Healthy DC-Basic Health Plan

MEDSTAR FAMILY CHOICE DISTRICT OF COLUMBIA QUICK AUTHORIZATION GUIDE Effective 08/06/2026	MEDSTAR FAMILY CHOICE Basic Health Plan
Authorization is subject to quantity limits base on the DC Fee Schedule	
ALL OUT-OF-NETWORK/ NON-PAR SERVICE	Not Covered unless it is an emergency
Emergency Medical Conditions (ED)	**NO** Prior Authorization Required
INPATIENT ADMISSIONS (Concurrent Reviews & Elective Procedures) **(In Network and Out of Network)**	**Prior Authorization Required**
INPATIENT ADMISSIONS for Psychiatric diagnoses **OUTPATIENT RESIDENTIAL TREATMENT for Substance Use diagnosis** **(In Network and Out of Network)**	**Prior Authorization Required**
OUTPATIENT In-Network **(Practitioner AND Facility)** **Facility based procedures (includes outpatient Chemotherapy and Radiation Therapy)**	**NO** Prior Authorization Required, unless included below under the 'Exceptions Requiring Prior Authorization' section (See **EXCEPTIONS** below)
EXCEPTIONS REQUIRING PRIOR AUTHORIZATION	
ABA Services	**Not a Covered Benefit**
Abortions	Elective Therapeutic Abortions are **NOT A COVERED BENEFIT by MFC-DC.** **Prior Authorization Required f**or Medical Abortions ONLY if the Federal Criteria are met
Acupuncture for Children < 21 years old	**Not a Covered Benefit**
Acupuncture for Enrollees ≥21 years old	**Not a Covered Benefit**
Audiology Services **Cochlear Implants**	**Hearing Aids are not covered.** **Prior Authorization Required** for:
Bariatric Surgery Program - Including OP Surgeries	**Prior Authorization Required**
Cardiac Rehabilitation	**Prior Authorization Required**
Chiropractic Services for Enrollees <21 years old	NOT A COVERED BENEFIT
Chiropractic Services (Services provided by a Chiropractor to include PT) for Enrollees ≥21 years old	NOT A COVERED BENEFIT
Clinical Trials	**Prior Authorization Required**
Continuous Glucose Monitors (CGM) **Insulin Pumps** DEXCOM FREESTYLE LIBRE	**Not a Covered Benefit**

Cosmetic procedures	**NOT A COVERED BENEFIT:** Examples of cosmetic procedures include (but not limited to): -Breast reduction (male or female) -Blepharoplasty -Brow ptosis -Rhinoplasty -Sclerotherapy -Septoplasty -Skin tag removal -Panniculectomy
Coumadin Clinics	**Not a Covered Benefit**
Diabetes and Nutritional Counseling	**Prior Authorization Required** after > THREE (3) visits ***per Calendar Year*** (Office, Homecare or Hospital Based services)
Early Intervention (EI) Services	**Not a Covered Benefit**
Epidural injections (cervical and lumbar) **Facet blocks** **Rhizotomies** **SI Joint**	**NO** Prior Authorization Required
Erectile Dysfunction Procedures	**Prior Authorization Required**
Eye procedures and surgeries	**Prior Authorization Required** for: -Blepharoplasty; -Capsulotomy; -Corneal relaxing incision for correction of surgically induced astigmatism; -Corneal wedge resection for correction of surgically induced astigmatism; -Destruction of lesion of lid margin; -Ectropion repair; -Entropion repair; -Eyelid lesion excision or reconstruction; -Implantation of Intraocular devices; -Insertion of intraocular lens prosthesis (secondary implant) not associated with concurrent cataract removal; -Keratoplasty, -Orbital Prosthesis; -Ptosis repair; -Radial keratotomy; -Strabismus repair; **** Some eye procedure may be found under the Cosmetic Procedures ****
Fertility Treatment	**Prior Authorization Required - required benefit for BHP**
Genetic Counseling	**Not a Covered Benefit**
Genetic Testing	**Prior Authorization Required**
Gender Reassignment Surgery/Transgender Surgery	**Prior Authorization Required**
Heart Failure Clinics	**Prior Authorization Required**
Home Health Care	**Prior Authorization Required for all visits** **PDN is not a covered benefit**
Home Infusion Services **(in the Home and Free-Standing Facility)**	**NO** Prior Authorization Required **from In-Network provider** (for the Home Infusion Therapy or Medications)
Hospice Care (IP and OP) **Skilled Nursing Facility** **Acute Rehab Facility**	**Prior Authorization Required** **Custodial Care is not a covered benefit**
Hyperbaric Oxygen	**Prior Authorization Required**
Investigational Surgery **Emerging Technology, Services, Procedures** **(Also See Clinical Trials)**	**Prior Authorization Required**
Laboratory Services **(includes Genetic Testing)**	**NO** Prior Authorization Required if done at an in-network freestanding lab facility.

Medications - High Cost Med List	Prior authorization required whether being administered inpatient or outpatient for the following medications:			
	Abecma Q2055 Actimmune J9216 Adcetris J9042 Alhemo J3590 Altuviio J7214 Amondys 45 J1426 Andembry J3590 Anktiva J9028 Aqneursa J8499 Benefix J7195 Breyanzi Q2054 Bylvay J8499 Carvykti Q2056 Cholbam J8499 Cinryze J0598 Ctexli J8499 Danyelza J9348 Daybue J8499 Duvyzat J8499 Elevidys J1413 Eloctate J7205 Empaveli J7799 Encelto J3403 Evkeeza J1305	Fabhalta J8499 Filsuvez J3490 Gattex J3490 Givlaari J0223 Haegarda J0599 Hemgenix J1411 Hemlibra J7170 Hympavzi J7172 Jivi J7208 Joenja J8499 Juxtapid J8499 Kanuma J2840 Kimmtrak J9274 Krystexxa JJ2507 Lamzede J0217 Livmarli J8499 Miplyffa J8499 Myalept J3490 Nexviazyme J0219 Norovseven J7189 Nulibry J3490	Olpruva J8499 Omisirge J3590 Orladeyo J8499 Oxlumo J0224 Pombiliti ATGA J1203 Procysbi J8499 Qfitlia J7174 Ravicti J8499 Rethymic J3590 Revcovi J3590 Rivfloza J3490 Roctavian J1412 Rynocil J3402 Ryplazim J2998 Scemblix J8999 Sohonos J8499 Soliris J1299 Spinraza J2326 Strensiq J3490	Takhzyro J0593 Tryngolza J3490 Veopoz J9376 Viltepso J1427 Vimizim J1322 Vyjuvek J3401 Vykat XR J8499 Vyondys J1429 Vyvgart Hytrulo J9334 Wainua J3490 Xenopozyme J0218 Xolremdi J8499 Xyntha J7185 Yescarta Q2041 Zokinvy J8499 Zolgensma J3399
Medical Drug Formulary	**The following drugs require prior authorization**			
	Chemical Name (Drug Class)	**HCPCS**	**Preferred Products**	**Non-Preferred Products**
	Aflibercept (VEGF Inhibitor)	Q5147	Pavblu	Eylea J0178
	Bevacizumab (VEGF Inhibitor)	Q5118	Zirabev	Avastin J9035 Mvasi Q5107 Vegzelma Q5129
	Infliximab (TNF inhibitor)	Q5121	Avsola	Remicade J1745 Renflexis Q5104 Inflectra Q5103
	Pegfilgrastim (Hematopoietic agent)	Q5108	Fulphila	NeulastaJ2506 Fylnetra Q5130 Nyvepria Q5122 Stimufend Q5127 Udenyca Q5111
	Ranibizumab (VEGF Inhibitor)	Q5128	Cimerli	Lucentis J2778 Byooviz Q5124
	Rituximab (Anti-CD20 monoclonal antibody)	Q5123 Q5119	Riabni Ruxience	Rituxan J9312 Truxima Q5115
	Tocilizumab (IL-6 antagonist)	Q5135	Tyenne	Actemra J3262 Tofidence Q5133
	Trastuzumab (HER2 receptor antagonist)	Q5114 Q5113	Ogivri Herzuma	Herceptin J9355 Kanjinti Q5117 Ontruzant Q5112 Trazimera Q5116
	Denosumab (RANKL inhibitor)	Q5136 Q5157	Jubbonti/Wyost Stoboclo/Osenvelt	Prolia/Xgeva J0897

