Samaritan Health Plans

2019 PRIOR AUTHORIZATION LIST

FOR LARGE GROUP EVERYDAY CHOICES PLANS

Coverage of certain medical services and surgical procedures requires Samaritan Health Plans' written authorization before the services are performed. Your provider can request prior authorization by phone, fax, or mail. If for any reason your provider will not or does not request prior authorization for you, you must contact the Plan yourself. In some cases, additional information or a second opinion can be required before authorizing coverage.

Benefits are determined by the plan. Items listed may have limited coverage or not be covered at all. Please refer to your Member Certificate for benefit coverage details.

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

- Bariatric surgery (benefit is for in-network services only)
- Capsule/wireless endoscopies and motility monitoring studies
- Durable Medical Equipment (DME) and supplies, prosthetics and orthotics with billed amount greater than $1000 for purchase. Rental items with rental fee greater than $1000 per month or rental length greater than 3 months
- Genetic testing
  - **Exception**: standard prenatal testing
- Hospitalization for dental procedures, including Ambulatory Surgery Center (ASC)
- Hyperbaric oxygen therapy
- Infused/injected medications (see attached list)
- Inpatient hospital care (including mental health and substance use disorder) *
  - **Exception**: labor & delivery
  - **Exception**: newborn stays less than 5 days
- Inpatient rehabilitation care*
- Neck and back surgery (including in-office procedures)
- Potentially cosmetic, experimental, or reconstructive surgery and services, including new and emerging technologies and clinical trials**
- Radiological services (for the following):
  - Magnetic Resonance Imaging (MRI)
  - Positron Emission Tomography (PET) scans
  - Virtual colonoscopy
- Residential services for mental health and substance use disorder
- Sclerotherapy
- Skilled Nursing Facility (SNF)
- Skin substitute – tissue engineered
- Transplants
  - **Exception**: corneal transplants
- Urine drug tests (prior authorization required after 12 units per year)
- Uvulopalatopharyngoplasty

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

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

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

Medically necessary: Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

- Consistent with the symptoms of a health condition or treatment of a health condition
- Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective
- Not solely for the convenience of member or a provider of the service or medical supplies; and
- The most cost effective of the alternative levels of medical services or medical supplies, which can be safely provided to the member in the provider's judgment

- In Samaritan's determination as based on available information and documentation, and in accordance with the terms of the Plan

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

Samaritan Health Plans reserves the right to review or otherwise deny services that are not found to be medically necessary.

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

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