Codes	Clinical Information Requested
	J3490 J3590 J9212 J9213 J9216 J9218 Q0515 Q3025 Q3026 90284	
Sinuplasty (Balloon Sinus Ostial Dilation)	31295 31296 31297 **31298**	Physician office notes that include: 1. History of illness 2. Recent physical exam 3. Treatment for chronic rhinosinusitis. a. Duration of treatment/medical therapy, if applicable b. Nasal lavage c. Antibiotic therapy, if bacterial infection is suspected d. Systemic and/or topical steroids e. Topical and/or systemic decongestants f. Treatment of concomitant allergic rhinitis 4. CT scan findings of one of the following: a. Mucosal thickening b. Bony remodeling, c. Bony thickening or d. Obstruction of the ostiomeatal complex 5. Evidence that the sinusitis involves frontal, maxillary, or sphenoid sinuses 6. Planned procedure: include if the procedure will be part of a functional endoscopic sinus surgery (FESS) 7. Additional testing, if applicable: a. Endoscopically obtained cultures b. Allergy testing c. Peripheral eosinophil count d. Immunodeficiency evaluation

Service Category	CPT Codes	Clinical Information Requested
Sleep Apnea Treatment and Surgeries	21685 41512 41530 41599 42145 42299 S2080	1. Physician office notes that include history of condition 2. Sleep study indicating a diagnosis of sleep apnea 3. Respiratory Disturbance Index 4. Documentation of excessive daytime sleepiness a. Documented using Epworth Sleepiness Scale or other validated scale b. Documentation that it interferes with daily activity or work (e.g., causes safety issues) 5. Documentation indicating failed response or intolerance to CPAP usage or other non-invasive treatment with involvement of qualified sleep specialist. 6. Documented counseling by Physician trained in sleep disorders about the benefits and risks of surgery. 7. Documentation if weight not a concern, or if weight loss was tried and failed. 8. For uvulopalatopharyngoplasty to correct OSA include the following additional information : a. Evidence of retrolingual obstruction as the cause of OSA or previous failure of Uvulopalatopharyngoplasty to correct the Obstructive Sleep Apnea . 9. For maxillomandibular osteotomy and advancement include the following additional information : a. Craniofacial disproportion or deformities, with evidence of maxillomandibular deficiency b. Use and failure of an oral appliance; or documentation that the dental device is inappropriate given the member's anatomy 10. For mandibular osteotomy to correct OSA include the following additional information: a. Functional obstruction mostly retrolingual or lower pharyngeal b. Use and failure of an oral appliance; or documentation that the dental device is inappropriate give the member's anatomy 11. Physician plan of care with proposed procedures including expected outcome

Service Category	CPT Codes	Clinical Information Requested
Attended Sleep Study	95805, 95810, 95811, E0601	1. Physician's office notes with the following information: a. Physical exam that includes the height, weight and BMI b. Clinical signs and symptoms of OSA c. Epworth Sleepiness Score d. Co-morbid conditions i. Pulmonary - provide the PaCO2 results ii. Cardiac- provide the class III, IV CHF iii. Neuro e. Results of previous sleep testing f. Indicate if the testing is for a Commercial Driving License (CDL) 2. If requesting 95811, indicate if it is for Pap titration or split night which is preferred when possible 3. When the member is already on PAP therapy, please send most recent print out for compliance. 4. For MSLT 95805, please provide any information that shows that other causes of Excessive Daytime Sleepiness have been excluded
Spinal Stimulator for Pain Management	63650 63655 63685 L8683 L6889	1. Specific device to be implanted including all documentation. 2. Indicate if this request is for a trial or permanent placement 3. Physician office notes including: a. Condition requiring procedure b. Physical examination c. Treatments tried and failed including: i. Spine surgery ii. Physical therapy iii. Medications/injections 4. Documentation of physical and psychological evaluations 5. Documentation of physical evidence 6. For permanent placement include documentation of pain relief with temporary implant
Spinal Surgery – for Pain and Nerve/Cord Compression	22100 22101 22102 22103 22110 22112 22114 22116 22206 22207 22208 22216 22220 22222 22224 22226 22526 22527 22532 22533 22534 22548 22551 22552	1. Physician office notes including: a. Condition requiring procedure b. History and co-morbid medical condition(s) c. Documentation of member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving). d. Physical exam, including neurologic exam

