

Priority Health Commercial and MyPriority Plans

Medical Drug List



Priority Health Medical Drug List
Commercial (Employer Group) & MyPriority (Individual/Family)

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lowercase italics = Generic drugs
UPPERCASE = Brand name drugs

Coverage Level

Notes & Restrictions

HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
* Miscellaneous Medical Drugs				
<i>* Miscellaneous Medical Drugs</i>				
Q5149	N/A	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg	Not Covered	CA (Covered Alternatives: J0178 - Eylea (aflibercept), J0177 - Eylea HD (aflibercept hd), Q5147 - Pavblu (aflibercept-ayyh). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5150	N/A	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg	Not Covered	CA (Covered Alternatives: J0178 - Eylea (aflibercept), J0177 - Eylea HD (aflibercept hd), Q5147 - Pavblu (aflibercept-ayyh). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5153	N/A	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	Not Covered	
Q5155	N/A	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	Not Covered	CA (Covered Alternatives: J0178 - Eylea (aflibercept), J0177 - Eylea HD (aflibercept hd), Q5147 - Pavblu (aflibercept-ayyh). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Antidote Therapeutics				
<i>Antidote Therapeutics</i>				
J0716	ANASCORP	Injection, centruroides immune f(ab)2, up to 120 milligrams (Code Price is per 1 vial) (For billing prior to 1/1/13 use C9288 or J3590)	Preferred Specialty	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	Non-Specialty	CC (Rattlesnake Antivenom)
J0895	<i>deferoxamine</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	DESFERAL	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J1610	GLUCAGON EMERGENCY KIT (HUMAN)	Injection, glucagon hydrochloride, per 1 mg	Non-Specialty	

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J1611	GLUCAGON (HCL) EMERGENCY KIT	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1612	GVOKE HYPOPEN 1- PK 1 MG/0.2 ML	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
Chemotherapy Antidotes/Protectants				
J0207	ETHYOL	Injection, amifostine, 500mg (All NDCs Inactive October 2024)	Preferred Specialty	
J0640	<i>leucovorin calcium injection</i>	Injection, leucovorin calcium, per 50 mg	Non-Specialty	
J0641	<i>levoleucovorin calcium</i>	Injection, levoleucovorin, not otherwise specified, 0.5 mg	Preferred Specialty	
J0642	KHAPZORY	Injection, levoleucovorin (khapzory), 0.5 mg	Preferred Specialty	
J1190	<i>dexrazoxane hcl</i>	Injection, dexrazoxane hydrochloride, per 250 mg	Non-Specialty	
J1448	COSELA	Injection, trilaciclib, 1mg	Preferred Specialty	PA
J9209	<i>mesna intravenous</i>	Injection, mesna, 200 mg	Non-Specialty	
J9209	MESNEX INTRAVENOUS	Injection, mesna, 200 mg	Non-Specialty	

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Antihistamine Drugs				
Ethanolamine Derivatives				
J1200	<i>diphenhydramine hcl injection</i>	Injection, diphenhydramine HCl, up to 50 mg	Non-Specialty	
First Generation Antihistamines				
J1200	<i>diphenhydramine hcl injection</i>	Injection, diphenhydramine HCl, up to 50 mg	Non-Specialty	
Other Antihistamines				
J1308	<i>famotidine (pf)-nacl (iso-os)</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial 25's, sdv, p/f, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial inner, p/f, sub</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial inner, sub, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial outer, p/f, sub</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial outer, sub, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, inner, sdv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, outer, sdv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, sub, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, sub, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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J1308	<i>famotidine 20 mg/2 ml vial sdv,pf,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial suv, pf</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial 10's,mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mdv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mdv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mov, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mov, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mov, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mov, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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Phenothiazine Derivatives				
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
Second Generation Antihistamines				
J1201	QUZYTIR	Injection, cetirizine hydrochloride, 0.5 mg	Not Covered	
Anti-Infective Agents				
1st Generation Cephalosporin Antibiotics				
J0687	<i>cefazolin intravenous</i>	Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg	Non-Specialty	
J0688	<i>cefazolin intravenous</i>	Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg	Non-Specialty	
J0689	<i>cefazolin in dextrose (iso-os)</i>	Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial 25's, plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial 25's, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial inner, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial inner, suv, plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial inner, sdv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	

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J0690	<i>cefazolin 1 gm vial outer, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial outer, suv, plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial outer, sdv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial plf, sdv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial sdv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 1 gm vial suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 2 gm vial inner, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 2 gm vial outer, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 3 gm vial inner, plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 3 gm vial outer, plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 500 mg vial 10's, outer, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 500 mg vial 25's</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 500 mg vial 25's, plf</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	

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J0690	<i>cefazolin 500 mg vial 25's, sdv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 500 mg vial inner, suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 500 mg vial plf, sdv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin 500 mg vial suv</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin in dextrose (iso-os)</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin intravenous</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J3490	<i>cefazolin sod 100 gm bulk bag</i>	Unclassified drugs	Non-Specialty	
J3490	<i>cefazolin sod 300 gm bulk bag</i>	Unclassified drugs	Non-Specialty	
J7999	<i>cefazolin in dextrose 5 %</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Non-Specialty	
2Nd Generation Cephalosporin Antibiotics				
J0525	CEFOTAN	Injection, cefotetan disodium, 10 mg	Non-Specialty	
J0525	<i>cefotetan</i>	Injection, cefotetan disodium, 10 mg	Non-Specialty	
3Rd Generation Cephalosporin Antibiotics				
J0714	AVYCAZ	Injection, ceftazidime and avibactam, 0.5 g/0.125 g (For billing prior to 1/1/16 use C9399 or J3490)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.)

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5Th Generation Cephalosporin Antibiotics				
J0681	ZEVTERA	Injection, ceftobiprole medocaril sodium, 3 mg	Not Covered	
J0695	ZERBAXA	Injection, ceftolozane 50 mg and tazobactam 25 mg (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9452 or J3490)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.)
J0712	<i>ceftaroline fosamil</i>	Injection, ceftaroline fosamil, 10 mg (For billing prior to 1/1/12 use J3490 or C9282)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.)
J0712	TEFLARO	Injection, ceftaroline fosamil, 10 mg (For billing prior to 1/1/12 use J3490 or C9282)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.)
Amebicides				
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
Aminoglycoside Antibiotics				
J0291	ZEMDRI	Injection, plazomicin, 5 mg	Not Covered	
J3535	TOBI PODHALER	Drug administered through a metered dose inhaler	Pharmacy Only	
Aminomethylcyclines				
J0121	NUZYRA INTRAVENOUS	Injection, omadacycline, 1 mg	Not Covered	

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Antimalarials				
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
Antiprotozoals, P Jirovecii Pneumonia				
J2545	NEBUPENT	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg	Non-Specialty	
J2545	<i>pentamidine</i>	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg	Non-Specialty	
S0080	PENTAM	Injection, pentamidine isethionate, 300 mg (Code deleted effective 12/31/2025)	Non-Specialty	
S0080	<i>pentamidine</i>	Injection, pentamidine isethionate, 300 mg (Code deleted effective 12/31/2025)	Non-Specialty	
Antituberculosis Agents				
J1834	<i>isoniazid injection</i>	Injection, isoniazid, 1 mg	Not Covered	
Azole Antifungals				
J1833	CRESEMBA INTRAVENOUS	Injection, isavuconazonium sulfate, 1 mg (For billing prior to 1/1/16 use C9456 or J3490)	Preferred Specialty	

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J3465	VFEND IV	Injection, voriconazole, 10 mg	Preferred Specialty	
J3465	<i>voriconazole intravenous</i>	Injection, voriconazole, 10 mg	Preferred Specialty	
J3465	<i>voriconazole-hpbcd</i>	Injection, voriconazole, 10 mg	Preferred Specialty	
Carbapenem Antibiotics				
J0742	RECARBRIO	Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg	Not Covered	
J1335	<i>ertapenem</i>	Injection, ertapenem sodium, 500 mg	Non-Specialty	
J2183	<i>meropenem</i>	Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg	Preferred Specialty	
J2184	<i>meropenem-0.9% sodium chloride</i>	Injection, meropenem (b. braun), not therapeutically equivalent to j2185, 100 mg	Preferred Specialty	
J2185	<i>meropenem</i>	Injection, meropenem, 100 mg	Preferred Specialty	
J2186	VABOMERE	Injection, meropenem and vaborbactam, 10mg/10mg, (20mg)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin- tazobactam.)
Cephamycin Antibiotics				
J0525	CEFOTAN	Injection, cefotetan disodium, 10 mg	Non-Specialty	
J0525	<i>cefotetan</i>	Injection, cefotetan disodium, 10 mg	Non-Specialty	

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Cmv Antivirals				
J3490	PREVYMIS INTRAVENOUS	Unclassified drugs	Preferred Specialty	PA
Cyclic Lipopeptide Antibiotics				
J0872	<i>daptomycin</i>	Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg	Non-Specialty	
J0873	<i>daptomycin</i>	Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg	Non-Specialty	
J0874	<i>daptomycin in 0.9 % sod chlor</i>	Injection, daptomycin (baxter), not therapeutically equivalent to j0878, 1 mg	Non-Specialty	
J0877	<i>daptomycin</i>	Injection, daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	Non-Specialty	
J0878	<i>daptomycin</i>	Injection, daptomycin, 1 mg	Non-Specialty	
J3490	<i>daptomycin</i>	Unclassified drugs	Non-Specialty	
Echinocandin Antifungals				
J0349	REZZAYO	Injection, rezafungin, 1 mg	Not Covered	
J0637	<i>caspofungin</i>	Injection, caspofungin acetate, 5 mg	Non-Specialty	
J2246	<i>micafungin in 0.9 % sodium chl</i>	Injection, micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1 mg	Non-Specialty	
J2247	<i>micafungin</i>	Injection, micafungin sodium (par pharm) not thereapeutically equivalent to j2248, 1 mg	Preferred Specialty	

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J2248	<i>micafungin</i>	Injection, micafungin sodium, 1 mg	Preferred Specialty	
Extended-Spectrum Penicillins				
C9399	<i>piperacillin-tazobactam</i>	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
J2543	<i>piperacillin-tazobactam</i>	Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	Non-Specialty	
J2543	ZOSYN IN DEXTROSE (ISO-OSM)	Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	Non-Specialty	
J3490	<i>piperacillin-tazobactam</i>	Unclassified drugs	Non-Specialty	
Fluorocyclines				
J0122	XERAVA	Injection, eravacycline, 1 mg	Not Covered	
Glycopeptide Antibiotics				
J0875	<i>dalbavancin</i>	Injection, dalbavancin, 5 mg (For billing prior to 1/1/16 use C9443 or J3490)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0875	DALVANCE	Injection, dalbavancin, 5 mg (For billing prior to 1/1/16 use C9443 or J3490)	Not Covered	CA (Covered Alternative(s): J0875 - dalbavancin (geq) Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2406	KIMYRSA	Injection, oritavancin (kimyrsa), 10 mg	Non-Preferred	PA

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J2407	ORBACTIV	Injection, oritavancin (orbactiv), 10 mg (For billing prior to 1/1/16 use C9444 or J3490)	Non-Preferred	PA
J3095	VIBATIV	Injection, telavancin, 10 mg (For billing prior to 1/1/11 use J3490 or C9258)	Non-Preferred	PA
J3374	<i>vancomycin hcl 1.25 gram vial inner, suv, plf</i>	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	<i>vancomycin hcl 1.25 gram vial outer, suv, plf</i>	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	<i>vancomycin hcl 1.25 gram vial suv, plf</i>	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	<i>vancomycin hcl 1.5 gram vial inner, suv, plf</i>	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	<i>vancomycin hcl 1.5 gram vial outer, suv, plf</i>	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	<i>vancomycin hcl 1.5 gram vial suv, plf</i>	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	

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J3375	TYZAVAN	Injection, vancomycin hydrochloride (xellia), not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3375	<i>vancomycin-diluent combo no. 1</i>	Injection, vancomycin hydrochloride (xellia), not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
Hiv Capsid Inhibitors				
J0738	YEZTUGO SUBCUTANEOUS	Injection, lenacapavir, 1 mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, reference your plan documents and the Priority Health preventive health care guidelines.; Quantity Limit (2 injections per 1 year)
J0752	YEZTUGO ORAL	Oral, lenacapavir, 300 mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, reference your plan documents and the Priority Health preventive health care guidelines.; Quantity Limit (4 tablets per 1 year)
Hiv Entry And Fusion Inhibitors				
J1746	TROGARZO	Injection, ibalizumab-uiyk, 10 mg	Preferred Specialty	PA
Hiv Integrase Inhibitor Antiretrovirals				
J0739	APRETUDE	Injection, cabotegravir, 1 mg	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, reference your plan documents and the Priority Health preventive health care guidelines.
J0741	CABENUVA	Injection, cabotegravir and rilpivirine, 2mg/3mg	Preferred Specialty	

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Hiv Nucleoside, Nucleotide Rt Inhibitors				
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab inner</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab outer</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	TRUVADA 200 MG-300 MG TABLET	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	TRUVADA 200 MG-300 MG TABLET F/C	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	

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J0751	DESCOVY 200-25 MG TABLET	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
Interferon Antivirals				
J9215	ALFERON N	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	Non-Specialty	
Lincomycin Antibiotics				
J0736	CLEOCIN INJECTION	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin in 5 % dextrose</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin phosphate injection</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0737	<i>clindamycin in 0.9 % sod chlor</i>	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg	Non-Specialty	
Monobactam Antibiotics				
J0457	AZACTAM	Injection, aztreonam, 100 mg	Non-Specialty	
J0457	<i>aztreonam</i>	Injection, aztreonam, 100 mg	Non-Specialty	
J0458	EMBLAVEO	Injection, aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg)	Not Covered	

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Monoclonal Antibodies (08:18)				
90378	SYNAGIS 100 MG/ML VIAL	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each (All NDCs Inactive as 12/31/2025)	Not Covered	
90378	SYNAGIS 50 MG/0.5 ML VIAL	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each (All NDCs Inactive as 12/31/2025)	Not Covered	
90380	BEYFORTUS	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use	Preventive	PA
90381	BEYFORTUS	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use	Preventive	PA
90382	ENFLONISIA	Respiratory syncytial virus, monoclonal antibody, seasonal dose, 0.7 mL, for intramuscular use	Preventive	PA
J0638	ILARIS (PF)	Injection, canakinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9399)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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Q0224	PEMGARDA (EUA)	Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to COVID-19 vaccination, 4500 mg	Not Covered	
Nitroimidazole Derivatives, Misc				
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
Nucleoside And Nucleotide Antivirals				
J0248	VEKLURY	Injection, remdesivir, 1 mg	Non-Preferred	
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab inner</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab outer</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	TRUVADA 200 MG-300 MG TABLET	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0750	TRUVADA 200 MG-300 MG TABLET F/C	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J0751	DESCOVY 200-25 MG TABLET	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Pharmacy Only	
J1570	<i>ganciclovir sodium</i>	Injection, ganciclovir sodium, 500 mg	Non-Specialty	

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Other Misc. Antibacterial Agents				
J0911	DEFENCATH	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	Not Separately Payable	
Oxazolidinone Antibiotics				
J2020	<i>linezolid in dextrose 5%</i>	Injection, linezolid, 200 mg	Preferred Specialty	
J2020	ZYVOX INTRAVENOUS	Injection, linezolid, 200 mg	Not Covered	CA (Covered Alternative(s): J2020 - linezolid (geq), J2021 - linezolid (hospira). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2021	<i>linezolid-0.9% sodium chloride</i>	Injection, linezolid (hospira), not therapeutically equivalent to j2020, 200 mg	Preferred Specialty	
J3090	SIVEXTRO INTRAVENOUS	Injection, tedizolid phosphate, 1 mg (For billing prior to 1/1/16 use C9446 or J3490)	Preferred Specialty	PA
Penicillinase-Resistant Penicillins				
J2291	<i>nafcillin in dextrose iso-osm</i>	Injection, nafcillin sodium (baxter), 20 mg	Non-Specialty	
Pleuromutilins				
J0691	XENLETA INTRAVENOUS	Injection, lefamulin, 1 mg (All NDCs inactive effective 1/3/2024)	Not Covered	

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<i>Polyene Antifungals</i>				
J0285	<i>amphotericin b</i>	Injection, amphotericin B, 50mg	Non-Specialty	
<i>Quinolone Antibiotics</i>				
J3490	BAXDELA INTRAVENOUS	Unclassified drugs	Not Covered	
<i>Siderophore Cephalosporins</i>				
J0699	FETROJA	Injection, cefiderocol, 10 mg	Not Covered	
<i>Tetracycline Antibiotics</i>				
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
Antineoplastic Agents				
<i>Antineoplastic Agents</i>				
A9513	LUTATHERA	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	Preferred Specialty	PA
A9543	ZEVALIN (Y-90)	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries (Code Price is per dose)	Preferred Specialty	PA
A9607	PLUVICTO	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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C9257	AVASTIN 100 MG/4 ML VIAL P/F,SUV	Injection, bevacizumab, 0.25 mg	Preferred Specialty	PA; No PA required for ICD-10 codes B39.4, B39.5, B39.9, E08.311, E08.3211 - E08.3213, E08.3311 - E08.3313, E08.3411 - E08.3413, E08.3511 - E08.3513, E08.3591 - E08.3593, E09.311, E09.3211 - E09.3213, E09.3311 - E09.3313, E09.3411 - E09.3413, E09.3511 - E09.3513, E09.3591 - E09.3593, E10.311, E10.3211 - E10.3213, E10.3311 - E10.3313, E10.3411 - E10.3413, E10.3511 - E10.3513, E10.3591-E10.3593, E11.3100-E11.3199, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411 - E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211- E13.3213, E13.3311 - E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591- E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 - H35.3233, H35.351 -H35.353, H35.81, H40.89, H44.2a1- H44.2E3.

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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C9257	AVASTIN 400 MG/16 ML VIAL P/F,SUV	Injection, bevacizumab, 0.25 mg	Preferred Specialty	PA; No PA required for ICD-10 codes B39.4, B39.5, B39.9, E08.311, E08.3211 - E08.3213, E08.3311 - E08.3313, E08.3411 - E08.3413, E08.3511 - E08.3513, E08.3591 - E08.3593, E09.311, E09.3211 - E09.3213, E09.3311 - E09.3313, E09.3411 - E09.3413, E09.3511 - E09.3513, E09.3591 - E09.3593, E10.311, E10.3211 - E10.3213, E10.3311 - E10.3313, E10.3411 - E10.3413, E10.3511 - E10.3513, E10.3591-E10.3593, E11.3100-E11.3199, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411 - E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211- E13.3213, E13.3311 - E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591- E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 - H35.3233, H35.351 -H35.353, H35.81, H40.89, H44.2a1- H44.2E3.
C9306	EMRELIS	Injection, telisotuzumab vedotin- tllv, 1 mg (Code deleted effective 12/31/2025)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9307	LYNOZYFIC	Injection, linvoseltamab-gcpt, 1 mg	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9308	KYXATA	Injection, carboplatin (avyxa), 1 mg	Not Covered	CA (Covered Alternative(s): J9045 - carboplatin (geq), J9045 - Paraplatin. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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C9399	AMTAGVI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	BLENREP	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Preferred	PA
C9399	INLEXZO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Preferred	PA; Quantity Limit (10 doses per 1 year - Maximum 18 months treatment)
C9399	KEYTRUDA QLEX	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	RYBREVANT FASPRO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
J0614	GRAFAPEX	Injection, treosulfan, 50 mg	Preferred Specialty	PA; No PA required if billed with ICD-10 C92.00, C92.02, C92.A0, C92.A2, D46.Z, D46.9

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J0870	RYTELO	Injection, imetelstat, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0893	<i>decitabine</i>	Injection, decitabine (sun pharma), not therapeutically equivalent to j0894, 1 mg	Preferred Specialty	
J0894	<i>decitabine</i>	Injection, decitabine, 1 mg	Preferred Specialty	
J1323	ELREXFIO	Injection, elranatamab-bcmm, 1 mg	Not Covered	
J1326	VYLOY 300 MG VIAL	Injection, zolbetuximab-clzb, 2 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT 11.25 MG 3MO KIT 3 MONTH, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT 3.75 MG KIT P/F, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT 3.75 MG KIT SUV, P/F, SAMPLE	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT-PED	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1950	LUPRON DEPOT-PED (3 MONTH)	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1951	FENSOLVI	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1952	CAMCEVI (6 MONTH)	Leuprolide injectable, camcevi, 1 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J2860	SYLVANT	Injection, siltuximab, 10 mg (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9455 or J3590)	Preferred Specialty	PA
J3055	TALVEY	Injection, talquetamab-tgvs, 0.25 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3263	LOQTORZI	Injection, toripalimab-tpzi, 1 mg	Preferred Specialty	PA
J3315	TRELSTAR	Injection, triptorelin pamoate, 3.75 mg	Non-Specialty	
J3316	TRIPTODUR	Injection, triptorelin, extended-release, 3.75 mg	Non-Preferred	
J7999	<i>bevacizumab</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Preferred Specialty	No PA required for ICD-10 codes B39.4, B39.5, B39.9, E08.311, E08.3211 - E08.3213, E08.3311 - E08.3313, E08.3411 - E08.3413, E08.3511 - E08.3513, E08.3591 - E08.3593, E09.311, E09.3211 - E09.3213, E09.3311 - E09.3313, E09.3411 - E09.3413, E09.3511 - E09.3513, E09.3591 - E09.3593, E10.311, E10.3211 - E10.3213, E10.3311 - E10.3313, E10.3411 - E10.3413, E10.3511 - E10.3513, E10.3591-E10.3593, E11.3100-E11.3199, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411 - E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211- E13.3213, E13.3311 - E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591-E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 - H35.3233, H35.351 -H35.353, H35.81, H40.89, H44.2a1-H44.2E3.
J8610	<i>methotrexate sodium oral</i>	Methotrexate, oral, 2.5 mg	Non-Specialty	
J8610	TREXALL	Methotrexate, oral, 2.5 mg	Non-Specialty	

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J9000	ADRIAMYCIN	Injection, doxorubicin hydrochloride, 10 mg	Non-Specialty	
J9000	<i>doxorubicin</i>	Injection, doxorubicin hydrochloride, 10 mg	Non-Specialty	
J9011	DATROWAY	Injection, datopotamab deruxtecan-dlnk, 1 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9015	PROLEUKIN	Injection, aldesleukin, per single-use vial	Non-Specialty	
J9019	ERWINASE 10,000 UNIT VIAL P/F, INNER	Injection, asparaginase (Erwinaze), 1,000 IU (For billing prior to 1/1/13 use C9289 or J9999) (Code deleted effective 12/31/2025)	Non-Preferred	PA
J9019	ERWINASE 10,000 UNIT VIAL P/F, OUTER	Injection, asparaginase (Erwinaze), 1,000 IU (For billing prior to 1/1/13 use C9289 or J9999) (Code deleted effective 12/31/2025)	Non-Preferred	PA
J9021	RYLAZE	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	Preferred Specialty	PA
J9022	TECENTRIQ	Injection, atezolizumab, 10 mg (For billing prior to 1/1/18 use J9999 or C9483 for OPSS billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9023	BAVENCIO	Injection, avelumab, 10 mg (For billing prior to 1/1/18 use J9999 or C9491 for OPSS billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9024	TECENTRIQ HYBREZA	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9026	IMDELLTRA	Injection, tarlatamab-dlle, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J9028	ANKTIVA	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9029	ADSTILADRIN	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9030	TICE BCG	BCG live intravesical instillation, 1 mg	Non-Specialty	
J9032	BELEODAQ	Injection, belinostat, 10 mg (For billing prior to 1/1/16 use C9442 or J9999)	Preferred Specialty	PA
J9033	<i>bendamustine</i>	Injection, bendamustine hydrochloride, 1 mg	Non-Specialty	
J9033	TREANDA	Injection, bendamustine hydrochloride, 1 mg	Non-Specialty	
J9034	BENDEKA	Injection, bendamustine HCl (Bendeka), 1 mg	Non-Specialty	
J9035	AVASTIN 100 MG/4 ML VIAL P/F,SUV	Injection, bevacizumab, 10 mg	Not Covered	CA (Covered Alternatives: Q5107 - Mvasi (bevacizumab-awwb), Q5118 - Zirabev (bevacizumab-bvzr) for non-ophthalmic coverage. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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J9035	AVASTIN 400 MG/16 ML VIAL P/F,SUV	Injection, bevacizumab, 10 mg	Not Covered	CA (Covered Alternatives: Q5107 - Mvasi (bevacizumab-awwb), Q5118 - Zirabev (bevacizumab-bvzr) for non-ophthalmic coverage. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9036	BELRAPZO	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	Non-Specialty	
J9036	<i>bendamustine</i>	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	Non-Specialty	
J9039	BLINCYTO	Injection, blinatumomab, 1 microgram (For billing prior to 1/1/16 use C9449 or J9999)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9040	<i>bleomycin</i>	Injection, bleomycin sulfate, 15 units	Non-Specialty	
J9041	<i>bortezomib injection</i>	Injection, bortezomib, 0.1 mg	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9041	VELCADE	Injection, bortezomib, 0.1 mg	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9042	ADCETRIS	Injection, brentuximab vedotin, 1 mg (For billing prior to 1/1/13 use C9287 or J9999)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9043	JEVTANA	Injection, cabazitaxel, 1 mg (For billing prior to 1/1/12 use J9999 or C9276)	Non-Preferred	PA

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J9045	<i>carboplatin intravenous solution</i>	Injection, carboplatin, 50 mg	Non-Specialty	
J9045	PARAPLATIN 1,000 MG/100 ML VL MUV, P/F	Injection, carboplatin, 50 mg	Non-Specialty	
J9045	PARAPLATIN 50 MG/5 ML VIAL MUV, P/F	Injection, carboplatin, 50 mg	Non-Specialty	
J9045	PARAPLATIN 600 MG/60 ML VIAL MUV, P/F	Injection, carboplatin, 50 mg	Non-Specialty	
J9046	<i>bortezomib intravenous recon soln</i>	Injection, bortezomib (dr. reddy's), not therapeutically equivalent to j9041, 0.1 mg (All NDCs inactive effective 1/10/2024)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9047	KYPROLIS	Injection, carfilzomib, 1 mg (For billing prior to 1/1/14 use C9295 or J9999)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32.
J9048	<i>bortezomib intravenous recon soln</i>	Injection, bortezomib (fresenius kabi), not therapeutically equivalent to j9041, 0.1 mg (All NDCs inactive as of 4/3/2024)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9049	<i>bortezomib injection</i>	Injection, bortezomib (hospira), not therapeutically equivalent to j9041, 0.1 mg	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9050	BICNU	Injection, carmustine, 100 mg	Non-Specialty	
J9050	<i>carmustine</i>	Injection, carmustine, 100 mg	Non-Specialty	
J9052	<i>carmustine</i>	Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg	Non-Specialty	

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J9054	BORUZU	Injection, bortezomib (boruzu), 0.1 mg	Not Covered	CA (Covered Alternatives: J9049 - bortezomib (Hospira), J9046 - bortezomib (Dr. Reddy's), J9048 - bortezomib (fresenius kabi), J9041 - Velcade (bortezomib). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9055	ERBITUX	Injection, cetuximab, 10 mg	Preferred Specialty	PA
J9056	VIVIMUSTA	Injection, bendamustine hydrochloride (vivimusta), 1 mg	Not Covered	CA (Covered Alternatives: J9033 - Treanda (bendamustine hydrochloride), J9034 - Bendeka (bendamustine HCl), J9036 - Belrapzo (bendamustine hydrochloride). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9057	ALIQOPA	Injection, copanlisib, 1 mg (All NDCs inactive as of 10/16/2024)	Preferred Specialty	PA
J9060	<i>cisplatin</i>	Injection, cisplatin, powder or solution, per 10 mg	Non-Specialty	
J9061	RYBREVANT	Injection, amivantamab-vmjw, 2 mg	Preferred Specialty	PA
J9063	ELAHERE	Injection, mirvetuximab soravtansine-gynx, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9065	<i>cladribine</i>	Injection, cladribine, per 1 mg	Non-Specialty	
J9071	<i>cyclophosphamide 1 gm/5 ml vial, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	

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J9071	<i>cyclophosphamide 1 gm/5 ml vl suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 2 gm/10 ml vl muv, plf</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml muv, plf</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9072	<i>cyclophosphamide 1 gm/2 ml vl</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9072	<i>cyclophosphamide 2 gm/4 ml vl</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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J9072	<i>cyclophosphamide 500 mg/ml v1</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9072	FRINDOVYX	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9073	<i>cyclophosphamide 1 gm/5 ml v1 mov, p1f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 2 gm/10 ml v1 mov, p1f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 500 mg/2.5 ml mov, p1f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 1 gm/10 ml v1 inner, mov, p1f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 1 gm/10 ml v1 outer, mov, p1f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	

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J9074	<i>cyclophosphamide 2 gm/20 ml vl inner, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vl outer, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vl inner, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vl outer, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9075	<i>cyclophosphamide intravenous recon soln</i>	Injection, cyclophosphamide, not otherwise specified, 5mg	Non-Specialty	
J9076	<i>cyclophosphamide 1 gm/5 ml vl muv, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
J9076	<i>cyclophosphamide 500 mg/2.5 ml muv, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
J9118	ASPARLAS	Injection, calaspargase pegol-mknl, 10 units	Non-Preferred	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
J9119	LIBTAYO	Injection, cemiplimab-rwlc, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9120	COSMEGEN	Injection, dactinomycin, 0.5 mg	Non-Specialty	
J9120	<i>dactinomycin</i>	Injection, dactinomycin, 0.5 mg	Non-Specialty	
J9130	<i>dacarbazine</i>	Dacarbazine, 100 mg	Non-Specialty	
J9144	DARZALEX FASPRO	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32 and E85.81.

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J9145	DARZALEX	Injection, daratumumab, 10 mg (For billing prior to 1/1/17 use J9999 or C9476 for OPSS billing)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32 and E85.81.
J9153	VYXEOS	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	Preferred Specialty	PA
J9155	FIRMAGON	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9155	FIRMAGON KIT W DILUENT SYRINGE	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9161	LYMPHIR	Injection, denileukin diftitox-cxdl, 1 mcg	Not Covered	
J9171	<i>docetaxel</i>	Injection, docetaxel, 1 mg	Preferred Specialty	
J9172	DOCIVYX	Injection, docetaxel (docivyx), 1 mg	Not Covered	CA (Covered Alternative(s): J9171 - docetaxel. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9173	IMFINZI	Injection, durvalumab, 10 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9174	BEIZRAY	Injection, docetaxel (beizray), 1 mg	Not Covered	
J9174	BEIZRAY-ALBUMIN	Injection, docetaxel (beizray), 1 mg	Not Covered	

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J9176	EMPLICITI	Injection, elotuzumab, 1 mg (For billing prior to 1/1/17 use J9999 or C9477 for OPBS billing)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9177	PADCEV	Injection, enfortumab vedotin-ejfv, 0.25 mg	Preferred Specialty	PA
J9178	ELLEENCE	Injection, epirubicin HCl, 2 mg	Preferred Specialty	
J9178	<i>epirubicin 200 mg/100 ml vial sub, pif</i>	Injection, epirubicin HCl, 2 mg	Preferred Specialty	
J9179	<i>eribulin</i>	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)	Non-Preferred	
J9179	HALAVEN	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)	Non-Preferred	
J9181	ETOPOPHOS	Injection, etoposide, 10 mg	Non-Specialty	
J9181	<i>etoposide intravenous</i>	Injection, etoposide, 10 mg	Non-Specialty	
J9183	INLEXZO	Gemcitabine intravesical system, 225 mg	Non-Preferred	PA; Quantity Limit (10 doses per 1 year - Maximum 18 months treatment)
J9184	AVGEMSI	Injection, gemcitabine hydrochloride (avyxa), 200 mg	Not Covered	
J9190	ADRUCIL	Injection, fluorouracil, 500 mg	Non-Specialty	
J9190	<i>fluorouracil intravenous</i>	Injection, fluorouracil, 500 mg	Non-Specialty	
J9196	<i>gemcitabine</i>	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg	Preferred Specialty	
J9200	<i>floxuridine</i>	Injection, floxuridine, 500 mg	Non-Specialty	

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J9201	<i>gemcitabine</i>	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg	Preferred Specialty	
J9202	ZOLADEX	Goserelin acetate implant, per 3.6 mg	Preferred Specialty	
J9203	MYLOTARG	Injection, gemtuzumab ozogamicin, 0.1 mg (For billing prior to 1/1/18 use J9999 or C9399 for OPSS billing)	Non-Preferred	PA
J9204	POTELIGEO	Injection, mogamulizumab-kpkc, 1 mg	Non-Preferred	PA
J9205	ONIVYDE	Injection, irinotecan liposome, 1 mg (For billing prior to 1/1/17 use J9999 or C9474 for OPSS billing)	Preferred Specialty	PA
J9206	CAMPTOSAR	Injection, irinotecan, 20 mg	Preferred Specialty	
J9206	<i>irinotecan</i>	Injection, irinotecan, 20 mg	Preferred Specialty	
J9207	IXEMPRA	Injection, ixabepilone, 1 mg	Non-Specialty	
J9208	IFEX	Injection, ifosfamide, 1 gram	Non-Specialty	
J9208	<i>ifosfamide</i>	Injection, ifosfamide, 1 gram	Non-Specialty	
J9211	IDAMYCIN PFS	Injection, idarubicin hydrochloride, 5 mg	Non-Specialty	
J9211	<i>idarubicin</i>	Injection, idarubicin hydrochloride, 5 mg	Non-Specialty	
J9215	ALFERON N	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	Non-Specialty	

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J9217	ELIGARD	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	ELIGARD (3 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	ELIGARD (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J9217	ELIGARD (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	LUPRON DEPOT (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	LUPRON DEPOT (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J9217	LUPRON DEPOT 22.5 MG 3MO KIT SUV, P/F	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	LUPRON DEPOT 7.5 MG KIT SINGLE DOSE	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	VABRINTY (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Not Covered	
J9218	<i>leuprolide</i>	Leuprolide acetate, per 1 mg	Non-Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9223	ZEPZELCA	Injection, lurbinectedin, 0.1 mg	Non-Specialty	PA
J9226	SUPPRELIN LA	Histrelin implant (Supprelin LA), 50 mg	Non- Preferred	PA
J9227	SARCLISA	Injection, isatuximab-irfc, 10 mg	Preferred Specialty	PA

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J9228	YERVOY	Injection, ipilimumab, 1 mg (For billing prior to 1/1/12 use J9999 or C9284)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9229	BESPONSA	Injection, inotuzumab ozogamicin, 0.1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9245	<i>melphalan hcl</i>	Injection, melphalan hydrochloride, not otherwise specified, 50 mg	Non-Specialty	
J9246	EVOMELA	Injection, melphalan (evomela), 1 mg	Preferred Specialty	PA
J9248	HEPZATO	Injection, melphalan (hepzato), 1 mg	Preferred Specialty	PA
J9248	HEPZATO (50 MM CATHETER)	Injection, melphalan (hepzato), 1 mg	Preferred Specialty	PA
J9248	HEPZATO (62 MM CATHETER)	Injection, melphalan (hepzato), 1 mg	Preferred Specialty	PA
J9249	IVRA	Injection, melphalan (apotex), 1 mg	Not Covered	CA (Covered Alternative(s): J9245 - Alkeran (melphalan hydrochloride), J9246 - Evomela (melphalan), J9248 - Hepzato (melphalan). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9263	<i>oxaliplatin</i>	Injection, oxaliplatin, 0.5 mg	Non-Specialty	
J9264	ABRAXANE	Injection, paclitaxel protein-bound particles, 1 mg	Preferred Specialty	
J9264	<i>paclitaxel protein-bound</i>	Injection, paclitaxel protein-bound particles, 1 mg	Preferred Specialty	

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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J9266	ONCASPAR	Injection, pegaspargase, per single dose vial	Preferred Specialty	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
J9267	<i>paclitaxel</i>	Injection, paclitaxel, 1 mg	Non-Specialty	
J9268	NIPENT	Injection, pentostatin, per 10 mg	Preferred Specialty	
J9269	ELZONRIS	Injection, tagraxofusp-erzs, 10 micrograms	Preferred Specialty	PA
J9271	KEYTRUDA	Injection, pembrolizumab, 1 mg (For billing prior to 1/1/16 use C9027 or J9999)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9272	JEMPERLI	Injection, dostarlimab-gxly, 10 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9273	TIVDAK	Injection, tisotumab vedotin-tftv, 1 mg	Preferred Specialty	PA
J9274	KIMMTRAK	Injection, tebentafusp-tebn, 1 microgram	Preferred Specialty	PA
J9275	UNLOXCYT	Injection, cosibelimab-ipdl, 2 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9277	KEYTRUDA QLEX	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9278	KYXATA	Injection, carboplatin (avyxa), 1 mg	Not Covered	CA (Covered Alternative(s): J9045 - carboplatin (geq), J9045 - Paraplatin. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9280	<i>mitomycin intravenous</i>	Injection, mitomycin, 5 mg	Non-Specialty	
J9280	MUTAMYCIN	Injection, mitomycin, 5 mg	Non-Specialty	

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J9281	JELMYTO	Mitomycin pyelocalyceal instillation, 1 mg	Non-Preferred	PA; Quantity Limit (17 doses per 1 lifetime); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9282	ZUSDURI	Mitomycin, intravesical instillation, 1 mg	Non-Preferred	PA; Quantity Limit (6 doses per 1 lifetime); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9286	COLUMVI	Injection, glofitamab-gxbm, 2.5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9289	OPDIVO QVANTIG	Injection, nivolumab, 2 mg and hyaluronidase-nvhy	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9292	AXTLE	Injection, pemetrexed dipotassium, 10 mg	Not Covered	CA (Covered Alternative(s): J9294 - pemetrexed (hospira), J9296 - pemetrexed (accord), J9297 - pemetrexed (sandoz), J9305 - Alimta (pemetrexed), J9314 - pemetrexed (teva), J9322 - pemetrexed (bluepoint), J9323 - pemetrexed ditromethamine. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9293	<i>mitoxantrone</i>	Injection, mitoxantrone hydrochloride, per 5 mg	Non-Specialty	
J9294	<i>pemetrexed disodium</i>	Injection, pemetrexed (hospira), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9296	<i>pemetrexed disodium</i>	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9297	<i>pemetrexed disodium</i>	Injection, pemetrexed (sandoz), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	

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J9298	OPDUALAG	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9299	OPDIVO	Injection, nivolumab, 1 mg (For billing prior to 1/1/16 use C9453 or J9999)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9301	GAZYVA	Injection, obinutuzumab, 10 mg (For billing prior to 1/1/15 use C9021 or J9999)	Preferred Specialty	PA
J9302	ARZERRA	Injection, ofatumumab, 10 mg (For billing prior to 1/1/11 use J9999 or C9260)	Non-Preferred	PA
J9303	VECTIBIX	Injection, panitumumab, 10 mg	Preferred Specialty	PA
J9304	PEMFEXY	Injection, pemetrexed (pemfexy), 10 mg	Not Covered	CA (Covered Alternative(s): J9294 - pemetrexed (hospira), J9296 - pemetrexed (accord), J9297 - pemetrexed (sandoz), J9305 - Alimta (pemetrexed), J9314 - pemetrexed (teva), J9322 - pemetrexed (bluepoint), J9323 - pemetrexed ditromethamine. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9305	ALIMTA	Injection, pemetrexed, not otherwise specified, 10 mg	Non-Specialty	
J9305	<i>pemetrexed disodium</i>	Injection, pemetrexed, not otherwise specified, 10 mg	Non-Specialty	
J9306	PERJETA	Injection, pertuzumab, 1 mg (For billing prior to 1/1/14 use C9292 or J9999)	Preferred Specialty	PA; No PA required for ICD-10 code C50.

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J9307	FOLOTYN	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)	Preferred Specialty	PA
J9307	<i>pralatrexate</i>	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)	Preferred Specialty	PA
J9308	CYRAMZA	Injection, ramucirumab, 5 mg (For billing prior to 1/1/16 use C9025 or J9999)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9309	POLIVY	Injection, polatuzumab vedotin-piiq, 1 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9311	RITUXAN HYCELA	Injection, rituximab 10 mg and hyaluronidase	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9312	RITUXAN	Injection, rituximab, 10 mg	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9314	<i>pemetrexed</i>	Injection, pemetrexed (teva), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	

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J9316	PHESGO	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	Preferred Specialty	PA; No PA required if billed with ICD-10 C50
J9317	TRODELVY	Injection, sacituzumab govitecan-hziy, 2.5 mg	Preferred Specialty	PA
J9318	<i>romidepsin</i>	Injection, romidepsin, non-lyophilized, 0.1 mg	Preferred Specialty	PA
J9319	ISTODAX	Injection, romidepsin, lyophilized, 0.1 mg	Preferred Specialty	PA
J9319	<i>romidepsin</i>	Injection, romidepsin, lyophilized, 0.1 mg	Preferred Specialty	PA
J9320	ZANOSAR	Injection, streptozocin, 1 gram	Non-Specialty	
J9321	EPKINLY	Injection, epcoritamab-bysp, 0.16 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9322	<i>pemetrexed disodium</i>	Injection, pemetrexed (bluepoint), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9324	PEMRYDI RTU	Injection, pemetrexed (pemrydi rtu), 10 mg	Not Covered	CA (Covered Alternative(s): J9294 - pemetrexed (hospira), J9296 - pemetrexed (accord), J9297 - pemetrexed (sandoz), J9305 - Alimta (pemetrexed), J9314 - pemetrexed (teva), J9322 - pemetrexed (bluepoint), J9323 - pemetrexed ditromethamine. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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J9325	IMLYGIC	Injection, talimogene laherparepvec, per 1 million plaque forming units (For billing prior to 1/1/17 use J9999 or C9472 for OPSS billing)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9326	EMRELIS	Injection, telisotuzumab vedotin-tllv, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9329	TEVIMBRA	Injection, tislelizumab-jsgr, 1mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9331	FYARRO	Injection, sirolimus protein-bound particles, 1 mg	Preferred Specialty	PA
J9341	TEPYLUTE	Injection, thiotepa (tepylute), 1 mg	Non-Specialty	
J9345	ZYNYZ	Injection, retifanlimab-dlwr, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9347	IMJUDO	Injection, tremelimumab-actl, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9348	DANYELZA	Injection, naxitamab-gqqk, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9349	MONJUVI	Injection, tafasitamab-cxix, 2 mg	Preferred Specialty	PA
J9350	LUNSUMIO	Injection, mosunetuzumab-axgb, 1 mg (Code reused effective 7/1/2023)	Preferred Specialty	PA
J9350	LUNSUMIO VELO	Injection, mosunetuzumab-axgb, 1 mg (Code reused effective 7/1/2023)	Not Covered	
J9351	<i>topotecan</i>	Injection, topotecan, 0.1 mg	Preferred Specialty	

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J9352	YONDELIS	Injection, trabectedin, 0.1 mg (For billing prior to 1/1/17 use J9999 or C9480 for OPPS billing)	Preferred Specialty	PA
J9353	MARGENZA	Injection, margetuximab-cmkb, 5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9354	KADCYLA	Injection, ado-trastuzumab emtansine, 1 mg (For billing prior to 1/1/14 use C9131 or J9999)	Preferred Specialty	PA
J9355	HERCEPTIN	Injection, trastuzumab, excludes biosimilar, 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9356	HERCEPTIN HYLECTA	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk	Not Covered	CA (Covered Biosimilars: Ogivri or Trazimera)
J9358	ENHERTU	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9359	ZYNLONTA	Injection, loncastuximab tesirine-lpyl, 0.075 mg	Preferred Specialty	PA
J9360	<i>vinblastine</i>	Injection, vinblastine sulfate, 1 mg	Non-Specialty	
J9370	VINCASAR PFS	Vincristine sulfate, 1 mg	Non-Specialty	
J9370	<i>vincristine</i>	Vincristine sulfate, 1 mg	Non-Specialty	
J9380	TECVAYLI	Injection, teclistamab-cqyv, 0.5 mg (Code reused effective 7/1/2023)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9382	BIZENGRI	Injection, zenocutuzumab-zbco, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J9390	<i>vinorelbine</i>	Injection, vinorelbine tartrate, per 10 mg	Non-Specialty	
J9393	<i>fulvestrant</i>	Injection, fulvestrant (teva), not therapeutically equivalent to j9395, 25 mg (All NDCs inactive as of 10/16/2023)	Preferred Specialty	
J9394	<i>fulvestrant</i>	Injection, fulvestrant (fresenius kabi) not therapeutically equivalent to j9395, 25 mg	Preferred Specialty	
J9395	FASLODEX	Injection, fulvestrant, 25 mg	Preferred Specialty	
J9395	<i>fulvestrant</i>	Injection, fulvestrant, 25 mg	Preferred Specialty	
J9400	ZALTRAP	Injection, ziv-aflibercept, 1 mg (For billing prior to 1/1/14 use C9296 or J9999)	Non-Preferred	
J9600	PHOTOFRIN	Injection, porfimer sodium, 75 mg	Preferred Specialty	
J9601	LYNOZYFIC	Injection, linvoseltamab-gcpt, 1 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	AMTAGVI	Not otherwise classified, antineoplastic drugs	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	BLENREP	Not otherwise classified, antineoplastic drugs	Non-Preferred	PA
J9999	INLEXZO	Not otherwise classified, antineoplastic drugs	Non-Preferred	PA; Quantity Limit (10 doses per 1 year - Maximum 18 months treatment)
J9999	KEYTRUDA QLEX	Not otherwise classified, antineoplastic drugs	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J9999	KYXATA	Not otherwise classified, antineoplastic drugs	Not Covered	CA (Covered Alternative(s): J9045 - carboplatin (geq), J9045 - Paraplatin. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9999	RYBREVANT FASPRO	Not otherwise classified, antineoplastic drugs	Not Covered	
J9999	UNITUXIN	Not otherwise classified, antineoplastic drugs	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2041	YESCARTA	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (For billing prior to 4/1/18 use J9999 or C9399 for OPSS billing) (Code Price is for drug ONLY) (Code re-used by CMS)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2042	KYMRIAH	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code was reused by CMS 1/1/2019) (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Code Price is per 250 mL)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2053	TECARTUS	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2054	BREYANZI	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2054	BREYANZI CD4 COMPONENT (2OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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Q2054	BREYANZI CD8 COMPONENT (1OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2055	ABECMA	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2056	CARVYKTI	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2058	AUCATZYL	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion (Split dose infusion; complete therapy=2 separate infusions 10 days apart)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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Q5107	MVASI	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	Preferred Specialty	
Q5112	ONTRUZANT	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg	Preferred Specialty	
Q5113	HERZUMA	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5114	OGIVRI	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	Preferred Specialty	
Q5115	TRUXIMA	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5116	TRAZIMERA	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5117	KANJINTI	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5118	ZIRABEV	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg	Preferred Specialty	

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Q5119	RUXIENCE	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5123	RIABNI	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5126	ALYMSYS	Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg	Not Covered	CA (Covered Alternatives: Q5107 - Mvasi (bevacizumab-awwb), Q5118 - Zirabev (bevacizumab-bvzr) for non-ophthalmic coverage. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5129	VEGZELMA	Injection, bevacizumab-adcd (vezzelma), biosimilar, 10 mg	Not Covered	CA (Covered Biosimilars: Mvasi or Zirabev)
Q5146	HERCESSI	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5160	JOBEVNE	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	Not Covered	
Antitoxins, Immune Glob, Toxoids, Vaccines				
Allergenic Extracts (Therapeutic)				
J3590	PALFORZIA (LEVEL 0)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 1)	Unclassified biologics	Pharmacy Only	PA

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J3590	PALFORZIA (LEVEL 2)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 3)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 4)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 5)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 6)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 7)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 8)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 9)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 10)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA (LEVEL 11 UP-DOSE)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA INITIAL (1- 3 YRS)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA INITIAL (4- 17 YRS)	Unclassified biologics	Pharmacy Only	PA
J3590	PALFORZIA INITIAL (4- 17 YRS)	Unclassified biologics	Preferred Specialty	PA
J3590	PALFORZIA LEVEL 11 MAINTENANCE	Unclassified biologics	Pharmacy Only	PA

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Antitoxins And Immune Globulins				
90284	CUVITRU	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each (Use 90284 for CPT billing requirements ONLY - see also J1559, J1561, J1562, and J1569 for non-CPT billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
90284	GAMMAGARD LIQUID ERC	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each (Use 90284 for CPT billing requirements ONLY - see also J1559, J1561, J1562, and J1569 for non-CPT billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
90284	GAMMAKED	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each (Use 90284 for CPT billing requirements ONLY - see also J1559, J1561, J1562, and J1569 for non-CPT billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
90284	GAMUNEX-C	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each (Use 90284 for CPT billing requirements ONLY - see also J1559, J1561, J1562, and J1569 for non-CPT billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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90284	HIZENTRA	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each (Use 90284 for CPT billing requirements ONLY - see also J1559, J1561, J1562, and J1569 for non-CPT billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
90284	XEMBIFY	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each (Use 90284 for CPT billing requirements ONLY - see also J1559, J1561, J1562, and J1569 for non-CPT billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0565	ZINPLAVA	Injection, bezlotoxumab, 10 mg (For billing prior to 1/1/18 use J3590 or C9490 for OPSS billing)	Not Covered	
J0716	ANASCORP	Injection, centruroides immune f(ab)2, up to 120 milligrams (Code Price is per 1 vial) (For billing prior to 1/1/13 use C9288 or J3590)	Preferred Specialty	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	Non-Specialty	CC (Rattlesnake Antivenom)
J1459	PRIVIGEN	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g liquid), 500 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1551	CUTAQUIG	Injection, immune globulin (cutaquig), 100 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J1552	ALYGLO	Injection, immune globulin (alyglo), 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammalex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1554	ASCENIV	Injection, immune globulin (asceniv), 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammalex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1555	CUVITRU	Injection, immune globulin (Cuvitru), 100 mg (For billing prior to 1/1/18 use J3590 or C9399 for OPSS billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1556	BIVIGAM	Injection, immune globulin (Bivigam), 500 mg (For billing prior to 1/1/14 see C9130 or J1599)	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammalex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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J1557	GAMMAPLEX	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1557	GAMMAPLEX (WITH SORBITOL)	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1558	XEMBIFY	Injection, immune globulin (xembify), 100 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1559	HIZENTRA	Injection, immune globulin (Hizentra), 100 mg (For billing prior to 1/1/11 use J3590 or C9399) (see also 90284 for CPT billing requirements)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1561	GAMUNEX-C	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1566	GAMMAGARD S-D (IGA < 1 MCG/ML)	Injection, immune globulin, intravenous, lyophilized (e.g powder), not otherwise specified, 500 mg (Only Carimune NF, Panglobulin NF and Gammagard S/D should be billed using this code)	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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J1568	OCTAGAM	Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1569	GAMMAGARD LIQUID 10% VIAL INNER,P/F, SUV	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg	Preferred Specialty	PA
J1569	GAMMAGARD LIQUID 10% VIAL OUTER,P/F, SUV	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg	Preferred Specialty	PA
J1569	GAMMAGARD LIQUID 10% VIAL OUTER,P/F, SUV	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1569	GAMMAGARD LIQUID ERC	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1572	FLEBOGAMMA DIF	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1573	HEPAGAM B	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5 mL (see J1571 for IM use)	Non-Specialty	
J1575	HYQVIA	Injection, immune globulin/hyaluronidase, (Hyqvia), 100 mg immune globulin (For billing prior to 1/1/16 use C9399 or J3590)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J1576	PANZYGA	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1599	YIMMUGO	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2790	HYPERRHO 1,500 UNIT SYRINGE P/F,INNER,SDV	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	Non-Specialty	
J2790	HYPERRHO 1,500 UNIT SYRINGE P/F,OUTER,SDV	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	Non-Specialty	

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J2790	RHOGAM ULTRA-FILTERED PLUS	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	Non-Specialty	
J2791	RHOPHYLAC	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU (see also 90384 and 90386 for CPT billing requirements)	Non-Specialty	
Vaccines				
91304	NUVAXOVID 2025-2026 (PF)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use	Preventive	
91319	COMIRNATY 2025-2026(5-11Y)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	Preventive	
91320	COMIRNATY 2025-26 (12Y UP)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	Preventive	

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91321	SPIKEVAX 2025-26 (6M-11Y) (PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, 25 mcg/0.25 mL dosage, for intramuscular use	Preventive	
91322	SPIKEVAX 2025-2026(12Y UP)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, 50 mcg/0.5 mL dosage, for intramuscular use	Preventive	
91323	MNEXSPIKE 2025-2026 (PF)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 10 mcg/0.2 mL dosage, for intramuscular use	Preventive	
Autonomic Drugs				
Alpha- And Beta-Adrenergic Agonists				
J0163	ADRENALIN IN 0.9 % SOD CHLOR	Injection, epinephrine in sodium chloride (endo), 0.1 mg	Non-Specialty	
J0164	<i>epineph bitart in 0.9% sod chl intravenous solution</i>	Injection, epinephrine in sodium chloride (baxter), 0.1 mg	Non-Specialty	
J3490	REZIPRES	Unclassified drugs	Non-Specialty	
Alpha-Adrenergic Agonists (12:12)				
J2371	<i>phenylephrine hcl injection</i>	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	

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J2371	VAZCULEP	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2372	BIORPHEN	Injection, phenylephrine hydrochloride (biorphen), 20 micrograms	Non-Specialty	
J2373	IMMPHENTIV	Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms	Non-Specialty	
Antimuscarinics/Antispasmodics				
J0462	<i>atropine injection solution</i>	Injection, atropine sulfate, not therapeutically equivalent to j0461, 0.01 mg	Non-Specialty	
J0462	<i>atropine intravenous solution</i>	Injection, atropine sulfate, not therapeutically equivalent to j0461, 0.01 mg	Non-Specialty	
J0463	<i>atropine injection solution</i>	Injection, atropine sulfate (fresenius and therapeutically equivalent), 0.01 mg	Non-Specialty	
J7677	YUPELRI	Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram	Not Covered	
Antiparkinsonian Agents				
J0515	<i>benztropine injection</i>	Injection, benztropine mesylate, per 1mg	Non-Specialty	
Botulinum Toxins				
J0585	BOTOX	Injection, onabotulinumtoxinA, 1 unit	Preferred Specialty	PA

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J0585	BOTOX COSMETIC	Injection, onabotulinumtoxinA, 1 unit	Not Covered	
J0586	DYSPORE	Injection, abobotulinumtoxinA, 5 units (For billing prior to 1/1/10 use J3590 or C9399)	Preferred Specialty	PA
J0587	MYOBLOC	Injection, rimabotulinumtoxinB, 100 units	Preferred Specialty	PA
J0588	XEOMIN	Injection, incobotulinumtoxinA, 1 unit	Preferred Specialty	PA
J0589	DAXXIFY	Injection, daxibotulinumtoxinA-lanm, 1 unit	Preferred Specialty	PA
J3590	JEUVEAU	Unclassified biologics	Not Covered	
<i>Gaba-Derivative Skeletal Muscle Relaxant</i>				
J0475	<i>baclofen intrathecal kit</i>	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	<i>baclofen intrathecal solution</i>	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN 10,000 MCG/20 ML SYRG P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN 20,000 MCG/20 ML SYRG P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN 40,000 MCG/20 ML SYRG P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN INTRATHECAL SOLUTION	Injection, baclofen, 10 mg	Preferred Specialty	

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J0475	LIORESAL IT 10 MG/20 ML AMPULE INNER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/20 ML KIT OUTER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/20 ML KIT SUV, P/F	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML AMPULE INNER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML AMPULE SUV, P/F, INNER	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML KIT OUTER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML KIT SUV, P/F, OUTER	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML AMPULE INNER, SUV, P/F	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML AMPULE INNER,SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML KIT OUTER, SUV, P/F	Injection, baclofen, 10 mg	Preferred Specialty	

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J0475	LIORESAL IT 40 MG/20 ML KIT OUTER,SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0476	<i>baclofen intrathecal syringe</i>	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	GABLOFEN 50 MCG/ML SYRINGE P/F, SUV	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	LIORESAL IT 0.05 MG/ML AMPULE INNER, SUV, P/F	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	LIORESAL IT 0.05 MG/ML AMPULE OUTER, SUV, P/F	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	LIORESAL IT 0.05 MG/ML AMPULE SUV, P/F	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
Neuromuscular Blocking Agents				
J0330	<i>succinylcholine 100 mg/5 ml syringe suv, p/f, inner</i>	Injection, succinylcholine chloride, up to 20mg	Non-Specialty	
J0330	<i>succinylcholine 100 mg/5 ml syringe suv, p/f, outer</i>	Injection, succinylcholine chloride, up to 20mg	Non-Specialty	
J0330	<i>succinylcholine chloride injection</i>	Injection, succinylcholine chloride, up to 20mg	Non-Specialty	
Non-Sel. Beta-Adrenergic Blocking Agents				
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	

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J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, sub, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, sub, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
Parasympathomimetic (Cholinergic Agents)				
J2710	BLOXIVERZ	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe inner, sub</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe outer, sub</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine methylsulfate intravenous solution</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2711	PREVDUO	Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg	Non-Specialty	

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Selective Alpha-1-Adrenergic Block.Agent				
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, sub, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, sub, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
Selective Beta-2-Adrenergic Agonists				
J3105	<i>terbutaline subcutaneous</i>	Injection, terbutaline sulfate, up to 1 mg	Non-Specialty	
J7611	<i>albuterol sulfate inhalation solution for nebulization</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, concentrated form, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sulfate inhalation solution for nebulization</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
Selective Beta-Adrenergic Blocking Agent				
J1805	BREVIBLOC	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	BREVIBLOC IN NAACL (ISO-OSM)	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol in nacl (iso- osm)</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol intravenous solution</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1806	<i>esmolol in sterile water</i>	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	Non-Specialty	
J3490	RAPIBLYK	Unclassified drugs	Not Covered	
Smoking Cessation Agents				
J2315	VIVITROL	Injection, naltrexone, depot form, 1 mg	Preferred Specialty	
Blood Derivatives				
Blood Derivatives				
J0256	ARALAST NP	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0256	PROLASTIN-C	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0256	ZEMAIRA	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0257	GLASSIA	Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg (For billing prior to 1/1/12 use J3590 or C9399)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2998	RYPLAZIM	Injection, plasminogen, human-tvmh, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Blood Formation, Coagulation, Thrombosis				
Antianemia Drugs				
J0882	ARANESP (IN POLYSORBATE)	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	Preferred Specialty	
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Preferred Specialty	
J0896	REBLOZYL	Injection, luspatercept-aamt, 0.25 mg	Preferred Specialty	PA
J0901	VAFSEO	Vadadustat, oral, 1 mg (for esrd on dialysis)	Not Covered	
Anticoagulants, Miscellaneous				
J0911	DEFENCATH	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	Not Separately Payable	

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Blood Form., Coag, Thrombosis Agents Misc.				
J0791	ADAKVEO	Injection, crizanlizumab-tmca, 5 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Direct Thrombin Inhibitors				
J0582	<i>bivalirudin intravenous solution</i>	Injection, bivalirudin (endo), not therapeutically equivalent to j0583, 1 mg	Non-Specialty	
Hematopoietic Agents				
J0882	ARANESP (IN POLYSORBATE)	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	Preferred Specialty	
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Preferred Specialty	
J0896	REBLOZYL	Injection, luspatercept-aamt, 0.25 mg	Preferred Specialty	PA
J0901	VAFSEO	Vadadustat, oral, 1 mg (for esrd on dialysis)	Not Covered	
J1449	ROLVEDON	Injection, eflapegrastim-xnst, 0.1 mg	Not Covered	
J2277	APHEXDA	Injection, motixafortide, 0.25 mg	Non-Preferred	
J2506	NEULASTA	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Preferred Specialty	
J2506	NEULASTA ONPRO	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Preferred Specialty	
J2562	MOZOBIL	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)	Non-Preferred	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J2562	<i>plerixafor</i>	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)	Non-Preferred	
J2802	NPLATE	Injection, romiplostim, 1 microgram	Preferred Specialty	PA
J2820	LEUKINE	Injection, sargramostim (GM-CSF), 50 mcg	Preferred Specialty	
J9361	RYZNEUTA	Injection, efbemalenograstim alfavuxw, 0.5 mg	Not Covered	
Q5101	ZARXIO	Injection, filgrastim-sndz, biosimilar, (Zarxio), 1 microgram	Preferred Specialty	
Q5108	FULPHILA	Injection, pegfilgrastim-jmdb (fulphila), biosimilar, 0.5 mg	Preferred Specialty	
Q5110	NIVESTYM	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram	Preferred Specialty	
Q5111	UDENYCA	Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5111	UDENYCA AUTOINJECTOR	Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5111	UDENYCA ONBODY	Injection, pegfilgrastim-cbqv (udenyc), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5120	ZIEXTENZO	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5122	NYVEPRIA	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5125	RELEUKO	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	Preferred Specialty	
Q5127	STIMUFEND	Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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Q5130	FYLNETRA	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5148	NYPOZI	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	Not Covered	CA (Covered Alternative(s): J1442 - Neupogen (filgrastim), Q5110 - Nivestym (filgrastim-aafi), Q5125 - Releuko (filgrastim-ayow), Q5101 - Zarxio (filgrastim-sndz). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Hemostatics				
J1411	HEMGENIX	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1412	ROCTAVIAN	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10 ¹³ vector genomes	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2597	DDAVP INJECTION	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	
J2597	<i>desmopressin injection</i>	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	
J3290	CYKLOKAPRON	Injection, tranexamic acid, 5 mg	Not Covered	
J3290	<i>tranexamic acid intravenous</i>	Injection, tranexamic acid, 5 mg	Not Covered	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7165	BALFAXAR	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	Non-Specialty	
J7170	HEMLIBRA	Injection, emicizumab-kxwh, 0.5 mg	Pharmacy Only	
J7173	ALHEMO PEN	Injection, concizumab-mtci, 0.5 mg	Pharmacy Only	
J7174	QFITLIA	Injection, fitusiran, 0.04 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7174	QFITLIA PEN	Injection, fitusiran, 0.04 mg	Not Covered	
J7175	COAGADEX	Injection, factor X, (human), 1 IU (For billing prior to 1/1/17 use J3590 or C9399 for OPSS billing)	Pharmacy Only	
J7177	FIBRYGA	Injection, human fibrinogen concentrate (fibryga), 1 mg (Price is per 1mg. Product contains approximately 1 gram (900-1300mg))	Not Separately Payable	
J7179	VONVENDI	Injection, Von Willebrand factor (recombinant), (Vonvendi), 1 IU VWF:RCo (For billing prior to 1/1/17 use J7199 or C9399 for OPSS billing)	Pharmacy Only	
J7180	CORIFACT	Injection, factor XIII (antihemophilic factor, human), 1 IU (Code Price is per 1 IU - Corifact contains 1000-1600 Units) (For billing prior to 1/1/12 use J3590 or C9399)	Pharmacy Only	

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J7181	TRETTEN	Injection, factor XIII A-subunit, (recombinant), per IU For billing prior to 1/1/15 use C9134 or J3590)	Pharmacy Only	
J7182	NOVOEIGHT	Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU	Pharmacy Only	
J7183	WILATE	Injection, Von Willebrand factor complex (human), Wilate, 1 IU VWF:RCO	Pharmacy Only	
J7185	XYNTHA	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU	Pharmacy Only	
J7185	XYNTHA SOLOFUSE	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU	Pharmacy Only	
J7186	ALPHANATE	Injection, antihemophilic factor VIII/Von Willebrand factor complex (human), per factor VIII I.U.	Pharmacy Only	
J7187	HUMATE-P	Injection, Von Willebrand factor complex (Humate-P), per IU, VWF:RCO	Pharmacy Only	
J7188	OBIZUR	Injection, factor VIII (antihemophilic factor, recombinant), (Obizur), per IU (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9399 or J7199)	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7189	NOVOSEVEN RT	Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram	Pharmacy Only	
J7190	HEMOFIL M HIGH	Factor VIII (antihemophilic factor [human]) per IU	Pharmacy Only	
J7190	HEMOFIL M LOW	Factor VIII (antihemophilic factor [human]) per IU	Pharmacy Only	
J7190	HEMOFIL M MID	Factor VIII (antihemophilic factor [human]) per IU	Pharmacy Only	
J7190	HEMOFIL M SUPER HIGH	Factor VIII (antihemophilic factor [human]) per IU	Pharmacy Only	
J7190	KOATE	Factor VIII (antihemophilic factor [human]) per IU	Pharmacy Only	
J7192	ADVATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Pharmacy Only	
J7192	KOGENATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Pharmacy Only	
J7192	RECOMBINATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Pharmacy Only	
J7193	ALPHANINE SD	Factor IX (antihemophilic factor, purified, non-recombinant) per IU	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7194	PROFILNINE	Factor IX, complex, per IU	Pharmacy Only	
J7195	BENEFIX	Injection factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified	Pharmacy Only	
J7198	FEIBA NF	Anti-inhibitor, per IU	Pharmacy Only	
J7200	RIXUBIS	Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU (For billing prior to 1/1/15 use C9133 or J7195)	Pharmacy Only	
J7201	ALPROLIX	Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1 IU	Pharmacy Only	
J7202	IDELVION	Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, 1 IU (For billing prior to 1/1/17 use J7199 or C9139 for OPPS billing)	Pharmacy Only	
J7203	REBINYN	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	Pharmacy Only	
J7204	ESPEROCT	Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu	Pharmacy Only	
J7205	ELOCTATE	Injection, factor VIII, Fc fusion protein (recombinant), per IU	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7207	ADYNOVATE	Injection, factor VIII, (antihemophilic factor, recombinant), pegylated, 1 IU (For billing prior to 1/1/17 use J7199 or C9137 for OPSS billing)	Pharmacy Only	
J7208	JIVI	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	Pharmacy Only	
J7209	NUWIQ	Injection, factor VIII, (antihemophilic factor, recombinant), (Nuwiq), 1 IU (For billing prior to 1/1/17 use J7199 or C9138 for OPSS billing)	Pharmacy Only	
J7210	AFSTYLA	Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU (For billing prior to 1/1/18 use J7199 or C9140 for OPSS billing)	Pharmacy Only	
J7211	KOVALTRY	Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU (For billing prior to 1/1/18 use J7192)	Pharmacy Only	
J7212	SEVENFACT	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	Pharmacy Only	
J7213	IXINITY	Injection, coagulation factor ix (recombinant), ixinity, 1 i.u.	Pharmacy Only	

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J7214	ALTUVIIIIO	Injection, factor viii/von willebrand factor complex, recombinant (altuviio), per factor viii i.u.	Pharmacy Only	
Iron Preparations				
J1437	MONOFERRIC	Injection, ferric derisomaltose, 10 mg	Non-Preferred	
J1439	INJECTAFER	Injection, ferric carboxymaltose, 1 mg	Non-Preferred	
J1750	INFED	Injection, iron dextran, 50 mg (Code reinstated effective 1/1/09)	Non-Specialty	
J1756	VENOFER	Injection, iron sucrose, 1 mg	Non-Specialty	
J2916	FERRLECIT	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	Non-Specialty	
J2916	<i>sodium ferric gluconate-sucrose</i>	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	Non-Specialty	
Q0138	FERAHEME	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) (For billing prior to 1/1/10 use J3490 or C9399)	Non-Specialty	
Q0138	<i>ferumoxytol</i>	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) (For billing prior to 1/1/10 use J3490 or C9399)	Non-Specialty	
Thrombolytic Agents				
J3101	TNKASE	Injection, tenecteplase, 1 mg	Non-Specialty	

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Von Willebrand Factor-Related Antithromb				
J3590	CABLIVI INJECTION KIT	Unclassified biologics	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Cardiovascular Drugs				
Alpha-Adrenergic Blocking Agents (24:16)				
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, suv, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, suv, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
Angptl3 Inhibitors (24:06)				
J1305	EVKEEZA	Injection, evinacumab-dgnb, 5mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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Antilipemic Agents, Miscellaneous				
C9399	REDEMPLO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	TRYNGOLZA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
J1306	LEQVIO	Injection, inclisiran, 1 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3490	REDEMPLO	Unclassified drugs	Pharmacy Only	
Beta-Adrenergic Blocking Agents (24:20)				
J1805	BREVIBLOC	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	BREVIBLOC IN NACL (ISO-OSM)	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol in nacl (iso-osm)</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol intravenous solution</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1806	<i>esmolol in sterile water</i>	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, suv, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, suv, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J3490	RAPIBLYK	Unclassified drugs	Not Covered	
Bradykinin Receptors Antagonists				
J1744	FIRAZYR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Pharmacy Only	
J1744	<i>icatibant</i>	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Pharmacy Only	
J1744	SAJAZIR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Pharmacy Only	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Calcium-Channel Blocking Agents				
J0759	CLEVIPREX	Injection, clevidipine butyrate, 1 mg	Not Covered	
Cardiotonic Agents				
J1160	<i>digoxin injection</i>	Injection, digoxin, up to 0.5 mg	Non-Specialty	
J1160	LANOXIN INJECTION	Injection, digoxin, up to 0.5 mg	Non-Specialty	
J1160	LANOXIN PEDIATRIC	Injection, digoxin, up to 0.5 mg	Non-Specialty	
Class II Antiarrhythmics				
J1805	BREVIBLOC	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	BREVIBLOC IN NAACL (ISO-OSM)	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol in nacl (iso-osm)</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol intravenous solution</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1806	<i>esmolol in sterile water</i>	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, suv, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, suv, plf</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J3490	RAPIBLYK	Unclassified drugs	Not Covered	
<i>Dihydropyridines</i>				
J0759	CLEVIPREX	Injection, clevidipine butyrate, 1 mg	Not Covered	
<i>Kallikrein Inhibitors (24:48:08)</i>				
J0593	TAKHZYRO	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)	Pharmacy Only	
J0593	TAKHZYRO 300 MG/2 ML VIAL	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)	Pharmacy Only	
J1290	KALBITOR	Injection, ecallantide, 1 mg (For billing prior to 1/1/11 use J3590 or C9263)	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Loop Diuretics (24:36)				
J1807	<i>ethacrynate sodium</i>	Injection, ethacrynate sodium, 1 mg	Not Covered	
J1938	<i>furosemide injection</i>	Injection, furosemide, 1 mg	Non-Specialty	
J1941	FUROSCIX	Injection, furosemide (furoscix), 20 mg	Not Covered	
Nitrates And Nitrites				
J2305	<i>nitroglycerin in 5 % dextrose</i>	Injection, nitroglycerin, 5 mg	Non-Specialty	
J2305	<i>nitroglycerin intravenous</i>	Injection, nitroglycerin, 5 mg	Non-Specialty	
Osmotic Diuretics (24:36)				
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
Vasodilating Agents, Misc (24:08)				
J0759	CLEVIPREX	Injection, clevidipine butyrate, 1 mg	Not Covered	
Vasodilating Agents, Miscellaneous				
J0759	CLEVIPREX	Injection, clevidipine butyrate, 1 mg	Not Covered	
J1325	<i>epoprostenol</i>	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	FLOLAN	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	VELETRI	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1749	AURLUMYN 100 MCG/ML VIAL SUV	Injection, iloprost, 0.1 mcg	Not Covered	CC (No PA Required - Inpatient Use Only)
J1749	AURLUMYN 100 MCG/ML VIAL SUV, P/F	Injection, iloprost, 0.1 mcg	Not Covered	
J3285	REMODULIN 100 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	REMODULIN 20 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	REMODULIN 200 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	REMODULIN 50 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	<i>treprostinil sodium</i>	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3535	TYVASO DPI 16 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 16 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 16 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 16-32-48 MCG TITRAT	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 32 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 32 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 32 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Pharmacy Only	

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J3535	TYVASO DPI 32-64 MCG MAINT KIT	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 48 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 48 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 48 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 64 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 64 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 64 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 80 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Pharmacy Only	
J3535	TYVASO DPI 80 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Pharmacy Only	
J7686	TYVASO	Treprostinil, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	TYVASO INSTITUTIONAL START KIT	Treprostinil, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J7686	TYVASO REFILL KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	TYVASO STARTER KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Cellular And Gene Therapy				
Cellular Therapy				
C9399	AMTAGVI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL 100KG-LESS THAN 112.5KG SUV, P/F, OUTER	Injection, remestemcel-l-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy
J3402	RYONCIL 112.5KG-LESS THAN 125KG SUV, P/F, OUTER	Injection, remestemcel-l-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy
J3402	RYONCIL 12.5 KG-LESS THAN 25KG SUV, P/F, OUTER	Injection, remestemcel-l-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J3402	RYONCIL 125KG-LESS THAN 137.5KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy
J3402	RYONCIL 137.5KG-LESS THAN 150KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy
J3402	RYONCIL 25 KG-LESS THAN 37.5KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL 37.5 KG-LESS THAN 50KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL 50 KG-LESS THAN 62.5KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL 62.5 KG-LESS THAN 75KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL 75 KG-LESS THAN 87.5KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL 87.5KG-LESS THAN 100KG SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL LESS THAN 12.5 KG KIT SUV, P/F, OUTER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3402	RYONCIL VIAL SUV, P/F, INNER	Injection, remestemcel-I-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J3590	LANTIDRA	Unclassified biologics	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	OMISIRGE	Unclassified biologics	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	RETHYMIC	Unclassified biologics	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	AMTAGVI	Not otherwise classified, antineoplastic drugs	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Code Price is per 250 mL)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Gene Therapy				
C9399	ITVISMA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	

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C9399	KEBILIDI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
C9399	PAPZIMEOS	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Cellular/Gene Therapy	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1411	HEMGENIX	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1412	ROCTAVIAN	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10 ¹³ vector genomes	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	ELEVIDYS	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Not Covered	
J3387	SKYSONA	Injection, elivaldogene autotemcel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3391	LENMELDY	Injection, atidarsagene autotemcel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3392	CASGEVY	Injection, exagamglogene autotemcel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J3393	ZYNTEGLO	Injection, betibeglogene autotemcel, per treatment	Not Covered	
J3394	LYFGENIA	Injection, lovotibeglogene autotemcel, per treatment	Not Covered	
J3398	LUXTURNA	Injection, voretigene neparovec-rzyl, 1 billion vector genomes	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3399	ZOLGENSMA	Injection, onasemnogene abeparovec-xioi, per treatment, up to 5x10 ¹⁵ vector genomes	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3401	VYJUVEK	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 ⁹ pfu/ml vector genomes, per 0.1 ml	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3403	ENCELTO	Revakinagene taroretcel-lwey, per implant	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3404	PAPZIMEOS	Injection, zopapogene imadenovec-drba suspension, per therapeutic dose	Cellular/Gene Therapy	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	ITVISMA	Unclassified biologics	Preferred Specialty	
J3590	PAPZIMEOS	Unclassified biologics	Cellular/Gene Therapy	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9029	ADSTILADRIN	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J9325	IMLYGIC	Injection, talimogene laherparepvec, per 1 million plaque forming units (For billing prior to 1/1/17 use J9999 or C9472 for OPSS billing)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2041	YESCARTA	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (For billing prior to 4/1/18 use J9999 or C9399 for OPSS billing) (Code Price is for drug ONLY) (Code re-used by CMS)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2042	KYMRIAH	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code was reused by CMS 1/1/2019) (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2053	TECARTUS	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q2054	BREYANZI	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2054	BREYANZI CD4 COMPONENT (2OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2054	BREYANZI CD8 COMPONENT (1OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2055	ABECMA	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Q2056	CARVYKTI	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2057	TECELRA	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2058	AUCATZYL	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion (Split dose infusion; complete therapy=2 separate infusions 10 days apart)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Central Nervous System Agents				
<i>Amyotrophic Lateral Sclerosis(ALS) Agent</i>				
J1301	<i>edaravone</i>	Injection, edaravone, 1 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1301	RADICAVA	Injection, edaravone, 1 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1304	QALSODY	Injection, tofersen, 1 mg	Not Covered	

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Anorexigenic Agents, Miscellaneous				
C9399	ZEPBOUND 10 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	ZEPBOUND 12.5 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J3490	ZEPBOUND 7.5 MG/0.5 ML VIAL	Unclassified drugs	Pharmacy Only	
Anticholinergic Agents (Cns)				
J0515	<i>benztropine injection</i>	Injection, benztropine mesylate, per 1mg	Non-Specialty	
Antidepressants, Miscellaneous				
J3490	KETALAR	Unclassified drugs	Not Covered	CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
J3490	<i>ketamine injection</i>	Unclassified drugs	Not Covered	CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
Antimanic Agents				
J0401	ABILIFY MAINTENA	Injection, aripiprazole (abilify maintena), 1 mg	Non-Preferred	

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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J0402	ABILIFY ASIMTUFII	Injection, aripiprazole (abilify asimtufii), 1 mg	Preferred Specialty	
J1943	ARISTADA INITIO	Injection, aripiprazole lauroxil, (aristada initio), 1 mg	Non- Preferred	
J1944	ARISTADA	Injection, aripiprazole lauroxil, (aristada), 1 mg	Non- Preferred	
J2358	ZYPREXA RELPREVV	Injection, olanzapine, long-acting, 1 mg	Non-Specialty	
J2359	<i>olanzapine intramuscular</i>	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2359	ZYPREXA INTRAMUSCULAR	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2794	RISPERDAL CONSTA	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2794	<i>risperidone microspheres</i>	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2798	PERSERIS	Injection, risperidone, (perseris), 0.5 mg	Non- Preferred	
J2799	UZEDY	Injection, risperidone (uzedy), 1 mg	Preferred Specialty	
J3486	GEODON INTRAMUSCULAR	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	
J3486	<i>ziprasidone mesylate</i>	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	
Antimigraine Agents, Miscellaneous				
J0131	<i>acetaminophen 1,000 mg/100 ml bag plf, single use</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0131	<i>acetaminophen 1,000 mg/100 ml bag single-use, plf</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv, plf</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv, plf</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0134	<i>acetaminophen 1,000 mg/100 ml bag plf, suv, inner</i>	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0134	<i>acetaminophen 1,000 mg/100 ml bag plf, suv, outer</i>	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0136	<i>acetaminophen 1,000 mg/100 ml bag plf, suv</i>	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0136	<i>acetaminophen 500 mg/50 ml bag single use, p/f</i>	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0137	<i>acetaminophen 1,000 mg/100 ml bag inner, single use</i>	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0137	<i>acetaminophen 1,000 mg/100 ml bag outer, single use</i>	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0138	COMBOGESIC IV	Injection, acetaminophen 10 mg and ibuprofen 3 mg	Not Covered	
Anxiolytics, Sedatives, And Hypnotics, Misc				
C9399	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, INNER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, OUTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 1,000 MCG/250 ML BTL SINGLE USE, P/F	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, INNER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, OUTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BOTTLE INNER, SUV, P/F	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BOTTLE OUTER, SUV, P/F	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, INNER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	

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C9399	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, OUTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J3490	PRECEDEX 1,000 MCG/250 ML BTL SINGLE-USE, P/F	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, INNER	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, OUTER	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BOTTLE INNER, SUV, P/F	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BOTTLE OUTER, SUV, P/F	Unclassified drugs	Non-Specialty	
<i>Atypical Antipsychotics</i>				
J0401	ABILIFY MAINTENA	Injection, aripiprazole (abilify maintena), 1 mg	Non- Preferred	
J0402	ABILIFY ASIMTUFII	Injection, aripiprazole (abilify asimtufii), 1 mg	Preferred Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1943	ARISTADA INITIO	Injection, aripiprazole lauroxil, (aristada initio), 1 mg	Non-Preferred	
J1944	ARISTADA	Injection, aripiprazole lauroxil, (aristada), 1 mg	Non-Preferred	
J2358	ZYPREXA RELPREVV	Injection, olanzapine, long-acting, 1 mg	Non-Specialty	
J2359	<i>olanzapine intramuscular</i>	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2359	ZYPREXA INTRAMUSCULAR	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2426	INVEGA SUSTENNA	Injection, paliperidone palmitate extended release (invega sustenna), 1 mg	Preferred Specialty	
J2427	INVEGA HAFYERA	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg	Preferred Specialty	
J2427	INVEGA TRINZA	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg	Preferred Specialty	
J2428	ERZOFRI 117 MG/0.75 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera & Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J2428	ERZOFRI 156 MG/ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2428	ERZOFRI 234 MG/1.5 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2428	ERZOFRI 351 MG/2.25 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J2428	ERZOFRI 39 MG/0.25 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2428	ERZOFRI 78 MG/0.5 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2794	RISPERDAL CONSTA	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2794	<i>risperidone microspheres</i>	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2798	PERSERIS	Injection, risperidone, (perseris), 0.5 mg	Non- Preferred	
J2799	UZEDY	Injection, risperidone (uzedy), 1 mg	Preferred Specialty	
J3486	GEODON INTRAMUSCULAR	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J3486	<i>ziprasidone mesylate</i>	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	
Barbiturates (Anticonvulsants)				
J2560	<i>phenobarbital sodium</i>	Injection, phenobarbital sodium, up to 120 mg	Non-Specialty	
J2561	SEZABY	Injection, phenobarbital sodium (sezaby), 1 mg	Not Covered	CA (Covered Alternative(s): J2560 - phenobarbital sodium. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Barbiturates (Anxiolytic, Sedative/Hyp)				
J2560	<i>phenobarbital sodium</i>	Injection, phenobarbital sodium, up to 120 mg	Non-Specialty	
J2561	SEZABY	Injection, phenobarbital sodium (sezaby), 1 mg	Not Covered	CA (Covered Alternative(s): J2560 - phenobarbital sodium. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Benzodiazepines (Anticonvulsants)				
J2060	ATIVAN INJECTION	Injection, lorazepam, 2 mg	Non-Specialty	
J2060	<i>lorazepam injection</i>	Injection, lorazepam, 2 mg	Non-Specialty	
J3360	<i>diazepam injection</i>	Injection, diazepam, up to 5 mg	Non-Specialty	
J3490	<i>midazolam intramuscular</i>	Unclassified drugs	Pharmacy Only	
Benzodiazepines (Anxiolytic, Sedative/Hyp)				
J2060	ATIVAN INJECTION	Injection, lorazepam, 2 mg	Non-Specialty	
J2060	<i>lorazepam injection</i>	Injection, lorazepam, 2 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J2252	<i>midazolam in nacl,iso-osmo(pf) intravenous solution</i>	Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to j2250, 1 mg	Non-Specialty	
J3360	<i>diazepam injection</i>	Injection, diazepam, up to 5 mg	Non-Specialty	
Butyrophenones				
J1630	<i>haloperidol lactate injection</i>	Injection, haloperidol, up to 5 mg	Non-Specialty	
J1630	<i>haloperidol lactate intramuscular</i>	Injection, haloperidol, up to 5 mg	Non-Specialty	
J1631	<i>haloperidol decanoate</i>	Injection, haloperidol decanoate, per 50 mg	Non-Specialty	
Calcitonin Gene-Related Peptide Antag.				
J3031	AJOVY AUTOINJECTOR	Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	Pharmacy Only	
J3031	AJOVY SYRINGE	Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	Pharmacy Only	
J3032	VYEPTI	Injection, eptinezumab-jjmr, 1 mg	Non-Preferred	PA
Central Nervous System Agents, Misc.				
J3490	VYLEESI	Unclassified drugs	Pharmacy Only	

PA-Prior Authorization; SOS-Site of Service; CC-Coverage Change; CA-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
<i>Dibenzoxapines</i>				
J2062	ADASUVE	Loxapine for inhalation, 1 mg	Not Covered	CC (No PA Required - Inpatient Use Only)
<i>Dopamine Precursors</i>				
J7340	DUOPA	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 mL	Non-Preferred	PA
<i>Nmda Antagonists</i>				
J0013	SPRAVATO	Esketamine, nasal spray, 1 mg	Non-Preferred	PA
S0013	SPRAVATO	Esketamine, nasal spray, 1 mg (Code deleted effective 12/31/2025)	Non-Preferred	PA
<i>Non-Barbiturates</i>				
J3490	KETALAR	Unclassified drugs	Not Covered	CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
J3490	<i>ketamine injection</i>	Unclassified drugs	Not Covered	CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
<i>Nonergot-Deriv.Dopamine Receptor Agonist</i>				
C9399	ONAPGO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0364	APOKYN	Injection, apomorphine hydrochloride, 1 mg	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0364	<i>apomorphine</i>	Injection, apomorphine hydrochloride, 1 mg	Pharmacy Only	
Non-Opioid Analgesics				
J0131	<i>acetaminophen 1,000 mg/100 ml bag plf, single use</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml bag single-use, plf</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv, plf</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv, plf</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0134	<i>acetaminophen 1,000 mg/100 ml bag plf, suv, inner</i>	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0134	<i>acetaminophen 1,000 mg/100 ml bag plf, suv, outer</i>	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0136	<i>acetaminophen 1,000 mg/100 ml bag plf, suv</i>	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0136	<i>acetaminophen 500 mg/50 ml bag single use, plf</i>	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0137	<i>acetaminophen 1,000 mg/100 ml bag inner, single use</i>	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0137	<i>acetaminophen 1,000 mg/100 ml bag outer, single use</i>	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0138	COMBOGESIC IV	Injection, acetaminophen 10 mg and ibuprofen 3 mg	Not Covered	
J2278	PRIALT	Injection, ziconotide, 1 microgram	Preferred Specialty	
Opioid Agonists (28:08)				
J1171	DILAUDID 0.2 MG/ML SYRINGE SUV, P/F, INNER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 0.2 MG/ML SYRINGE SUV, P/F, OUTER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 0.5 MG/0.5 ML SYRINGE SUV, P/F, INNER	Injection, hydromorphone, 0.1 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1171	DILAUDID 0.5 MG/0.5 ML SYRINGE SUV, P/F, OUTER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 1 MG/ML SYRINGE SUV, P/F, INNER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 1 MG/ML SYRINGE SUV, P/F, OUTER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 2 MG/ML SYRINGE SUV, P/F, INNER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 2 MG/ML SYRINGE SUV, P/F, OUTER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	<i>hydromorphone (pf)</i>	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	<i>hydromorphone injection</i>	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J2175	DEMEROL	Injection, meperidine hydrochloride, per 100 mg	Non-Specialty	
J2175	DEMEROL (PF)	Injection, meperidine hydrochloride, per 100 mg	Non-Specialty	
J2175	<i>meperidine (pf)</i>	Injection, meperidine hydrochloride, per 100 mg	Non-Specialty	
Opioid Antagonists (28:10)				
J2315	VIVITROL	Injection, naltrexone, depot form, 1 mg	Preferred Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Opioid Partial Agonists				
J0577	BRIXADI	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	Preferred Specialty	
J0578	BRIXADI	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	Preferred Specialty	
J0592	<i>buprenorphine hcl injection</i>	Injection, buprenorphine hydrochloride, 0.1 mg	Non-Specialty	
Q9991	SUBLOCADE	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg (For billing prior to 7/1/18 use J3490 or C9399 for Hospital OPPS use) (Code Price is per 100 mg)	Preferred Specialty	
Q9992	SUBLOCADE	Injection, buprenorphine extended-release (Sublocade), greater than 100 mg (For billing prior to 7/1/18 use J3490 or C9399 for Hospital OPPS use) (Code Price is per 300 mg)	Preferred Specialty	
Phenothiazines				
J2679	<i>fluphenazine hcl injection</i>	Injection, fluphenazine hcl, 1.25 mg	Non-Specialty	
J2680	<i>fluphenazine decanoate</i>	Injection, fluphenazine decanoate, up to 25 mg	Non-Specialty	
J3230	<i>chlorpromazine injection</i>	Injection, chlorpromazine HCl, up to 50 mg	Non-Specialty	

