PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **November 13, 2026**

Subject: **Approved Medical Drug Policies**

Summary: **Approved Medical Drug Policies**

AmeriHealth Caritas Louisiana would like to inform you of four updated medical drug policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guidelines are effective **December 15, 2026**, and will be located at the following link on our website under Pharmacy Prior Authorization Criteria: https://www.amerihealthcaritasla.com/pdf/pharmacy/acla-non-pdl-prior-auth-criteria.pdf.

1. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Agents PA Criteria
2. Insulin-Like Growth Factor-1 Receptor (Igf-1r) Antagonists For Thyroid Eye Disease
3. Omisirge PA Criteria
4. Primary Hemophagocytic Lymphohistiocytosis (HLH) Agents PA Criteria

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions:
Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert?
You can always find a complete listing of provider alerts on the Newsletters and Updates page of our website. page of our website.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com

Field Name	Field Description
Prior Authorization Group Description	**Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Agents**
Drugs	Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	**Combination with maintenance immunoglobulins, eculizumab, nipocalimab, ravulizumab, rituximab, rozanolixizumab, zilucoplan, or inebilizumab**
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA-approved labeling
Prescriber Restrictions	Prescriber must be a neurologist or neuromuscular specialist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 3 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria
 	
Date: **7/2026**
	****Drug is being requested through the member's medical benefit****
	
	Initial Authorization:
	• Diagnosis of CIDP confirmed by **all of the following and supported by submission of current and relevant chart documentation:**
	  ○ **E**lectrodiagnostic **findings in at least one nerve** (e.g. electromyography or nerve conduction studies)
	  ○ **Other causes of neuropathy are ruled out (toxin induced, Lyme disease, IgM neuropathy, hereditary neuropathy, prominent sphincter disturbance, multifocal motor neuropathy, diabetic neuropathy)**
	• Patient has progressive or relapsing/remitting disease course for ≥2 months
	• Medication is prescribed at an FDA approved dose
	• **Documentation is provided of trial/failure or intolerance to one of the following:**
	  ○ **Immunoglobulins**
	  ○ **Plasma Exchange**
	  ○ **Corticosteroids**
	
	Re-Authorization:
	• Documentation of significant clinical improvement in neurologic symptoms or stabilization of disease **(ex. objective measures of efficacy)**
	• Medication is prescribed at an FDA approved dose

	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Field Name	Field Description
Prior Authorization Group Description	**Insulin-Like Growth Factor-1 Receptor (Igf-1r) Antagonists For Thyroid Eye Disease**
Drugs	Tepezza (teprotumumab-trbw)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years age or older
Prescriber Restrictions	Prescriber must be an ophthalmologist, endocrinologist, or specialist with expertise in the treatment of Grave's disease with thyroid eye disease.
Coverage Duration	If all of the criteria are met, the request will be approved for up to 24 weeks of treatment (8 total infusions). Retreatment requests will not be allowed beyond the 8 dose limit.
Other Criteria	****Drug is being requested through the member's medical benefit**** **<u>Initial Authorization:</u>** Tepezza is approved when all of the following are met: • Dosing does not exceed dosing guidelines as outlined in the package insert • Patient has a confirmed diagnosis of Graves' disease • **<u>Documentation of one of the following:</u>** o **<u>Moderate to severe active TED with CAS > 4 and at least one of the following:</u>** ▪ **<u>Eyelid retraction ≥ 2 mm</u>** ▪ **<u>Moderate or severe soft tissue involvement</u>** ▪ **<u>Proptosis > 3 mm above normal for race and sex</u>** ▪ **<u>Periodic or constant diplopia</u>** o **<u>Chronic TED with one of the following:</u>** ▪ **<u>≥ 3 mm increase in proptosis from before diagnosis of TED</u>** ▪ **<u>Proptosis > 3 mm above normal values for race and sex</u>** • Patient must be euthyroid or thyroxine and free triiodothyronine levels are less than 50% above or below normal limits (submit laboratory results with request) • Patients of reproductive potential: attestation the patient is not pregnant, and appropriate contraception methods will be used before, during, and 6 months after the last infusion
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	• Patient has had a trial and therapy failure of, or contraindication to: o For active disease: oral or IV glucocorticoids **<u>Re-authorization:</u>** • Retreatment or renewal requests beyond a total of 24 weeks of treatment (8 total infusions) will not be allowed. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Omisirge**
Drugs	**Omisirge (omidubicel-onlv)**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Patient has previously received this medication
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with an oncologist**, hematologist, or transplant specialist**
Coverage Duration	If all the criteria are met, the initial request will be approved for a one-time treatment.