	Ustekinumab (IL-23 inhibitor)	Q5100 Q5099	Yesintek Steqeyma	Stelara J3357, AJ3358 Otulfi Q9999 Selarsdi Q9998 Wezlana Q5137 Pyzchiva Q9996, Q9997
Medical Drug Buy and Bill	The following J codes require prior authorization:			
	C9047-Cablivi (caplacizumab)	J2323-Natalizumab(Tysabri)	J7171-Adzynma (ADAMTS13)	J9264-Paclitaxelprotein-bound(Abraxane)
	C9399-Lenmeldy (atidarsagene autotemce	J2327-Ustekinumab(Stelara)	J7208-Jivi(factor VIII, recombinant human pegylate	J9271-Pembrolizumab(Keytruda)
	C9399-Ojemda (tovorafenib)	J2350-Ocrelizumab(Ocrevus)	J8499-Chenodal (chenodiol)	J9272-Nivolumab+relatlimab(Opdualag)
	C9399-Rydapt (midostaurin)	J2353-Octreotide(SandostatinLAR)	J8499-mifepristone (Korlym)	J9273-Tivdak (tisotumab vedotin)
	C9399-Zilbrysq (zilucoplan)	J2506-Pegfilgrastim(Neulasta andbiosimil	J8499-Orfadin (nitisinone)	J9286-Columvi (glofitamab)
	J0177-Aflibercept(Eylea)	J2508-Elfabrio (pegunigalsidase alfa-iwxj)	J8999-Cabometyx (cabozantinib)	J9298-Nivolumab(Opdivo)
	J0178-Faricimab(Vabysmo)	J2802-Sutimlimab(Enjaymo)	J8999-Ogsiveo (nirogacestat)	J9299-Nivolumab(Opdivo,alternativebillingunit)
	J0218-Xenopozyme (olipudase alfa-rpcp)	J3032-Eptinezumab(Vyepti)	J9021-Atezolizumab(Tecentriq)	J9303-Panitumumab(Vectibix)
	J0218-Xenpozyme (olipudase alfa-rpcp)	J3055-Talvey (talquetamab)	J9022-Ado-trastuzumabemtansine(Kadcyla)	J9308-Ramucirumab(Cyramza)
	J0220-Lumizyme (alglucosidase alfa)	J3241-Tepezza (teprotumumab)	J9029-Adstiladrin (darbepoetin alfa)	J9312-Rituximab(Rituxan andbiosimilars)
	J0222-Onpattro (patisiran)	J3262-Tocilizumab(Actemra)	J9033-Bendamustine(Bendeka,Treanda)	J9316-Rituximab+hyaluronidase(RituxanHycela)
	J0225-Amvuttra (vutrisiran)	J3357-Stelara (Ustekinumab)	J9035-Bevacizumab(Avastin)	J9317-Sacituzumabgovitecan(Trodelvy)
	J0490-Belimumab(Benlysta)	J3358-Stelara (Ustekinumab)	J9039-Blinatumomab(Blincyto)	J9321-Axicabtageneciloleucel(Yescarta)
	J0567-Brineura (cerliponase alpha)	J3380-Vedolizumab(Entyvio)	J9039-Blincyto (blinatumomab)	J9321-Epkinly (epcoritamab-bysp)
	J0584 -Crysvita (burosumab)	J3394-Lyfgenia (lovotibeglogene autoemc	J9042-Brentuximabvedotin(Adcetris)	J9329-Tevimbra (tislelizumab)
	J0585-OnabotulinumtoxinA(Botox)	J3397-Mepsevii (vestronidase alpha)	J9047-Carfilzomib(Kyprolis)	J9331-Fyarro (nanoparticle albumin bound sirolimus)
	J0741-Anakinra(Kineret)	J3398-Luxturna (voretigene neparvovec)	J9061-Cisplatin	J9333-Rystiggo (rozanolixizumab)
	J0881-Darbepoetinalfa(Aranesp)	J3490-Lenmeldy (atidarsagene autotemce	J9063-Elahere (mirvetuximab)	J9347-Tafasitamab(Monjuvi)
	J0896-Luspatercept(Reblozyl)	J3490-Ojemda (tovorafenib)	J9119-Cemiplimab(Libtayo)	J9350-Lunsumio (mosunetuzumab)
	J0897-Denosumab(Prolia,Xgeva)	J3490-Orserdu (elacestrant)	J9144-Daratumumabhyaluronidase(DarzalexFaspro	J9352-Trastuzumab(Herceptin andbiosimilars)
	J1303-Ultomiris (ravulizumab)	J3490-Rydapt (midostaurin)	J9173-Durvalumab(Imfinzi)	J9354-Ado-trastuzumabemtansine(Kadcyla)
	J1323-Elrexfro (elranatamab)	J3490-Zilbrysq (zilucoplan)	J9177-Enfortumabvedotin(Padcev)	J9356-Herceptin Hylecta
	J1428-Exondys 51 (eteplirsen)	J3590-Amtagvi (lifileucel)	J9202-Goserelin(Zoladex)	J9358-Fam-trastuzumabderuxtecan(Enhertu)
	J1459-Immuneglobulin(IVIG),e.g.,Privigen	J3590-Casgevy (exagamglogene autolemc	J9204-Poteligeo (mogamulizumab)	J9359-Zynlonta (loncastuximab tesirine-lpyl)
	J1561-Immuneglobulin(IVIG),e.g.,Gamune	J3590-Enspryng (satralilzumab)	J9223-Leuprolideacetate(LupronDepot)	J9380-Tecvayli (teclistamab)
	J1743-Elaprase (Idursulfase)	J3590-Kebilidi (eladocagene exuparvovec	J9228-Ipilimumab(Yervoy)	J9381-Tzield (teplizumab)
	J1745-Infliximab(Remicade andbiosimilars	J3590-Lenmeldy (atidarsagene autotemce	J9228-Yervoy (ipilimumab)	J9999-Orserdu (elacestrant)
	J1786-Cerezyme (imiglucerase/ glucocereb	J3590-Skysona (elivaldogene autotemcel)	J92329-Briumvi	J9999-Unituxin (dinutuximab)
	J1823-Uplizna (inebilizumab-cdo)	J3590-Zilbrysq (zilucoplan)	J9261-Gemcitabine(Gemzar)	
	J2170-Increlex (mecasermin)	J3590-Zynteglo (betibeglogene autotemcel)		
Mount Washington Pediatric Hospital Services (Weight Smart Program/Outpatient Feeding Program and Sleep Studies)	**Not a Covered Benefit**			

