CountyCare
A MEDICAID HEALTH PLAN

Provider Notice

January 30, 2026

Prior Authorization Changes Effective 3/31/2026

As part of our prior authorization (PA) review process, CountyCare is updating the PA list for the following **MEDICATIONS BILLED UNDER THE MEDICAL BENEFIT.** These changes will be effective **March 31, 2026.**

The following codes **WILL REQUIRE prior authorization:**

HCPCS Code	Drug Brand Name	Description	Associated Drug Policy
J0614	Grafapex	Injection, treosulfan, 50 mg	RX.PA.033.CCH Specialty Drug Management
J1809	Nulibry	Injection, fosdenopterin, 0.1 mg	RX.PA.033.CCH Specialty Drug Management
Q5154	Omlyclo	Injection, omalizumab-igec (omlyclo), biosimilar, 5 mg	RX.PA.033.CCH Specialty Drug Management
Q5155	Yesafili	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	RX.PA.033.CCH Specialty Drug Management
Q5156	Avtzoma	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	RX.PA.033.CCH Specialty Drug Management
Q5157	Stoboclo/Osenvelt	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg	RX.PA.033.CCH Specialty Drug Management
Q5158	Bomyntra/Conexxence	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg	RX.PA.033.CCH Specialty Drug Management
Q5159	Ospomyvu	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg	RX.PA.033.CCH Specialty Drug Management
*	Papzimeos	zopapogene imadenovec-drba	RX.PA.033.CCH Specialty Drug Management
*	Qivigy	immune globulin intravenous, human-kthnm 10% solution	RX.PA.033.CCH Specialty Drug Management

*HCPCS codes/drugs noted with (*) above do not have HCPCS codes assigned by CMS at this time and are billed under 'Not Otherwise Classified' (NOC) codes. The PA requirement will automatically apply once CMS assigns a specific HCPCS code for the drug.

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The following codes will **NO LONGER REQUIRE** prior authorization:

HCPCS Code	Drug Brand Name	Description
J0165^	-	J0166: Injection, epinephrine (bpi), not therapeutically equivalent to J0165, 0.1 mg
J0168^	-	Injection, epinephrine (international medication systems), not therapeutically equivalent to J0165, 0.1 mg
J0169^	Adrenalin	Injection, epinephrine (adrenalin), not therapeutically equivalent to J0165, 0.1 mg

^HCPCS codes/drugs notated with (^) are reviewed by NCH for oncology-related diagnoses. If your request is not in-scope for NCH, these drugs will NOT require prior authorization through CountyCare.

For a full list of prior authorization codes, the 'Prior Authorization Look-Up Tool' is available here.

This notice is intended to provide guidance for in-network providers; however, all out-of-network provider requests are subject to prior authorization through Evolent Specialty Services (ESS). Out-of-network provider requests may be redirected to an in-network provider whenever possible and will be subject to physician review.

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 CountyCare Provider Services at countycareproviderservices@cookcountyhhs.org or your assigned Provider Relations Representative.

-SEE NEXT PAGE FOR CLINICAL POLICY CHANGES-

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Policies Changes Effective 3/31/2026

The following policies with associated criteria have been created and/or updated for the medications added to the PA list as outlined above. The policies can be found here.

EVH_CG_5000.CC ACUTE HEREDITARY ANGIOEDEMA PRODUCTS – *UPDATED POLICY*
The following changes were made to this policy:

- Added criteria to ensure requested dosing matches the FDA-approved package insert.
- Updated the Berinert age limit to 5 years and older.
- Identified Berinert as the preferred product for this policy. All other products are non-preferred and require a trial of Berinert.

EVH_CG_5008.CC DUCHENNE MUSCULAR DYSTROPHY DRUG THERAPIES – *UPDATED POLICY*
The approval duration for Elevidys was updated to 6 months.

EVH_CG_5029.CC RITUXIMAB PRODUCTS – *UPDATED POLICY*
Nineteen new indications were added to the policy for rituximab products – all supported off-label indications. Initial and reauthorization criteria were updated to include appropriate dosing requirements and hepatitis B screening.

EVH_CG_5106.CC RYONCIL (REMESTEMCEL-L-RKND) – *NEW POLICY*
The purpose of this policy is to define the prior authorization process for Ryoncil (remestemcel-L-rknd).

EVH_CG_5071.CC SAPHNELO (ANIFROLUMAB-FNIA) – *UPDATED POLICY*
Criteria added to ensure requested dosing matches the FDA approved package insert.

EVH_CG_5076.CC TEZPIRE (TEZEPELUMAB) – *UPDATED POLICY*
Added the new FDA-approved indication of Chronic Rhinosinusitis with Nasal Polyps (CRSwNP).

EVH_CG_5063.CC TEPEZZA (TEPROTUMUMAB-TRBW) – *NEW POLICY*
The purpose of this policy is to define the prior authorization process for Tepezza (teprotumumab-trbw)

EVH_CG_5054.CC VYEPTI – *UPDATED POLICY*
The prerequisite requirement of Botox, beta-blockers, anticonvulsants, and tricyclic antidepressants have been removed. Additionally, criteria has been added to ensure requested dosing matches the FDA-approved package insert.