

Prior Authorization Guidelines

This Prior Authorization Grid reflects services that **require** prior authorization and is not intended to be a comprehensive list of covered services. Providers should refer to the appropriate Evidence of Coverage (EOC), available online at www.antidotehealth.com/provider, for a complete list of covered benefits.

Category of Service	Services Requiring Prior Authorization
Behavioral Health	<ul style="list-style-type: none"> • All Admissions for: <ul style="list-style-type: none"> • Acute Inpatient Psychiatric • Partial Hospitalization Programs (PHP) • Residential Mental Health • Substance Use Disorder, including Detoxification • Applied Behavior Analysis (ABA) Services • Electroconvulsive Therapy (ECT) • Intensive Outpatient Program (IOP) • Psychological Testing • Psycho-diagnostic Evaluation • Psychotherapy Treatment • Office-based Opioid Treatment and Withdrawal Management • Transcranial Magnetic Stimulation (rTMS) • Vagus Stimulation Treatments
Diagnostic Imaging	<ul style="list-style-type: none"> • Computerized Tomography Scans (CT) • Magnetic Resonance Angiography (MRA) • Magnetic Resonance Imaging (MRI) • Nuclear Cardiology Procedures (e.g., Stress Tests/ Treadmill) • Positron-Emission Tomography (PET/PET-CT) • Single-Photon Emission Computerized Tomography (SPECT) • Ultrasounds - Level II
Durable Medical Equipment (DME), Medical Equipment and Supplies	<ul style="list-style-type: none"> • All DME, Medical Equipment and Supplies with a cost greater than \$500.00
Experimental/Investigational Treatment, Procedures and Drugs	<ul style="list-style-type: none"> • Clinical Trials • Investigational and Experimental Drug Therapies • Experimental Procedures • New Technologies non-FDA approved for use (e.g., Robotic Surgery) • Non-FDA approved and/or off-label use
Home Health/Hospice	<ul style="list-style-type: none"> • All Home Health Services (Registered Nurse, Physical, Speech and Occupational Therapists, Home Health Aides, etc.) • Home Intravenous (IV) Infusions • Hospice Services • PT/ OT/ Speech Therapy - PA required after 12th visit

Category of Service	Services Requiring Prior Authorization
Inpatient Admissions	<ul style="list-style-type: none"> • All Elective Inpatient Admissions and Admissions via ED to: <ul style="list-style-type: none"> • Acute Care Hospitals • Long Term Acute Care Hospital (LTACH) • Extended Care Facility (ECF) • Rehabilitation and Therapy Services: <ul style="list-style-type: none"> • Acute Inpatient Rehabilitation or Acute Rehabilitation Unit (AIR/ARU) • Skilled Nursing Facilities (SNF) • Subacute Nursing Facilities
Medications	<ul style="list-style-type: none"> • Infusion Services • Injections (Excluding Immunizations) >\$250 • Non-Formulary Prescription Drugs • Physician Administered Drugs (PADS)
Non-Contracted Providers/Out of Network	<ul style="list-style-type: none"> • All Non-Urgent/Non-Emergent Medical or Behavioral Health Services rendered by Non-Contracted Providers
Outpatient Services and Procedures	<ul style="list-style-type: none"> • Acupuncture Services • All Outpatient Procedures (e.g., Amniocentesis, Nerve Conduction Studies, Varicose Vein Treatment Performed Outside of a Physician's Office, Endoscopy and Colonoscopy) • All Outpatient Surgery (e.g., Cataract Surgery, Tonsillectomy, Abdominoplasty, Panniculectomy, Breast Reduction and Augmentation Surgery) • Automated External Defibrillator (AED), Holter, Mobile Cardiac Telemetry Monitoring Services • CAR T-cell Therapy • Cardiac and Pulmonary Rehabilitation • Chemotherapy and Radiation Treatment (e.g., Brachytherapy, Neutron Beam therapy, Proton Beam Therapy, Intensity-modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT), Stereotactic radiosurgery (SRS), Gamma-ray and CyberKnife) • Chiropractic Services • Dental Surgery, Dental Anesthesiology Service, Jaw Surgery and Orthognathic Procedures • Dialysis: All hemodialysis and peritoneal, continuous ambulatory peritoneal dialysis (CAPD), automated peritoneal dialysis (APD), Continuous cycling peritoneal dialysis (CCPD). • Gender Affirming Therapy and Surgery • Genetic Testing and Counseling • Hyperbaric Oxygen Therapy • Infertility Services • Neuropsychological testing • Non-routine Laboratory, Ultrasound and Radiology Services • Outpatient Therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)) • Pain Management Services • Reconstructive Procedures

Category of Service	Services Requiring Prior Authorization
Outpatient Services and Procedures	<ul style="list-style-type: none"> • Sleep Studies • Spinal Procedures, including all Injections • Surgical Implants (e.g., Pacemaker, Baclofen Pump, Neuro and Spinal Cord Stimulators, Cochlear Auditory Implant) • Temporomandibular Disorder (TMJ) Treatment • Unclassified Procedures • Ventricular Assist Device
Post Stabilization	<ul style="list-style-type: none"> • Inpatient Admission following Stabilization of an Emergency Condition
Prescription Medications	<ul style="list-style-type: none"> • Refer to the Antidote Health Formulary available at: https://www.antidotehealth.com/insurance/formulary-info to determine which prescription medications require Prior Authorization
Therapies (Home and Inpatient)	<ul style="list-style-type: none"> • All Physiological, Occupational and Speech Therapies, including: <ul style="list-style-type: none"> • Shockwave Therapy • Vestibular Therapy • Lymphatic Therapy • Respiratory Therapy • Urogynecological Therapy • Neurophysiological • Anorectal Rehabilitation
Weight Reduction	<ul style="list-style-type: none"> • All Bariatric Surgeries and Procedures
Transplants	<ul style="list-style-type: none"> • All Transplants and Related Services
Transportation: Non-Emergency Medical Transport	<ul style="list-style-type: none"> • Non-Emergency Medical Transport (NEMT) (including Fixed-Wing Air Transport)
Other	<ul style="list-style-type: none"> • All Non-urgent/Non-emergent Services Performed outside the Service Area • All Non-covered Services • Any Service that Exceeds the Benefit Limit

Prior Authorization is **not required** for the following services:

Category of Service	Services NOT Requiring Prior Authorization
Behavioral Health	<ul style="list-style-type: none"> Behavioral Health Counseling and Therapy Services, including: <ul style="list-style-type: none"> Family Couple Group Telebehavioral Health Services
Immunizations/Vaccinations	<ul style="list-style-type: none"> Performed at an Antidote Contracted Pharmacy Information about Antidote's Contracted Pharmacy Network is located at https://ahweblinks.rxadvance.com/FormularyPublish/pharmacylocatorV2.html?state=OH
Routine Services	<ul style="list-style-type: none"> Routine Laboratory Tests, Ultrasound and X-rays Performed in Conjunction with a Service not Requiring Prior Authorization or an Authorized Specialty Care Visit
Testing	<ul style="list-style-type: none"> Fetal Non-stress Testing HIV Testing
Transportation	<ul style="list-style-type: none"> Emergency Medical Transportation
Urgent Care	<ul style="list-style-type: none"> Telehealth for Urgent Care Services
Other	<ul style="list-style-type: none"> Family Planning Services