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Reversible Cox-1/Cox-2 Inhibitors				
J0138	COMBOGESIC IV	Injection, acetaminophen 10 mg and ibuprofen 3 mg	Not Covered	
J0668	ZYNRELEF	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	Not Covered	
J1737	XIFYRM	Injection, meloxicam (azurity), 1 mg	Not Covered	
Devices				
Devices				
J7318	DUROLANE	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	Not Covered	
J7320	GENVISC 850	Hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 mg (Code re-used by CMS effective 1/1/17) (GenVisc 850 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	
J7321	HYALGAN	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL, Supartz and Visco-3 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	

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J7321	SUPARTZ FX	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL, Supartz and Visco-3 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	
J7321	VISCO-3	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL, Supartz and Visco-3 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	
J7322	HYMOVIS	Hyaluronan or derivative, hymovis or hymovis one, for intra-articular injection, 1 mg	Not Covered	
J7322	HYMOVIS ONE	Hyaluronan or derivative, hymovis or hymovis one, for intra-articular injection, 1 mg	Not Covered	
J7323	EUFLEXXA	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose (20 mg/2 mL) (Note: Total dose regimen = 3 injections)	Not Covered	
J7324	ORTHOVISC	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL) (Note: Total dose regimen = 3 - 4 injections)	Not Covered	

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J7325	SYNVISC	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg (For billing prior to 1/1/10 see J7322 for Synvisc and J3490 for Synvisc-One)	Not Covered	
J7325	SYNVISC-ONE	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg (For billing prior to 1/1/10 see J7322 for Synvisc and J3490 for Synvisc-One)	Not Covered	
J7326	GEL-ONE	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	Not Covered	
J7327	MONOVISC	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose (For billing prior to 1/1/15 use C9399 or J3490) (Dose 88 mg/4 mL) (Note: Total dose regimen = 1 dose)	Not Covered	
J7328	GELSYN-3	Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg	Not Covered	
J7329	TRIVISC	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	Not Covered	
J7331	SYNOJOYNT 1% 20 MG/2 ML SYRING	Hyaluronan or derivative, synojynt, for intra-articular injection, 1 mg	Not Covered	
J7332	TRILURON	Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg	Not Covered	

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Diagnostic Agents				
Adrenocortical Insufficiency				
J0801	ACTHAR	Injection, corticotropin (acthar gel), up to 40 units	Pharmacy Only	
J0801	ACTHAR SELFJECT	Injection, corticotropin (acthar gel), up to 40 units	Pharmacy Only	
J0802	CORTROPHIN GEL	Injection, corticotropin (ani), up to 40 units	Pharmacy Only	
Diagnostic Agents				
A9596	ILLUCCIX	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie (NDC Unit Pricing is based on 7 mCi dose)	Non-Specialty	
J1611	<i>glucagon 1 mg vial inner, suv</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial outer, suv</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial suv, inner</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial suv, outer</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	

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J1611	<i>glucagon 1 mg vial suv,inner</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial suv,outer</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1612	GVOKE VIALDX	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
Gallbladder Function				
J2805	KINEVAC	Injection, sincalide, 5 micrograms	Non-Specialty	
J2805	<i>sincalide</i>	Injection, sincalide, 5 micrograms	Non-Specialty	
Kidney Function				
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
Myasthenia Gravis				
J2710	BLOXIVERZ	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe inner, suv</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe outer, suv</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine methylsulfate intravenous solution</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
Thyroid Function				
J3240	THYROGEN	Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial (Code Price is per 1 vial)	Preferred Specialty	

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Electrolytic, Caloric, And Water Balance				
<i>Electrolytic, Caloric, Water Balance Misc,</i>				
J0584	CRYSVITA	Injection, burosumab-twza 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Irrigating Solutions				
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
Loop Diuretics (40:28)				
C9399	LASIX ONYU	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
J1807	<i>ethacrynate sodium</i>	Injection, ethacrynate sodium, 1 mg	Not Covered	
J1938	<i>furosemide injection</i>	Injection, furosemide, 1 mg	Non-Specialty	
J1941	FUROSCIX	Injection, furosemide (furoscix), 20 mg	Not Covered	
J3490	LASIX ONYU	Unclassified drugs	Not Covered	
Osmotic Diuretics (40:28)				
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
Phosphate-Removing Agents				
J0607	FOSRENOL	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)	Pharmacy Only	
J0607	<i>lanthanum</i>	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)	Pharmacy Only	

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J0608	FOSRENOL	Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to j0607 (for esrd on dialysis)	Pharmacy Only	
J0609	AURYXIA	Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis)	Pharmacy Only	
J0615	<i>calcium acetate</i>	Calcium acetate, oral, 23 mg (for esrd on dialysis)	Pharmacy Only	
J0615	<i>calcium acetate(phosphat bind)</i>	Calcium acetate, oral, 23 mg (for esrd on dialysis)	Pharmacy Only	
Replacement Preparations				
J3490	<i>potassium phos in 0.9 % nacl intravenous piggyback</i>	Unclassified drugs	Non-Specialty	
Enzymes				
Enzyme Inhibitors				
J1202	OPFOLDA	Miglustat, oral, 65 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Enzymes				
C9399	REVCOVI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	PA
J0180	FABRAZYME	Injection, agalsidase beta, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0217	LAMZEDE	Injection, velmanase alfa-tycv, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J0218	XENPOZYME	Injection, olipudase alfa-rpcp, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0219	NEXVIAZYME	Injection, avalglucosidase alfa-ngpt, 4 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0221	LUMIZYME	Injection, alglucosidase alfa, (Lumizyme), 10 mg (For billing prior to 1/1/12 use J3590 or C9277)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0567	BRINEURA INTRAVENTRICULAR KIT	Injection, cerliponase alfa, 1 mg	Preferred Specialty	PA
J0775	XIAFLEX	Injection, collagenase, clostridium histolyticum, 0.01 mg (For billing prior to 1/1/11 use J3590 or C9266)	Preferred Specialty	PA
J1203	POMBILITI	Injection, cipaglucosidase alfa-atga, 5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1322	VIMIZIM	Injection, elosulfase alfa, 1 mg (For billing prior to 1/1/15 use C9022 or J3590)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1458	NAGLAZYME	Injection, galsulfase, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1743	ELAPRASE	Injection, idursulfase, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1786	CEREZYME	Injection, imiglucerase, 10 units	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1931	ALDURAZYME	Injection, laronidase, 0.1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2508	ELFABRIO	Injection, pegunigalsidase alfa-iwxj, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J2783	ELITEK	Injection, rasburicase, 0.5 mg	Non-Specialty	
J2840	KANUMA	Injection, sebelipase alfa, 1 mg (For billing prior to 1/1/17 use J3590 or C9478 for OPSS billing)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3060	ELELYSO	Injection, taliglucerase alfa, 10 units	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3385	VPRIV	Injection, velaglucerase alfa, 100 units (For billing prior to 1/1/11 use J3490 or C9271)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3397	MEPSEVII	Injection, vestronidase alfa-vjbjk, 1 mg	Not Covered	
J7171	ADZYNMA	Injection, adamts13, recombinant- krhn, 10 iu	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7639	PULMOZYME	Dornase alfa, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose form, per milligram	Pharmacy Only	
J9021	RYLAZE	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	Preferred Specialty	PA
J9118	ASPARLAS	Injection, calaspargase pegol- mkn1, 10 units	Non- Preferred	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
Eye, Ear, Nose And Throat (Eent) Preps.				
Antibacterials (52:04)				
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	

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J2280	<i>moxifloxacin-sod.chloride(iso)</i>	Injection, moxifloxacin, 100 mg	Non-Specialty	
J2281	<i>moxifloxacin-sod.ace,sul-water</i>	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg	Non-Specialty	
Antiglaucoma Agents, Miscellaneous				
J7315	MITOSOL	Mitomycin, ophthalmic, 0.2 mg (Code re-used by CMS effective 1/1/13) (For billing prior to 1/1/13 use J3490 or C9399)	Non-Specialty	
Anti-Inflammatory Agents (Eent)				
J3241	TEPEZZA	Injection, teprotumumab-trbw, 10 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7516	<i>cyclosporine intravenous</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	SANDIMMUNE INTRAVENOUS	Injection, cyclosporine, 250 mg	Non-Specialty	
Antivirals (Eent)				
J1570	<i>ganciclovir sodium</i>	Injection, ganciclovir sodium, 500 mg	Non-Specialty	
Corticosteroids (Eent)				
J1095	DEXYCU (PF)	Injection, dexamethasone 9 percent, intraocular, 1 microgram (Code reused by CMS January 1, 2019) (Each single dose vial provides a 0.005 mL dose equivalent to 517 micrograms)	Not Covered	
J3299	XIPERE (PF)	Injection, triamcinolone acetonide (xipere), 1 mg	Not Covered	

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J7311	RETISERT	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	Not Covered	
J7312	OZURDEX	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311E10.321 -E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.93, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390.
J7313	ILUVIEN	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311, E10.321 -E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.039, H30.20-H30.23,H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.

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J7314	YUTIQ	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes H30.001-H30.039, H30.20-H30.23,H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7402	SINUVA	Mometasone furoate sinus implant, (sinuva), 10 micrograms	Not Covered	
Eent Drugs, Miscellaneous				
J2779	SUSVIMO (INITIAL FILL)	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	Not Covered	CA (Covered Alternative(s): J2778 - Lucentis (ranibizumab), Q5124 - Byooviz (ranibizumab-nuna), Q5128 - Cimerli (ranibizumab-eqrn). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J2787	PHOTREXA CROSS-LINKING KIT	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	Preferred Specialty	
Q5124	BYOOVIZ	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	Preferred Specialty	PA
Eent Nonsteroidal Anti-Inflam. Agents				
J1097	OMIDRIA	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Non-Specialty	
Local Anesthetics (Eent)				
J2403	IHEEZO (PF)	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	Not Covered	
Macular Degeneration Agents				
J2781	SYFOVRE (PF)	Injection, pegcetacoplan, intravitreal, 1 mg	Preferred Specialty	PA

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J2782	IZERVAY (PF)	Injection, avacincapted pegol, 0.1 mg	Not Covered	
J3396	VISUDYNE	Injection, verteporfin, 0.1 mg	Preferred Specialty	PA; No PA required for ICD-10 codes B39.4,B39.5, H32,H35.3210-H35.3233, H35.711 - H35.713, H44.20- H44.2E9.
Mydriatics				
J1097	OMIDRIA	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Non-Specialty	
J2371	<i>phenylephrine hcl injection</i>	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2371	VAZCULEP	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
Osmotic Agents				
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
Prostaglandin Analogs				
J7351	DURYSTA	Injection, bimatoprost, intracameral implant, 1 microgram	Not Covered	
J7355	IDOSE TR	Injection, travoprost, intracameral implant, 1 microgram	Not Covered	
Vascular Endothelial Growth Factor Antag				
J0177	EYLEA HD	Injection, aflibercept hd, 1 mg	Preferred Specialty	PA
J0178	EYLEA	Injection, aflibercept, 1 mg	Preferred Specialty	PA

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0179	BEOVU	Injection, brolocizumab-dbl, 1 mg	Non-Preferred	PA; No PA required for ICD-10 codes H35.3210-H35.3213, H35.3220-H32.3223, H35.3230-H35.3233, H35.3290-H35.3293.
J2777	VABYSMO	Injection, faricimab-svoa, 0.1 mg	Preferred Specialty	PA
J2778	LUCENTIS 0.3 MG/0.05 ML VIAL P/F, SUV, SAMPLE	Injection, ranibizumab, 0.1 mg	Non-Preferred	PA
J2778	LUCENTIS INTRAVITREAL SYRINGE	Injection, ranibizumab, 0.1 mg	Non-Preferred	PA
J2779	SUSVIMO	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	Not Covered	
Q5128	CIMERLI	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	Preferred Specialty	PA
Q5147	PAVBLU	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	Preferred Specialty	PA
Vasoconstrictors				
J1097	OMIDRIA	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Non-Specialty	
J2371	<i>phenylephrine hcl injection</i>	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2371	VAZCULEP	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Gastrointestinal Drugs				
5-Ht3 Receptor Antagonists				
J1454	AKYNZEO (FOSNETUPITANT)	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	Non-Specialty	
J1626	<i>granisetron hcl 1 mg/ml vial sdv, plf</i>	Injection, granisetron hydrochloride, 100 mcg	Non-Specialty	
J1626	<i>granisetron hcl 1 mg/ml vial suv, plf</i>	Injection, granisetron hydrochloride, 100 mcg	Non-Specialty	
J1626	<i>granisetron hcl intravenous</i>	Injection, granisetron hydrochloride, 100 mcg	Non-Specialty	
J1627	SUSTOL	Injection, granisetron, extended- release, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9486 for OPPS billing)	Not Covered	
J2405	<i>ondansetron hcl (pf)</i>	Injection, ondansetron hydrochloride, per 1 mg	Non-Specialty	
J2405	<i>ondansetron hcl intravenous</i>	Injection, ondansetron hydrochloride, per 1 mg	Non-Specialty	
J2468	POSFREA	Injection, palonosetron hydrochloride (posfrea), 25 micrograms	Preferred Specialty	
J2469	<i>palonosetron</i>	Injection, palonosetron HCl, 25 mcg	Preferred Specialty	
Antiemetics, Miscellaneous				
J2358	ZYPREXA RELPREVV	Injection, olanzapine, long-acting, 1 mg	Non-Specialty	
J2359	<i>olanzapine intramuscular</i>	Injection, olanzapine, 0.5 mg	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2359	ZYPREXA INTRAMUSCULAR	Injection, olanzapine, 0.5 mg	Preferred Specialty	
Antiulcer Agents And Acid Suppressants				
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
Digestants				
J3490	GATTEX 30-VIAL	Unclassified drugs	Pharmacy Only	
J3490	GATTEX ONE-VIAL	Unclassified drugs	Pharmacy Only	
Dopamine Receptor Antagonists				
J0184	BARHEMSYS	Injection, amisulpride, 1 mg	Not Covered	
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
Gi Drugs, Miscellaneous				
J1440	REBYOTA	Fecal microbiota, live - jsml, 1 ml (Code reused effective 7/1/2023)	Not Covered	
Histamine H2-Antagonists				
J1308	<i>famotidine (pf)-nacl (iso-os)</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial 25's, sdv, pf, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial inner, pf, suv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1308	<i>famotidine 20 mg/2 ml vial inner, suv, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial outer, p/f, suv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial outer, suv, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, inner, sdv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, outer, sdv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, suv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, suv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial sdv,p/f,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial suv, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial 10's,mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mdv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mdv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial muv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial muv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1308	<i>famotidine 40 mg/4 ml vial</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mov, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mov, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
Immunomodulatory Agents (56:44)				
J2267	OMVOH INTRAVENOUS	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	Non-Preferred	PA
J2267	OMVOH PEN	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	Pharmacy Only	
J2267	OMVOH SUBCUTANEOUS	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	Pharmacy Only	
Neurokinin-1 Receptor Antagonists				
J0185	CINVANTI	Injection, aprepitant, 1 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1434	FOCINVEZ	Injection, fosaprepitant (focinvez), 1 mg	Not Covered	CA (Covered Alternative(s): J1453 - Emend (fosaprepitant), J1456 - fosaprepitant (teva). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1453	EMEND (FOSAPREPITANT)	Injection, fosaprepitant, 1 mg	Non-Specialty	
J1453	<i>fosaprepitant</i>	Injection, fosaprepitant, 1 mg	Non-Specialty	
J1454	AKYNZEO (FOSNETUPITANT)	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	Non-Specialty	
J1456	<i>fosaprepitant</i>	Injection, fosaprepitant (teva), not therapeutically equivalent to j1453, 1 mg	Non-Specialty	
J3490	APONVIE	Unclassified drugs	Preferred Specialty	
Opioid Antagonists (56:18)				
J2212	RELISTOR SUBCUTANEOUS	Injection, methylnaltrexone, 0.1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Not Covered	
Proton-Pump Inhibitors				
J1370	<i>esomeprazole sodium</i>	Injection, esomeprazole sodium, 1 mg	Not Covered	
J2470	<i>pantoprazole intravenous</i>	Injection, pantoprazole sodium, 40 mg	Non-Specialty	
J2470	PROTONIX INTRAVENOUS	Injection, pantoprazole sodium, 40 mg	Non-Specialty	

