Medicaid Prior Authorization (PA) Code Matrix for Outpatient Drug Services
March 1, 2025

To search this document, type in the keyword or code you are looking for by pressing press Ctrl F on your keyboard.
Please contact Molina at 1-855-322-4080 if you need more information about the Third-Party Proprietary Criteria referenced in this document or if information is needed in an alternate language.
Information that indicates certain items or services do not require authorization in this Prior Authorization (PA) Code Matrix document is only applicable for Participating Providers.

FOR ANY PA CHANGES DUE TO REGULATORY GUIDANCE RELATED TO COVID 19 – PLEASE SEE PROVIDER NOTIFICATIONS AND MOST CURRENT INFORMATION ON THE PROVIDER PORTAL.

Most Non-Participating Providers with the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
Prior authorization exceptions for Non-Participating Offices/Providers/Facilities:
- **Hospital Emergency Department Services;**
- **Evaluation and Management services associated with inpatient, ER visits and observation stays;**
- **Local Health Department (LHD) services**
- **Other services based on State requirements**
- **Radiologist, Anesthesiologist, and Pathologist professional services when billed in Place of Service Code 19, 21, 22, 23 or 24 (except dental anesthesia for STAR children**

All In-Patient admits and services require Prior Authorization, including: Acute Hospital, Neonatal Intensive Care Unit (NICU), Skilled Nursing Facilities (SNF), Rehabilitation, and Long-Term Acute Care (LTAC) Facilities.
The codes below are for Out-Patient services only.

Some services listed may not be covered by Medicaid. CMS or your local State Regulatory Agency determines many of the plan benefits. The absence of a code from this list does not mean that a service is a covered benefit. Refer to the Texas Medicaid Fee Schedule and Texas Medicaid Provider Procedures Manual for the most up to date plan benefit information.

Prior authorizations are not required for the following:
- **Emergency Services for Participating or Non-Participating Providers.**
- **Office visits at Participating Providers.**
- **Referrals to Participating Network Specialists.**

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost-effective setting of care.
For additional information please contact Molina Healthcare 1-855-322-4080.
Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.

Medicaid Behavioral Health and Medical Services Prior Authorization Code Matrix

TMPPM* Outpatient Drug Services

Pharmacy Services Screening Criteria Link

This document is NOT be utilized to make benefit coverage determinations. Please review the Texas Medicaid Provider Manual and Texas Medicaid Fee Schedule.

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

The prior authorization information reflected on this document is general in nature and is not intended to be relied upon in making medical decisions. The criteria listed below is generally accurate but may be different based on factors such as specific medical condition or type of provider requesting the service. Each patient will have unique medical conditions, submitted by his/her physician in a particularized manner, that will factor into documents required, criteria applied, and Molina's decision of whether to approve or deny a requested service. Please contact Molina or your doctor to get more information regarding prior authorization for any particular service.

Effective Date	Code	Definition	Criteria Utilized	Notes	Date of Annual Review
Prior to 9/1/2019	90284	IMMUNE GLOBULIN HUMAN SUBQ INFUSION 100 MG EA	TMPPM*		2/19/2025
10/1/2019	A9274	EXTERNAL AMB INSULIN DEL SYSTEM DISPOSABLE EA	TMPPM*		2/19/2025
Prior to 9/1/2019	A9542	INDIUM IN-111 IBRITUMOMAB TIUXETAN DX TO 5 MCI	TMPPM*		2/19/2025
Prior to 9/1/2019	C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS	TMPPM*		2/19/2025
Prior to 9/1/2019	E2102	ADJUNCTIVE CONTINUOUS GLUCOSE MONITOR/RECEIVER	TMPPM*	Replaces K0554 and A9278 starting 1/1/2023	2/19/2025
Prior to 9/1/2019	E2103	Non-adjunctive, non-implanted continuous glucose monitor or receiver.	TMPPM*	Replaces K0554 and A9278 starting 1/1/2023	2/19/2025
Prior to 9/1/2019	J0121	INJECTION OMADACYCLINE 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J0129	INJ ABATACEPT 10 MG USED MEDICARE ADM SUPV PHYS	TMPPM*		2/19/2025
10/1/2023	J0174	Leqembi (Lecanemab-irmb)	TMPPM*		2/19/2025
1/1/2025	J0175	Kisunla (Donanemab-azbt)	TMPPM*		2/19/2025
4/1/2021	J0180	Agalsidase beta	TMPPM*		2/19/2025
5/1/2024	J0217	Velmanase alfa-tycv (Lamzede)	TMPPM*		2/19/2025
5/1/2023	J0218	Xenpozyme (olipudase alfa-rpcp)	TMPPM*		2/19/2025

