Prior Authorization Changes Effective 9/12/2023

As part of our annual prior authorization (PA) review process, CountyCare is updating our PA list for the following medications. These changes will be effective **9/12/23**

In addition, the following policies with associated criteria have been created and/or updated for the medications added to the prior authorization list as outlined below. The policies can be found here.

RX.PA.017.CCH Intravenous Immune Globulin (IVIG), Intramuscular (IM) & Subcutaneous Immune Globulin (SCIG)
The purpose of this policy is to define the prior authorization process for all commercially available, formulary IVIG and SCIG products.

RX.PA.026.CCH OCULAR DISORDERS
The purpose of this policy is to define the prior authorization process for products used to treat ocular disorders, such as the anti-vascular endothelial growth factor agents (anti-VEGF) agents.

RX.PA.030.CCH RITUXIMAB PRODUCTS
The purpose of this policy is to define the prior authorization process for nononcologic indications for the rituximab products – Riabni (rituximab-arrx), Rituxan (rituximab), Rituxan Hycela (rituximab and hyaluronidase human), Ruxience (rituximab-pvvr), and Truxima (rituximab-abbs) indications for rituximab products. Note: NCH reviews prior authorization requests for all oncology-related diagnoses.

RX.PA.057.CCH INTRAVITREAL CORTICOSTEROIDS (OZURDEX®, ILUVIEN®, RETISERT®, YUTIQ®, XIPERE®)
The purpose of this policy is to define the prior authorization process for Ozurdex® (dexamethasone), Iluvien® (fluocinolone), Retisert® (flucinolone), Yutiq® (fluocinolone), and Xipere® (triamcinolone acetonide).

RX.PA.058.CCH APRETUDE (CABOTEGRAVIR)
The purpose of this policy is to define the prior authorization process for Apretude (cabotegravir) for at-risk adults and adolescents weighing at least 35kg for PrEP to reduce the risk of sexually acquired HIV-1 infection.

RX.PA.062.CCH NEXVIAZYME (AVALGLUCOSIDASE)
The purpose of this policy is to define the prior authorization process for Nexviazyme (avalglucosidase) for Pompe disease, late onset.

RX.PA.068.CCH LEQVIO (INCLISIRAN)

The purpose of this policy is to define the prior authorization process for Leqvio (inclisiran). Leqvio (inclisiran) is indicated, in adjunct to diet and maximally tolerated statin therapy, for patients who require additional lowering of low-density lipoprotein cholesterol (LDL-C) for the treatment of:

- Heterozygous familial hypercholesterolemia (HeFH)
- Clinical atherosclerotic cardiovascular disease (ASCVD)

RX.PA.072.CCH SAPHNELO (ANIFROLUMAB-FNIA)
The purpose of this policy is to define the prior authorization process for Saphenlo (anifrolumab-fnia) for systemic lupus erythematosus (SLE).

RX.PA.075.CCH ENJAYMO (SUTIMLIMAB-JOME)
The purpose of this policy is to define the prior authorization process for Enjaymo (sutimlimab-jome) for Cold Agglutin Disease (CAD).

RX.PA.076.CCH LUTEINIZING HORMONE RELEASING HORMONE (LHRH) AGENTS
The purpose of this policy is to define the prior authorization process for Luteinizing Hormone Releasing Hormone (LHRH) agents.

RX.PA.077.CCH TEZSPIRE (TEZEPELUMAB)
The purpose of this policy is to define the prior authorization process for TezspireTM (Tezepelumab) for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

RX.PA.078.CCH VYVGART (EFGARTIGIMOD ALFA-FCAB)
The purpose of this policy is to define the prior authorization process for Vyvgart (efgartigimod alfa-fcab) for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

RX.PA.079.CCH XENLETA (LEFAMULIN)
The purpose of this policy is to define the prior authorization process for Xenleta (Lefamulin) for the treatment of adults with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: *Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Haemophilus influenzae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae.*

UPDATE TO PREFERRED RITUXIMAB PRODUCTS: Riabni, Ruxience and Truxima are now the preferred rituximab products for CountyCare. The medical necessity criteria policy for each drug listed above can be found here

The new codes added for Prior Authorization (PA) for the above drugs are as follows:

Code Type	Code	Description
HCPCS	J0219	Injection, avalglucosidase alfa-ngpt, 4 mg
HCPCS	J0491	Injection, anifrolumab-fnia, 1 mg
HCPCS	J0691	Injection, lefamulin, 1 mg
HCPCS	J0739	Injection, cabotegravir 1 mg
HCPCS	J1302	Injection, sutimlimab-jome, 10 mg
HCPCS	J1306	Injection, inclisiran, 1 mg
HCPCS	J1551	Injection, immune globulin (cutaquig), 100 mg
HCPCS	J1952	Leuprolide injectable, camcevi, 1 mg*
HCPCS	J2356	Injection, tezepelumab-ekko, 1 mg
HCPCS	J2777	Injection, faricimab-svoa, 0.1 mg
HCPCS	J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg
HCPCS	J3299	Injection, triamcinolone acetonide (xipere), 1 mg
HCPCS	J8999	Prescription drug, oral, chemotherapeutic, nos*
HCPCS	J9273	Injection, tisotumab vedotin-tftv, 1 mg*
HCPCS	J9274	Inj, tebentafusp-tebn, 1 mcg*
HCPCS	J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg*
HCPCS	J9331	Injection, sirolimus protein-bound particles, 1 mg*
HCPCS	J9332	Injection, efgartigimod alfa-fcab, 2mg
HCPCS	J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg*

Please note: starred (*) codes above are reviewed by NCH for oncology-related diagnoses. If your request is not in-scope for NCH, the starred codes will require Prior Authorization through CountyCare.

The following codes are added to the medication list but **DO NOT require prior authorization**:

Code Type	Code	Description
HCPCS	J0742	Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg
HCPCS	J0879	Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis)
HCPCS	J1201	Injection, cetirizine hydrochloride, 0.5 mg
HCPCS	J2998	Injection, plasminogen, human-tvmh, 1 mg
HCPCS	J9071	Injection, cyclophosphamide, (auromedics), 5 mg
HCPCS	J1932	Injection, lanreotide, (cipla), 1 mg
HCPCS	Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 mcg

This policy is intended to provide guidance for In-Network facilities. All Out of Network requests are subject to prior authorization along with Medical Director review and may be redirected to an In-Network facility.

For a full list of Prior Authorization codes, the CPT Code Look-Up is available here.

To access the CountyCare Utilization Management Provider Portal when submitting authorizations or extensions, find the portal link here. If you need additional assistance on how to use the portal, please contact CountyCare Provider Services at ProviderServices@countycare.com or your Provider Relations Representative.

Contact us

Please contact CountyCare Provider Services at **312-864-8200, Option 6**. You can also use our Interactive Voice Response (IVR) system to verify eligibility. The Provider Services Representatives can assist you with eligibility and claim status. They can also connect you with your assigned PR Representative.

Thank you for working with us to ensure that CountyCare members receive quality care at the right time and in the right setting. If you have any questions or would like additional information, please contact your assigned Provider Relations Representative or if you do not know your assigned Representative, please contact CountyCareProviderServices@cookcountyhhs.org.