Provider Update

This update contains pertinent information about changes that will impact the Johns Hopkins HealthCare provider network.

Preauthorization Required for Selected Medical Injectables for USFHP Members

Effective Date: July 1, 2020
Line(s) of Business Affected: US Family Health Plan (USFHP)
Type of Change (Process, Material, Benefit, Site of Service): Corrected preauthorization requirement
Explanation of Change(s):
On March 1, 2020, USFHP implemented a new medical necessity preauthorization requirement for the following codes (listed in the next section) pertaining to physician-administered medical injectables in outpatient and office settings [Provider Update: PRUP81-JCodes Preauth-USFHP-(1/2020)]. On July 1, 2020, the places of service subject to the preauthorization requirement are being corrected to apply to all settings except Inpatient, Urgent Care, and Emergency.

In addition to medical necessity, some of the services will also be subject to site-of-service requirements. As such, if those services are performed in the outpatient hospital setting (Place of Service 22), the reasoning must also meet medical necessity.

Affected Codes:

J0129	J0178*	J0202	J0490	J0517*	J0717	J0800*	J1459	J1555	J1556
J1557	J1559	J1561	J1566	J1568	J1569	J1572	J1575	J1599	J1602
J1628	J1745	J2182*	J2323	J2350	J2357*	J2505*	J2778*	J2796*	J3031*
J3111	J3245	J3316*	J3358	J3380	J3398*	J7318	J7320	J7321	J7322*
J7323	J7324	J7325	J7326	J7327	J7328	J7329	J7331	J7332	J9226*
Q5103	Q5104	Q5108*	Q5109	Q5111*					

* Not subject to site of care requirement

The following is a list of preferred biosimilar drugs. Use of preferred biosimilar product prior to the use of non-preferred product is required. Please note that preferred biosimilar drugs are subject to prior authorization.

Non-Preferred Medical Injection Drug	Preferred Biosimilar
J1745	Q5104
J2505	Q5108 & Q5111

Prior Authorization Process
For prior authorization requests, submit the Medical Injectable Prior Authorization form along with clinical supporting documentation via fax to 410-424-2801.

NOTE: A complete list of the HCPCS Codes for all specialty medications that require prior authorization is available on our website.

Please contact the JHHC Provider Relations department at 888-895-4998 with any questions or concerns.

Johns Hopkins HealthCare Medical Injectable Prior Authorization Request Form *For USFHP*

For Internal Use Only
PA#:
Date Entered:

1. **Download a copy of this form on our website at: jhhc.com > For Providers > Resources & Guidelines > Forms.**
2. **Complete all requested information. *Incomplete form and lack of supporting progress notes may result in delay.***
3. **Fax completed form and supporting notes to Pharmacy Review Fax: 410-424-2801.**
   For questions, call: 1-888-819-1043, option 4.

Member Info (Please Print Legibly)			
NAME:		HEIGHT:	WEIGHT:
DOB:	SEX: ☐ Male ☐ Female	MEMBER ID:	RECEPIENT ID:
Prescriber Information			
NAME:		PROVIDER NPI:	
OFFICE CONTACT:		TAX ID:	
PHONE:		FAX:	
Billing Info [Outpatient | Office | Infusion Center]: ☐ ***Check if same as Prescriber Information***			
NAME:		ADDRESS:	
CONTACT:		PHONE:	FAX:
NPI:		TAX ID:	

Place of Service:
☐ **Freestanding Outpatient Infusion Center (POS Code 24)** ☐ **Office (POS 11)** ☐ **Patient's Home (POS 12)**
☐ **Outpatient (POS 19, 22)*** **Maryland hospital or regulated setting*

Drug Code (Medication requested):			
Drug Name	**HCPCS Billing Code**	**Dosage/Frequency (SIG)**	**Tx Duration (Months)**
Dates of Service:		***Number of Administrations Per Month:***	
ICD-10 Diagnosis Code(s):		***Drug Administration CPT Code(s):***	

Previous Therapy and Outcomes **Attach supporting progress notes–failure to attach may result in delay*	
Provider/Facility will supply (buy and bill) medication:	☐ **Yes** ☐ **No**

Attestations required for prior authorization review:

☐ Supporting progress notes/clinical documentation are attached.

☐ I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: _____ **Date:** _____

For Internal Use Only		
☐ Approved ☐ Denied ☐ Incomplete/Other		Duration of Approval: month(s)
Decision By:	Date Decision Rendered:	Dosage Approved: