Notice: Prior Authorization Updates

Humana P&T Prior Authorization Updates

Humana is required to communicate certain Utilization Management and Prior Authorization Updates prior to their effective date. The below information includes these changes.

Disclaimer: These changes must be approved by the Humana Pharmacy & Therapeutics (P&T) Committee on 01/18/2023 and the below information may be altered at that time. For final P&T Policies please refer to the published individual policy by searching for the Policy Title listed below. This information was posted on 01/25/2023.

Prior Authorization Updates							
Policy Title	Policy Type	Summary of Changes					
		Policy Archived[1]	Diagnosis Criteria Change[2]	Previous Treatment Change[3]	Age Change[4]	Coverage Limitation Change[5]	Expanded Indication[6]
Cosentyx (secukinumab)	Prior Authorization			X			
Inflectra (infliximab-dyyb)	Prior Authorization			X			
Orencia IV (abatacept)	Prior Authorization			X			
Remicade (infliximab)	Prior Authorization			X			
Skyrizi (risankizumab-rzaa)	Prior Authorization			X			
Infliximab	Prior Authorization			X			
Imfinzi (durvalumab)	Prior Authorization						X
Elepsia XR (levetiracetam extended-release)	Prior Authorization		X				
Tascenso ODT (fingolimod)	Prior Authorization			X			X

1 – Policy is no longer necessary and product is available without Utilization Management
2 – Criteria regarding the diagnosis has been reduced (e.g. decreased need for testing for diagnosis)
3 – Criteria regarding a Step through another agent has been removed or reduced (e.g. changing previous treatment from requiring 2 agents to 1 agent)
4 – Age requirement for medication has been lowered or removed
5 – Coverage Limitations have been removed from the policy
6 – Expanded Coverage for additional indication