Other Criteria
 	
Review/Revision Date: 7/2026
	****Drug is being requested through the member's medical benefit****
	
	Initial Authorization:
	• Patient has **one of the following:**
	  ○ **A** hematologic malignancy planned for umbilical cord blood transplantation (UCBT) following myeloablative conditioning
	  ○ **Diagnosis of severe aplastic anemia (SAA) as evidenced by bone marrow cellularity < 30% (excluding lymphocytes) AND at least two of the following:**
	  ▪ **Absolute neutrophil count (ANC) < 500 cells/µL**
	  ▪ **Platelet count < 20,000/µL**
	  ▪ **Reticulocyte count < 60,000/µL**
	• Prescriber attests that the patient is eligible for myeloablative allogeneic hematopoietic stem cell transplantation (HSCT) AND does not have a readily available matched related donor, matched unrelated donor, mismatched unrelated donor, or haploidentical donor
	• Patient has not received a prior allogenic HSCT
	• Patient does not have known allergy to dimethyl sulfoxide (DMSO), Dextran 40, gentamicin, human serum albumin, or bovine material
	• **Requests for severe aplastic anemia also require a trial and failure, intolerance, or contraindication to immunosuppressive therapy (i.e., anti-thymocyte globulin [ATG] + cyclosporine, eltrombopag + cyclosporine, etc.)**

	The safety and effectiveness of repeat administration of Omisirge have not been evaluated and will not be approved. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Primary Hemophagocytic Lymphohistiocytosis (HLH) Agents**
Drugs	Gamifant (emapalumab-lzsg)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	**N/A**
Required Medical Information	"See Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist, Immunologist, Transplant Specialist, or other specialist experienced in the treatment of immunologic disorders
Coverage Duration	Initial Authorization: 1 month Reauthorization: 3 months
Other Criteria	****Drug is being requested through the member's medical benefit**** **Initial Authorization** • **Member has been screened for latent tuberculosis infection** • **Member has or will receive prophylactic pre-medications (e.g. antivirals, antibiotics, antifungals) for Herpes Zoster, *Pneumocystis jirovecii*, and other fungal infections** • **Dosing is consistent with FDA approved labeling** • **For Primary HLH:** o Member has a diagnosis of Primary HLH o Prescriber attests that member has not achieved a satisfactory response to or is intolerant to conventional HLH therapy (e.g. etoposide, dexamethasone) or has recurrent disease o Prescriber attests that the member is a candidate for**, and has not yet received,** hematopoietic stem cell transplant (HSCT) • **For HLH/Macrophage Activation Syndrome (MAS) in Still's disease, including systemic Juvenile Idiopathic Arthritis (sJIA):** o **Member has a diagnosis of HLH/MAS in Still's disease, including sJIA** o **Prescriber attests that member has not achieved a satisfactory response to or is intolerant to high-dose glucocorticoid treatment**

Revision/Review Date **7**/2026	**Reauthorization** • Member continues to meet initial authorization criteria • Member is receiving prophylactic pre-medications (e.g. antivirals, antibiotics, antifungals) for Herpes Zoster, *Pneumocystis jirovecii*, and other fungal infections **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**