6/1/2022	J0219	Avalglucosidase Alfa-ngpt (Nexviazyme)	TMPPM*		2/19/2025
Prior to 9/1/2019	J0220	INJECTION ALGLUCOSIDASE ALFA 10 MG NOS	TMPPM*		2/19/2025
Prior to 9/1/2019	J0221	INJECTION ALGLUCOSIDASE ALFA LUMIZYME 10 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J0222	INJECTION PATISIRAN 0.1 MG	TMPPM*		2/19/2025
2/1/2023	J0225	Amvuttra (vutrisiran)	TMPPM*		2/19/2025
Prior to 9/1/2019	J0490	INJECTION BELIMUMAB 10 MG	TMPPM*		2/19/2025
2/1/2023	J0491	Anifrolumab-fnia (Saphnelo™)	TMPPM*		2/19/2025
Prior to 9/1/2019	J0517	INJECTION BENRALIZUMAB 1 MG	TMPPM*		2/19/2025
3/01/2025	J0567	Cerliponase alfa (Brineura)	TMPPM*		
Prior to 9/1/2019	J0584	INJECTION BUROSUMAB-TWZA 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J0585	BOTULINUM TOXIN TYPE A PER UNIT	TMPPM*		2/19/2025
Prior to 9/1/2019	J0586	INJECTION ABOBOTULINUMTOXINA 5 UNITS	TMPPM*		2/19/2025
Prior to 9/1/2019	J0587	INJECTION RIMABOTULINUMTOXINB 100 UNITS	TMPPM*		2/19/2025
Prior to 9/1/2019	J0588	INJECTION INCOBOTULINUMTOXIN A 1 UNIT	TMPPM*		2/19/2025
2/01/2025	J0589	DaxibotulinumtoxinAlanm (Daxxify brand toxin type A)	TMPPM*		2/19/2025
Prior to 9/1/2019	J0695	INJECTION CEFTOLOZANE 50 MG AND TAZOBACTAM 25 MG	TMPPM*		2/19/2025
4/1/2020	J0712	Injection, ceftaroline fosamil, 10 mg	TMPPM*		2/19/2025
Prior to 9/1/2019	J0714	INJECTION CEFTAZIDIME AND AVIBACTAM 0.5 G 0.125 G	TMPPM*		2/19/2025
7/1/2020	J0791	INJECTION, CRIZANLIZUMAB-TMCA, 5 MG	TMPPM*		2/19/2025

2/01/2025	J0870	RYTELO (imetelstat)	TMPPM*		2/19/2025
3/1/2024	J0881	INJECTION DARBEPOETIN ALFA 1 MCG NON-ESRD	TMPPM*		2/19/2025
Prior to 9/1/2019	J0885	INJECTION EPOETIN ALFA FOR NON-ESRD 1000 UNITS	TMPPM*		2/19/2025
Prior to 9/1/2019	J0888	INJECTION EPOETIN BETA 1 MICROGRAM	TMPPM*		2/19/2025
1/1/2021	J0896	INJECTION, LUPATERCEPT-AAMT, 0.25 MG	TMPPM*		2/19/2025
5/1/2024	J1203	CIPAGLUCOSIDASE ALFA_ATGA (POMBILITI)	TMPPM*		2/19/2025
Prior to 9/1/2019	J1301	INJECTION EDARAVONE 1 MG	TMPPM*		2/19/2025
2/1/2024	J1304	Tofersen (Qalsody)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
11/1/2023	J1411	Etranacogene dezaparvovec-drlb (Hemgenix)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
1/1/2024	J1412	Valoctocogene roxaparvovec-rvox (Roctavian)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
1/1/2024	J1413	Delandistrogene moxeparvovec-rokl (Elevidys)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
2/1/2023	J1426	Antisense oligonucleotides, casimersen (Amondys 45)	TMPPM*		2/19/2025
7/1/2021	J1427	INJECTION, VILTOLARSEN, 10 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1428	INJECTION ETEPLIRSEN 10 MG	TMPPM*		2/19/2025
1/1/2021	J1429	INJECTION, GOLODIRSEN, 10 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1458	INJECTION GALSULFASE 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1459	INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1460	INJECTION GAMMA GLOBULIN INTRAMUSCULAR 1 CC	TMPPM*		2/19/2025

