

May 2026



Epic Tapestry Link Implementation for Prior Authorizations

Effective Monday August 10, 2026, Network Health will be implementing Epic Tapestry Link for online prior authorizations (non-EviCore and non-CCUM), which be replacing iExchange.

Here's what you need to know:

- **iExchange will no longer be available as of Friday, August 7, 2026.**
- **You will be able to access Epic Tapestry Link on Monday August 10, 2026 via our secure provider portal**, and you may also SSO to EviCore and CCUM via Epic Tapestry Link.
- [Please click here](#) to register for our provider portal if you are not already a registered user. If you need assistance in registration, please reach out to your Provider Operations Manager.
- Prior authorizations that were entered in iExchange will be carried over into Epic Tapestry Link.
- Additional information will be forthcoming in future newsletters, as well as direct email from your Provider Operations Manager.
- If you have questions please reach out to your provider operations manager.

GLP-1 Bridge Program: Resource for Providers

You may have already started fielding patients' questions related to Medicare's GLP-1 Bridge program, going live on July 1, 2026. And at this point you may have more questions than answers, but you're not alone. While the Bridge program will be operating outside of insurance, Network Health is still expecting to receive calls and indeed we have already seen an increase in Bridge-related questions coming through our member experience center. The Centers for Medicare and Medicaid Services (CMS) may still be working on the finer details of the program, but we're happy to share with our providers what we know so far, arming you with the knowledge and resources needed for you and your patients.

1. **What medications are covered?** Wegovy (injection and tablet), Zepbound Kwipen and Foundayo oral tablets.
2. **Who is eligible for the program?**

Members must meet the following requirements:

- a. Medicare members with prescription drug coverage. This includes members who have Special Needs Plans, those with Low Income Subsidies (LIS) and members of employer/union group waiver plans (EGWPs).
 - b. Meet CMS' prior authorization criteria and have an active authorization in place (additional detail provided by CMS expected later this spring).
 - c. Patient is not being prescribed an eligible GLP-1 drug for a use covered under the Part D benefit, whether the drug is on the formulary or excluded. Current Part D eligible indications include:
 - a. Zepbound – treatment of moderate to severe obstructive sleep apnea in adults with obesity.
 - b. Wegovy tablets and injection – reducing the risk of major adverse cardiovascular events in adults with established cardiovascular disease and either obesity or overweight.
 - c. Wegovy injection only – treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis with moderate to advanced liver fibrosis.
3. **How do members obtain the medications?** A similar process and your clinic is likely used to: providers will need to submit a PA request and GLP-1 prescription. Except the PA request will be submitted to the CMS central processor. At this time, it appears the GLP-1 prescription can go to the patient's pharmacy of

choice, but we will provide an update if we obtain more information related to pharmacy restrictions.

4. **How does my clinic submit the prior authorization request?** Specific information has not yet been communicated, but CMS will provide additional details later this spring. What we do know is that PAs will be handled by CMS' central processor.
5. **What are the PA requirements?** Prescription is indicated to reduce excess body weight and maintain weight reduction in adults when combined with current and ongoing lifestyle modifications including structured nutrition and physical activity AND patient meets one of the following at the time of initiating GLP-1 therapy:
 - a. Body mass index (BMI) is 35 or greater
 - b. BMI is 30 or greater AND has one of the following diagnoses:
 - i. Heart failure with preserved ejection fraction
 - ii. Uncontrolled hypertension (>140 mm Hg systolic or >90 mm Hg diastolic, despite concurrent use of two antihypertensive medications)
 - iii. Chronic kidney disease stage 3a or above
 - c. BMI is 27 or greater AND has one of the following diagnoses:
 - i. Pre-diabetes (as defined by American Diabetes Association guidelines)
 - ii. Previous myocardial infarction
 - iii. Previous stroke
 - iv. Symptomatic peripheral artery disease
6. **What will it cost the member?** \$50 co-pay per claim regardless of LIS status or phase of the Part D benefit they are in. The \$50 will not be applied toward their Part D spend and will remain \$50 per claim throughout the year.
7. **How long will the program last?** At this time, we know it will begin for Medicare patients on July 1, 2026 and last through December 31, 2027. We do not yet know what is expected in 2028.