Service Category	CPT Codes				Clinical Information Requested
	22554	22556	22558	22585	e. History and duration of previous therapy, when applicable including: i. Physical therapy ii. Medications/injections iii. Previous surgery, iv. Other attempted treatments f. Planned procedure and plan of care; include if the surgery will be performed with direct visualization g. Complete report(s) of diagnostic h. Describe the surgical technique(s) planned. eg: AxialLIF, XLIF, GOLIF, LALIF, Image-guided minimally invasive lumbar Decompression (MILDR), Percutaneous endoscopic discectomy with or without laser, etc.) 2. Which of the following brand-named tools will you be using? a. Accurascope b. DSS® Brand Stabilization System c. Dynesysr Dynamic Stabilization System d. Decompression (MILDR) e. METRx Microdiscectomy System with video visualization f. METRx Microdiscectomy System with direct visualization Total artificial disc replacement g. X-STOP product h. Interspinous fixation device (e.g., Coflex-F device) i. Unlisted spine stabilization technique/system (please specify) j. Unlisted spinal decompression procedure (please specify) 3. Which of the following allograft products will you be using? Please indicate **all** products. Provide brand names, if applicable. a. None b. Cadaver allograft c. Animal allograft i. Demineralized bone matrix Allograft DBM ii. Synthetic DBM d. Amniotic tissue membrane e. Bone morphogenetic protein-7 (BMP-7) f. Bone morphogenetic protein-2 (BMP-2)
	22590	22595	22610	22612	
	22614	22630	22632	22633	
	22634		22800	22802	
	22804	22808	22810	22812	
	22818	22819	22830	22840	
	22841	22842	22846	22847	
	22848	22851	22855	22856	
	22857	22861	22862	22864	
	22865	22899		62287	
	63001	63003	63005	63011	
	63012	63015	63016	63017	
	63020	63030	63040	63042	
	63043	63044	63045	63046	
	63047	63048	63050	63051	
	63055	63056	63057	63064	
	63075	63076	63078	63081	
	63085	63087	63088	63090	
	63091	63101	63102	63103	
	63170	63172	63173	63180	
	63182	63185	63190	63191	
	63194	63195	63196	63197	
	63198	63199	63200		
		0098T	0163T	0164T	
	0165T	0171T	0172T	0195T	
	0196T	0200T	0201T	0202T	
	0219T	0220T	0221T	0222T	
	0274T	0275T	S2348		

Service Category	CPT Codes	Clinical Information Requested
		i. Please indicate which of the following: ii. Infuse bone graft/LT-cage lumbar tapered fusion device iii. Infuse bone graft/interfix threaded fusion device iv. Infuse bone graft/interfix rp threaded fusion device g. Other cage type (for example PEEK or other); Ceramic-Based Products – please indicate which of the following: i. Beta tricalcium phosphate (b-TCP) ii. Other; must provide the brand name h. Cell-based products – please indicate which of the following: i. Mesenchymal stem cells ii. Osteocel iii. Trinity Evolution iv. Infuse/Mastergraft Posterolateral Revision Device System v. Optimesh vi. Platelet-rich plasma (PRP) vii. Other.

Service Category	CPT Codes	Clinical Information Requested
Spinal Surgery – Scoliosis	22849 22850 22852 22843 22844 22845	1. Physician office notes including: a. Degree of curvature(s) b. Progression of curvature c. History and co-morbid medical condition(s) d. Member's symptoms and functional impairment e. Physical exam, including neurologic exam f. Results of relevant test(s) i. Diagnostic imaging ii. Pulmonary function test(s) f. History and duration of previous therapy, when applicable i. Physical therapy ii. Bracing iii. Medications/injections iv. Previous surgery v. Other attempted treatments 2. Which of the following allograft products will you be using? Provide brand names, if applicable. a. None b. Autograft c. Cadaver allograft d. Animal allograft e. Demineralized bone matrix; please indicate which of the following: i. Allograft DBM ii. Synthetic DBM f. Amniotic tissue membrane g. Bone morphogenetic protein-7 (BMP-7)Bone morphogenetic protein-2 (BMP-2); please indicate which of the following: i. Infuse bone graft/LT-cage lumbar tapered fusion device ii. Infuse bone graft/interfix threaded fusion device iii. Infuse bone graft/interfix RP threaded fusion device iv. Other cage type (for example PEEK or other); h. Ceramic-based products; please indicate which of the following: i. Beta tricalcium phosphate (b-TCP) ii. Other; must provide the brand name 3. Cell-based products; please indicate which of the following: a. Mesenchymal stem cells b. Osteocel