7/1/2021	J1554	INJECTION IMMUNE GLOBULIN (ASCENIV), 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1555	INJECTION IMMUNE GLOBULIN 100 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1556	INJECTION IMMUNE GLOBULIN BIVIGAM 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1557	INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1559	INJECTION IMMUNE GLOBULIN HIZENTRA 100 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1566	INJ IG IV LYPHILIZED NOT OTHERWISE SPEC 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1568	INJ IG OCTOGAM IV NONLYOPHILIZED 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1569	INJ IG GAMMAGARD LIQ IV NONLYOPHILIZED 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1572	INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1575	INJ IMMUNE GLOBULIN HYALURONIDASE 100 MG IG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1599	INJ IG IV NONLYOPHILIZED E.G. LIQUID NOS 500 MG	TMPPM*		2/19/2025
10/1/2020	J1632	INJECTION, BREXANOLONE, 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1743	INJECTION IDURSULFASE 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1746	INJECTION IBALIZUMAB-UIYK 10 MG	TMPPM*		2/19/2025
1/1/2021	J1823	INJECTION, INEBILIZUMAB-CDON, 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1826	INJECTION INTERFERON BETA-1A 30 MCG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1830	INJECTION INTERFERON BETA-1B 0.25 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J1950	INJECTION LEUPROLIDE ACETATE PER 3.75 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J2182	INJECTION MEPOLIZUMAB 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J2186	INJECTION MEROPENEM VABORBACTAM 10 MG 10 MG	TMPPM*		2/19/2025

Prior to 9/1/2019	J2326	INJECTION NUSINERSEN 0.1 MG	TMPPM*		2/19/2025
7/1/2022	J2356	TEZSPIRE (TEZEPELUMAB-EKKO)	TMPPM*		2/19/2025
Prior to 9/1/2019	J2357	INJECTION OMALIZUMAB 5 MG	TMPPM*		2/19/2025
4/1/2020	J2407	ORITAVANCIN, 10MG	TMPPM*		2/19/2025
5/1/2024	J2508	PEGUNIGALSIDASE ALFA_IWXJ (ELFABRIO)	TMPPM*		2/19/2025
5/1/2024	J2724	PROTEIN C CONCENTRATE, HUMAN, (CEPROTIN)	TMPPM*		2/19/2025
4/1/2020	J2770	Injection, quinupristin/dalfopristin, 500 mg (150/350)	TMPPM*		2/19/2025
Prior to 9/1/2019	J2786	INJECTION RESLIZUMAB 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J2787	RIBOFLAVIN 5'-PHOSPHATE OPHTHALMIC SOL TO 3 ML	TMPPM*		2/19/2025
Prior to 9/1/2019	J2820	INJECTION SARGRAMOSTIM 50 MCG	TMPPM*		2/19/2025
Prior to 9/1/2019	J3090	INJECTION TEDIZOLID PHOSPHATE 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J3095	INJECTION TELAVANCIN 10 MG	TMPPM*		2/19/2025
10/1/2020	J3241	INJECTION, TEPROTUMUMAB-TRBW, 10MG	TMPPM*		2/19/2025
2/1/2025	J3392	Exagamglogene autotemcel (Casgevy)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
7/1/2024	J3393	Betibeglogene Autotemcel (Zynteglo)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
7/1/2024	J3394	Lovotibeglogene autotemcel (Lyfgenia)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
Prior to 9/1/2019	J3397	INJECTION VESTRONIDASE ALFA-VJBK 1 MG	TMPPM*		2/19/2025
2/1/2023	J3399	Onasemnogene abeparvovec-xioi (Zolgensma)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025