8. **Where can I find the latest information?** CMS is maintaining a helpful FAQ section available here: <https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge>
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New Prior Authorization requirements with EviCore by Evernorth effective July 1, 2026

Effective July 1, 2026, the following services will require prior authorization from EviCore by Evernorth for Network Health members.

- Cardiac Imaging - for our Medicare lines of business (this requirement is already in place for all commercial membership)
- Cardiac Implantable Devices - for all Medicare and Commercial members in all lines of business. This includes removal and/or placement (or replacement) of Pacemakers, Defibrillators, Cardiac Resynchronization Therapy and Pulmonary Artery Pressure Sensors.

EviCore employs board certified specialists, including cardiologists and cardiothoracic surgeons, for peer review of these requests. Peer to peer discussions can be scheduled at your convenience directly with the reviewing physician.

EviCore will begin accepting requests for the Cardiac Imaging and Cardiac Implantable Devices programs on June 15, 2026, for dates of service July 1, 2026, and after. As a reminder, approval from EviCore is limited to the procedure itself. For procedures involving a planned inpatient stay, providers must submit a separate authorization request to Network Health for the inpatient level of care, even after the procedure has been approved.

We encourage you and your teams to attend one of the EviCore-led informative online training sessions to ensure your understanding of the prior authorization process and changes. All orientation sessions require advanced registration and will last approximately one hour. Please [click here](#) for more information on how to register and to select training dates that work best for your schedule.

Updated Payment Policies

The Anesthesia Policy – Commercial has been revised indicating that reimbursement for Modifiers P3, P4 and P5 will no longer be provided, effective July 1, 2026. If you have questions regarding this policy update, please reach out to your provider operations manager.

[Please click here](#) to review the full listing of our payment policies.

Provider Portal Enhancement

We are excited to share that the Member ID card is now available via our secure provider portal. To view the Member ID card, login to the provider portal and navigate to the Eligibility and Benefits tab. After selecting the member’s name, the ID Card will appear on the right side of the page. Simply click the “View” link to review both the front and back images of the member ID card.

Please note: the example below is fictional and is used for testing purposes only.

Print Copy Excel PDF							
Patient	Date of Birth	Member ID	Address	Plans	Status	ID Card	
(Eft) Mary T Davis	01/10/1980	987654321	1372 Wildflower Ct Neenah, WI 54956	STATE22 IYC HEALTH PLAN 250	Active		View

If you have questions regarding the update made to the provider portal, please reach out to your provider operations manager.

MDPP Elevator Speech

Nearly half of American adults aged 65 or older have prediabetes. Without weight loss or routine moderate physical activity, many of them will develop type 2 diabetes within a few years. People with prediabetes are also at higher risk of having a heart attack and stroke. The Medicare Diabetes Prevention Program (MDPP), offered by Network Health, can help make lasting changes to prevent type 2 diabetes and improve overall health. The program is free for participants who are enrolled in Medicare or Medicare Advantage plans and it is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC). It is backed by years of research showing that program participants aged 60 and older can cut their risk of type 2 diabetes by 71 percent—by losing weight, eating better, and being more active.

Participants will receive a full year of support from a lifestyle coach and peers with similar goals, along with tips and resources for making lasting healthy changes. The program provides weekly 1-hour core sessions for up to 6 months and then monthly sessions for the rest of the year. Participants will also learn how to manage stress, set and achieve realistic goals, stay motivated, and solve problems. Participants may even be able to manage other conditions like high cholesterol or high blood pressure with fewer medications.

Appointment Access Requirements

As a reminder, as part of our NCQA accreditation, our providers must meet the following appointment access times in order for us to maintain our accreditation. Here are the appointment access standards that must be met.

For Primary Care Services

1. Regular or routine care within 60 days of request
2. Urgent care appointment within 48 hours of request

For Specialist Services

1. Care within 30 days of the request
2. Non-life threatening, urgent appointment within 48 hours of request

For Behavioral Health Services

1. Non-life-threatening emergency within 6 hours of request
2. Urgent care appointment within 48 hours of request
3. Initial visit for routine care within 10 business days of request
4. Follow up appointment for a routine care visit within 30 days of request

Additionally, you must have an answering service, on-call provider, or message to direct patients to the emergency room for after-hours calls.