Service Category	CPT Codes	Clinical Information Requested
		c. Trinity Evolution d. Infuse/mastergraft posterolateral revision device system e. Optimesh f. Platelet-rich plasma (PRP) For **removal** of instrumentation: 1. Physician office notes addressing reason for removal 2. Operative report for insertion of instrumentation
Therapeutic Apheresis	36514	Physician office notes to include diagnosis being treated, medical history, and treatment plan.
Therapeutic procedures	97010 97012 97014 97016 97018 97022 97026 97028 97033 97034 97039 97113 97116 97124 97140 97110 97112	1. Current prescription 2. Name and tax ID number of the servicing provider/facility to facilitate claim processing 3. Physician office notes that include: a. Member diagnosis requiring therapeutic procedures b. Previous treatments rendered, dates of treatments and response c. Treatment plan
Therapeutic Embolization; Endometrial Ablation/ Cryoablation	37204 58356 58563	Physician office notes to include diagnosis being treated, medical history, and treatment plan.
Thorascopy – Sympathectomy for Treatment of Hyperdidrosis	32644	1. Physician office notes indicating condition requiring treatment and symptoms 2. Prior conservative treatments tried and failed, or not appropriate
Transection or Avulsion of Greater Occipital Nerve	64744	Physician office notes containing: 1. Member history 2. Previous treatments tried 3. Current treatment plan
Transplant of Tissue or Organs	All codes	For new transplants or for transplants within the last year Provider should call the number on the member's ID card when referring for any transplant service. For all other transplant-related requests include:

Service Category	CPT Codes	Clinical Information Requested
		1. Member history 2. Previous treatments tried 3. Current treatment plan

Service Category	CPT Codes	Clinical Information Requested
Upper Gastrointestinal Endoscopy with Delivery of Thermal Energy for Treatment of Gastroesophageal Reflux Disease	43257	This procedure is considered unproven. To request a review please submit physician office notes which include: 1. History of the medical condition requiring treatment 2. Previous treatments tried and response
Vagus Nerve Stimulation	L8680 L8682 L8685 L8686 L8687 L8688 61888 64568 64569 61885 61850 61863 61864 61867 61868 61886	1. Specific diagnosis/condition 2. Physician office notes that include: a. Medical and surgical history b. Prior pharmacological agents tried to which the seizures have been refractory c. Onset date of seizures d. Frequency of seizures/monthly 3. Documentation as to whether the member is a candidate for epilepsy surgery or has failed surgery. 4. Quality of Life assessment with quantifiable measures of date-to-life besides the occurrence of seizures 5. Indicate whether the member has a progressive disorder (e.g., malignant brain neoplasm, metabolic or degenerative disorder) For stimulation used for Idiopathic Parkinson's Disease, Essential Tremor and Primary Dystonia provide the following: 1. Specify specific procedure (e.g., thalamic VIM, STN or GPI deep brain stimulation) 2. Physician office notes that include: a. Symptoms b. Co-morbidities c. Previous movement disorder surgery within the affected basal ganglion 3. For Thalamic VIM include Fahn-Tolosa-Marin Clinical Tremor Rating Scale or equivalent scale 4. For STN or GPI include: a. Hoehn and Yahr stage or Unified Parkinson's

Service Category	CPT Codes	Clinical Information Requested
		Disease Rating Scale part III motor subscale b. L-dopa responsiveness **5.** Persistent disabling Parkinson symptoms despite optimal medical therapy
Varicose Vein Procedures (Ablation, Ligation, Vein Stripping, Sclerotherapy)	36470 36471 36475 36478 37700 37718 37722 37735 37780 37785 36468 36473	Physician office notes including: 1. Evaluation and complaints 2. Documentation of the following: a. Pain/other symptoms that interfere with daily activities related to vein disease b. Functional impairment specifics-(preparing meals, ability to walk, how long member can stand, getting dressed, driving) 3. Documentation of the specific functional impairment related to vein disease a. Severity of symptoms b. Which activities are affected by symptoms c. Which extremity (right, left or both) and veins that will be treated 4. Diagnostic studies with documentation of vein diameter and duration of reflux 5. Prior conservative treatment and duration 6. Pulses 7. Documentation stating presence or absence of DVT (deep vein thrombosis), aneurysm, and/or tortuosity 8. Proposed treatment plan with procedure code. 9. For inpatient requests, clinical documentation supporting the intent to admit the member to the inpatient level of care
Ventricular Assist Devices	All codes	Provider should call the number on the member's identification card when referring for any requests for ventricular assist devices.