1/1/2024	J3401	Beremagene geperpavec-svdt (Vyjuvek)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
Prior to 9/1/2019	J3490	UNCLASSIFIED DRUGS	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
Prior to 9/1/2019	J3590	UNCLASSIFIED BIOLOGICS	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
Prior to 9/1/2019	J3591	UNCLASS RX BIOLOGICAL USED FOR ESRD ON DIALYSIS	TMPPM*		2/19/2025
5/1/2024	J7171	APADAMTASE ALFA (ADZYNMA)	TMPPM*	Replaces C9167 starting 7/1/2024	2/19/2025
Prior to 9/1/2019	J7311	FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT	TMPPM*		2/19/2025
Prior to 9/1/2019	J7504	LYMPHCYT IMMUN GLOB EQUINE PARENTERAL 250 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J7511	LYMPHCYT IMMUN GLOB RABBIT PARENTERAL 25 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J8499	PRESCRIPTION DRUG ORAL NONCHEMOTHERAPEUTIC NOS	TMPPM*		2/19/2025
Prior to 9/1/2019	J8999	PRESCRIPTION DRUG ORAL CHEMOTHERAPEUTIC NOS	TMPPM*		2/19/2025
11/1/2024	J9026	Imdelltra (Tarlatamab-dlle)	TMPPM*	Replaces C9170 starting 2/1/2025	2/19/2025
11/1/2024	J9028	Anktiva (Nogapendekin Alfa Inbakicept-pmln)	TMPPM*	Replaces C9169 starting 2/1/2025	2/19/2025
Prior to 9/1/2019	J9204	INJECTION MOGAMULIZUMAB-KPKC 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J9210	INJECTION EMAPALUMAB-LZSG 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J9214	INJECTION INTERFERON ALFA-2B RECOMBINANT 1 M U	TMPPM*		2/19/2025
Prior to 9/1/2019	J9216	INJECTION INTERFERON GAMMA-1B 3 MILLION UNITS	TMPPM*		2/19/2025
Prior to 9/1/2019	J9218	LEUPROLIDE ACETATE PER 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J9229	INJECTION INOTUZUMAB OZOGAMICIN 0.1 MG	TMPPM*		2/19/2025

Prior to 9/1/2019	J9269	INJECTION TAGRAXOFUSP-ERZS 10 MCG	TMPPM*		2/19/2025
Prior to 9/1/2019	J9313	INJECTION MOXETUMOMAB PASUDOTOX-TDFK 0.01 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	J9355	INJECTION TRASTUZUMAB EXCLUDES BIOSIMILAR 10 MG	TMPPM*		2/19/2025
8/1/2023	J9381	Teplizumab-mzwv (Tzield)	TMPPM*		2/19/2025
Prior to 9/1/2019	J9999	NOT OTHERWISE CLASSIFIED ANTINEOPLASTIC DRUG	TMPPM*	Bevacizumab when billed for intraocular injection does not require a PA	2/19/2025
11/1/2023	Q2041	Axicabtagene ciloleucel (Yescarta)	TMPPM*		2/19/2025
9/1/2022	Q2042	Kymriah	TMPPM*		2/19/2025
6/1/2022	Q2053	Brexucabtagene Autoleucel (TECARTUS)	TMPPM*		2/19/2025
8/1/2024	Q2054	Lisocabtagene maraleucel (Breyanzi)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
4/01/2025	Q2057	Afamitresgene autoleucel (Tecelra)	TMPPM*	Prior authorization requests for codes used for **gene therapy** to be faxed to 866-420-3639	2/19/2025
9/1/2024	Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)	TMPPM*		2/19/2025
Prior to 9/1/2019	Q3027	INJECTION INTERFERON BETA-1A 1 MCG IM USE	TMPPM*		2/19/2025
Prior to 9/1/2019	Q3028	INJECTION INTERFERON BETA-1A 1 MCG SUBQ USE	TMPPM*		2/19/2025
11/1/2023	Q5130	Pegfilgrastim pbbk (Fylnetra)	TMPPM*		2/19/2025
1/1/2021	S0013	ESKETAMINE, NASAL SPRAY, 1 MG	TMPPM*		2/19/2025
Prior to 9/1/2019	S0122	INJECTION MENOTROPINS 75 IU	TMPPM*		2/19/2025
1/1/2021	S0145	INJECTION, PEGASYS, PEGYLATED INTERFERON ALFA-2A, 180 MCG per ml	TMPPM*		2/19/2025

*Texas Medicaid Provider Procedure Manual

** Codes may require age and/or diagnosis per the Texas Medicaid Provider Procedure Manual (TMPPM). **

Documentation Requirements:

• Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;
• History of the presenting problem
• Clinical exam;
• Pertinent diagnostic testing results, operative and/or pathological reports;
• Treatment plan and progress notes;
• Pertinent psychosocial history;
• Information and consultations with the treating practitioner;
• Pertinent evaluations from other health care practitioners and providers;
• Pertinent charts, graphs or photographic information, as appropriate;
• Rehabilitation evaluations;
• Information regarding the local delivery system; and
• Patient characteristics and information.