Neuropsychological Testing	**Prior Authorization Required**
Outpatient Rehabilitation Services **Physical Therapy (PT)** **Occupational Therapy (OT)** **Speech Language Pathology (SLP)**	**Prior Authorization Required** after >30 visits ***per calendar year***
Personal Care Aide (PCA)	**Not a Covered Benefit**
PET Scans	The following PET/PET CT codes require Prior Authorization: 78811, 78812, 78813, 78814, 78815, 78816, 78451, 78452, 78459, 78491, and 78492.
Psychiatric Diagnostic Evaluation	**NO Prior Authorization required.**
Private Duty Nursing	**Not a Covered Benefit**
Pulmonary Rehabilitation	**Prior Authorization Required**
Radiology: CT Scans, MRI's, X-RAYS, Nuclear Medicine, Sonograms, Digital Mammography	The following Advanced Imaging services/codes requires Prior Authorization: Breast Imaging: 77049 Cardiac Imaging: 75561, 75571, 75572, 75574 CT/CTA:70450, 70460, 70470, 70486, 70491, 70496, 70498, 71250, 71260, 71275, 72125, 72128, 72131, 73200, 73700, 74150, 74160, 74174, 74176, 74177, 74178 MRI/MRA: 70543, 70544, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 72141, 72146, 72148, 72156, 72157, 72158, 72192, 72195, 72197, 73218, 73220, 73221, 73222, 73223, 73718, 73720, 73721, 73723, 74181, 74183 Nuclear Cardiology: 78451, 78452, 78459, 78491, 78492 PET/PET CT: 78811, 78812, 78813, 78814, 78815, 78816 All other Radiology services and codes No Prior Authorization required if performed at participating free standing radiology facilities or a contracted hospital.
Sleep Studies and Polysomnograms	**NO** Prior Authorization Required if performed at a participating free-standing facilities, at a contracted hospital, Home.
Spinal Cord Stimulators, Vagus Nerve Stimulators and Sacral Nerve and Peripheral Nerve Stimulators trial and implantation	**Prior Authorization Required**
Sterilization Reversals	NOT A COVERED BENEFIT
Transplant Services: Pre-Transplant and Post-Transplant services Only	**Prior Authorization Required**
Transplant Surgery	**Prior Authorization Required**
Transportation: **- Ambulance** **- Van Transport** **- Wheelchair**	**Non Emergent Transporation is not covered** **NO** Prior Authorization Required for: - PAR Vendors - DC Fire and Emergency Medical Services (DC FEMS); and - Emergent/Urgent hospital to hospital transfers
Viscosupplementation for Knee Osteoarthritis	The following drugs require prior authorization. Durolane J7318 Gel-One J7326 Eufflexa J7323
DME: **PAR providers - Prior authorization required for items billed > $1000 or rental equipment over 90 days.** **Non PAR providers - Prior authorization required regardless of cost.**	*Visit website or contact Enrollee Services (1-**888-404-3549**) for in-network providers.

Custom Shoes **Diabetic Shoes** **Orthotics (**Braces, Splints) **Prosthetics**	Prior Authorization Required per item billed over $500 or exceeds Max Units for PAR provider. No Prior Authorization Required for CAM Walking Boots. The specific codes are: **L4360, L4361, L4386, L4387**
Hearing Aids **Cochlear Implants** **Auditory Osseointegrated Devices**	Prior Authorization Required for: **- All Hearing Aids (not a covered service)** - All auditory osseointegrated devices (BAHA) - Cochlear implant devices and replacement components (except microphone, transmitting cables and transmitting coils) **- Repair and replacement of any hearing devices, not covered for hearing aids**
Soft supplies and disposable items: **Includes enteral/parenteral (feeding) supplies, batteries, ear molds, components for hearing aids, cochlear implant or auditory osseointegrated devices, Ostomy Supplies, Catheters**	Prior Authorization Required per item billed over $750, per Enrollee/per provider/per month for PAR providers. *Visit our website or contact Enrollee Services (1-888-404-3549) for In-Network providers.

***Please visit our website at MedStarFamilyChoiceDC.com for assistance with finding in network vendors, physicians or facilities.**

***** This is a Quick Authorization Guide.**
It is not meant to be all inclusive.
For questions, please contact MFC-DC at: 1-(855)-798-4244;
Local: (202)-363-4348

The codes and guidance in this document is subject to Enrollee eligibility and the existence of coverage per the DC Medicaid Fee Schedule on the date of service.