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J2471	<i>pantoprazole intravenous</i>	Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg	Non-Specialty	
J2472	<i>pantoprazole in 0.9% sod chlor</i>	Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg	Non-Specialty	
Heavy Metal Antagonists				
Heavy Metal Antagonists				
J0895	<i>deferoxamine</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	DESFERAL	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
Hormones And Synthetic Substitutes				
Adrenals				
J1010	DEPO-MEDROL	Injection, methylprednisolone acetate, 1 mg	Non-Specialty	
J1010	<i>methylprednisolone acetate</i>	Injection, methylprednisolone acetate, 1 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J2919	<i>methylprednisolone sodium succ</i>	Injection, methylprednisolone sodium succinate, 5 mg	Non-Specialty	
J2919	SOLU-MEDROL	Injection, methylprednisolone sodium succinate, 5 mg	Non-Specialty	
J2919	SOLU-MEDROL (PF)	Injection, methylprednisolone sodium succinate, 5 mg	Non-Specialty	
J3304	ZILRETTA	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Not Covered	
J7312	OZURDEX	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311E10.321 -E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.93, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390.
J7402	SINUVA	Mometasone furoate sinus implant, (sinuva), 10 micrograms	Not Covered	
Androgens				
J1072	AZMIRO	Injection, testosterone cypionate (azmiro), 1 mg	Not Covered	
J1073	TESTOPEL	Testosterone pellet, implant, 75 mg	Non-Specialty	PA

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J3145	AVEED	Injection, testosterone undecanoate, 1 mg (For billing prior to 1/1/15 use C9023 or J3490)	Non-Specialty	PA
Antidiabetic Agents, Miscellaneous				
J9381	TZIELD	Injection, teplizumab-mzwv, 5 mcg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Antigonadotropins				
J1072	AZMIRO	Injection, testosterone cypionate (azmiro), 1 mg	Not Covered	
J3145	AVEED	Injection, testosterone undecanoate, 1 mg (For billing prior to 1/1/15 use C9023 or J3490)	Non-Specialty	PA
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7296	KYLEENA	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	Refer to Contraceptive Coverage	
J7301	SKYLA	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	Refer to Contraceptive Coverage	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	Refer to Contraceptive Coverage	
J9155	FIRMAGON	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9155	FIRMAGON KIT W DILUENT SYRINGE	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
Antiparathyroid Agents				
J0606	PARSABIV	Injection, etelcalcetide, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9399 for OPSS billing)	Non-Preferred	PA
Contraceptives				
J7294	ANNOVERA	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each	Pharmacy Only	
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7296	KYLEENA	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	Refer to Contraceptive Coverage	
J7301	SKYLA	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	Refer to Contraceptive Coverage	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	Refer to Contraceptive Coverage	
Estrogens				
J1000	DEPO-ESTRADIOL	Injection, depo-estradiol cypionate, up to 5 mg	Non-Specialty	
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
Glycogenolytic Agents				
J1610	GLUCAGON EMERGENCY KIT (HUMAN)	Injection, glucagon hydrochloride, per 1 mg	Non-Specialty	
J1611	GLUCAGON (HCL) EMERGENCY KIT	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon hcl</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1612	GVOKE HYPOPEN 1- PK 1 MG/0.2 ML	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
J1612	GVOKE VIALDX	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	

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Gonadotropins				
J1950	LUPRON DEPOT 11.25 MG 3MO KIT 3 MONTH, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT 3.75 MG KIT P/F, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT 3.75 MG KIT SUV, P/F, SAMPLE	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	LUPRON DEPOT-PED	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1950	LUPRON DEPOT-PED (3 MONTH)	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1951	FENSOLVI	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1952	CAMCEVI (6 MONTH)	Leuprolide injectable, camcevi, 1 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3315	TRELSTAR	Injection, triptorelin pamoate, 3.75 mg	Non-Specialty	
J3316	TRIPTODUR	Injection, triptorelin, extended-release, 3.75 mg	Non-Preferred	
J9202	ZOLADEX	Goserelin acetate implant, per 3.6 mg	Preferred Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	ELIGARD	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	ELIGARD (3 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	ELIGARD (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	ELIGARD (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	LUPRON DEPOT (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	LUPRON DEPOT (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	LUPRON DEPOT 22.5 MG 3MO KIT SUV, P/F	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	LUPRON DEPOT 7.5 MG KIT SINGLE DOSE	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	VABRINTY (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Not Covered	
J9218	<i>leuprolide</i>	Leuprolide acetate, per 1 mg	Non-Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9226	SUPPRELIN LA	Histrelin implant (Supprelin LA), 50 mg	Non- Preferred	PA

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Incretin Mimetics				
C9399	ZEPBOUND 10 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	ZEPBOUND 12.5 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	ZEPBOUND SUBCUTANEOUS PEN INJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J3490	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, INNER	Unclassified drugs	Pharmacy Only	
J3490	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, OUTER	Unclassified drugs	Pharmacy Only	
J3490	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, INNER	Unclassified drugs	Pharmacy Only	
J3490	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, OUTER	Unclassified drugs	Pharmacy Only	

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J3490	ZEPBOUND 7.5 MG/0.5 ML VIAL	Unclassified drugs	Pharmacy Only	
J3490	ZEPBOUND SUBCUTANEOUS PEN INJECTOR	Unclassified drugs	Pharmacy Only	
Melanocortin Receptor Agonists				
J7352	SCENESSE	Afamelanotide implant, 1 mg	Preferred Specialty	PA
Parathyroid Agents				
J3110	FORTEO	Injection, teriparatide, 10 mcg	Pharmacy Only	
J3110	<i>teriparatide</i>	Injection, teriparatide, 10 mcg	Pharmacy Only	
J3490	YORVIPATH	Unclassified drugs	Pharmacy Only	
Pituitary				
J0801	ACTHAR	Injection, corticotropin (acthar gel), up to 40 units	Pharmacy Only	
J0801	ACTHAR SELFJECT	Injection, corticotropin (acthar gel), up to 40 units	Pharmacy Only	
J0802	CORTROPHIN GEL	Injection, corticotropin (ani), up to 40 units	Pharmacy Only	
J2596	<i>vasopressin in 0.9 % sod chlor intravenous solution</i>	Injection, vasopressin (long grove), not therapeutically equivalent to j2598, 1 unit	Non-Specialty	
J2597	DDAVP INJECTION	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	
J2597	<i>desmopressin injection</i>	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	

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J2598	<i>vasopressin</i>	Injection, vasopressin, 1 unit	Non-Specialty	
J2598	VASOSTRICT	Injection, vasopressin, 1 unit	Non-Specialty	
J2599	<i>vasopressin</i>	Injection, vasopressin (american regent), not therapeutically equivalent to j2598, 1 unit	Non-Specialty	
J2601	<i>vasopressin in 0.9 % sod chlor intravenous solution</i>	Injection, vasopressin (baxter), 1 unit	Non-Specialty	
J2941	GENOTROPIN	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	GENOTROPIN MINIQUICK	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	HUMATROPE INJECTION CARTRIDGE	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	NORDITROPIN FLEXPRO	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	NUTROPIN AQ NUSPIN	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	OMNITROPE	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	SAIZEN SAIZENPREP	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	SEROSTIM	Injection, somatropin, 1 mg	Pharmacy Only	
J2941	ZOMACTON	Injection, somatropin, 1 mg	Pharmacy Only	
J3590	NGENLA	Unclassified biologics	Pharmacy Only	

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Progestins				
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Pharmacy Only	
J7296	KYLEENA	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	Refer to Contraceptive Coverage	
J7301	SKYLA	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	Refer to Contraceptive Coverage	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	Refer to Contraceptive Coverage	

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Somatostatin Agonists				
J1930	<i>lanreotide</i>	Injection, lanreotide, 1 mg (Code re-used by CMS effective 1/1/2009)	Non-Specialty	
J1930	SOMATULINE DEPOT	Injection, lanreotide, 1 mg (Code re-used by CMS effective 1/1/2009)	Non-Specialty	
J1932	<i>lanreotide</i>	Injection, lanreotide, (cipl), 1 mg	Non-Specialty	
J2353	<i>octreotide,microspheres</i>	Injection, octreotide, depot form for intramuscular injection, 1 mg	Preferred Specialty	
J2353	SANDOSTATIN LAR DEPOT	Injection, octreotide, depot form for intramuscular injection, 1 mg	Preferred Specialty	
J2354	BYNFEZIA	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	Pharmacy Only	
J2502	SIGNIFOR LAR	Injection, pasireotide long acting, 1 mg (Code Price is based on Median pricing methodology due to flat pricing) (For billing prior to 1/1/16 use C9454 or J3490)	Non-Preferred	PA
Somatotropin Agonists				
C9399	EGRIFTA SV	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	

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C9399	EGRIFTA WR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J2170	INCRELEX	Injection, mecasecmin, 1 mg	Pharmacy Only	
Thyroid Agents				
J0650	<i>levothyroxine intravenous</i>	Injection, levothyroxine sodium, not otherwise specified, 10 mcg	Non-Specialty	
J0651	<i>levothyroxine intravenous</i>	Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to j0650, 10 mcg	Non-Specialty	
J0652	<i>levothyroxine intravenous</i>	Injection, levothyroxine sodium (hikma), not therapeutically equivalent to j0650, 10 mcg	Non-Specialty	
Immunomodulatory Agents (90:00)				
Antimetabolites				
J9065	<i>cladribine</i>	Injection, cladribine, per 1 mg	Non-Specialty	
April Or Baff Inhibitor Agents				
C9399	VOYXACT	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
J3590	VOYXACT	Unclassified biologics	Not Covered	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Bone-Modifying Agents				
C9399	BILDYOS	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	BILPREVDA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	ENOBY	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0897	PROLIA	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	Not Covered	CA (Covered Alternative(s): C9399, J3590 - BILDYOS (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0897	XGEVA 120 MG/1.7 ML VIAL SUV, P/F	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	Not Covered	CA (Covered Alternative(s): C9399, J3590 - BILDYOS (denosumab- nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J0897	XGEVA 120 MG/1.7 ML VIAL SUV, STERILE, P/F	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J3111	EVENITY	Injection, romosozumab-aqqg, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	BILDYOS	Unclassified biologics	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	ENOBY	Unclassified biologics	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	BILPREVDA	Not otherwise classified, antineoplastic drugs	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5136	JUBBONTI	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): J3590, C9399 - BILDYOS (denosumab- nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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Q5136	WYOST	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5157	OSENVELT	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5157	STOBOCLO	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - BILDYOS (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5158	BOMYNTRA SUBCUTANEOUS SOLUTION	Injection, denosumab-bnht (bomyntra/conexence), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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Q5158	CONEXXENCE	Injection, denosumab-bnht (bomynta/conexxence), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - BILDYOS (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5159	OSPOMYV	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): C9399, J3590 - BILDYOS (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5162	BILDYOS	Injection, denosumab-nxxp (bilyos/bilprevda), biosimilar, 1 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5162	BILPREVDA	Injection, denosumab-nxxp (bilyos/bilprevda), biosimilar, 1 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Calcineurin Inhibitors, Misc (90:28)				
J7516	<i>cyclosporine intravenous</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	SANDIMMUNE INTRAVENOUS	Injection, cyclosporine, 250 mg	Non-Specialty	
J7525	PROGRAF INTRAVENOUS	Tacrolimus, parenteral, 5 mg	Non-Specialty	

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Complement Inhibitor Agents (90:20)				
C9399	YARTEMLEA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
J1299	SOLIRIS	Injection, eculizumab, 2 mg	Not Covered	CA (Covered Alternative(s): Q5151 - eculizumab-aagh (epysqli). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1302	ENJAYMO	Injection, sutimlimab-jome, 10 mg	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1303	ULTOMIRIS	Injection, ravulizumab-cwvz, 10 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1307	PIASKY	Injection, crovalimab-akkz, 10 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2781	SYFOVRE (PF)	Injection, pegcetacoplan, intravitreal, 1 mg	Preferred Specialty	PA
J2782	IZERVAY (PF)	Injection, avacincapted pegol, 0.1 mg	Not Covered	
J3490	EMPAVELI	Unclassified drugs	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	YARTEMLEA	Unclassified biologics	Not Covered	

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Q5152	BKEMV	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	Not Covered	CA (Covered Alternative(s): Q5151 - eculizumab-aagh (epysqli). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Complement Inhibitors (90:08)				
J3490	ZILBRYSQ	Unclassified drugs	Pharmacy Only	
Disease-Modifying Antirheumat Drugs Misc				
J0129	ORENCIA (WITH MALTOSE)	Injection, abatacept, 10 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug self administered)	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0129	ORENCIA CLICKJECT	Injection, abatacept, 10 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug self administered)	Pharmacy Only	
J3380	ENTYVIO	Injection, vedolizumab, intravenous, 1 mg	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	ENTYVIO PEN	Unclassified biologics	Pharmacy Only	
Disease-Modifying Antirheumatic Drugs				
J1628	TREMFYA INTRAVENOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Not Covered	

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J1628	TREMFYA ONE-PRESS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1628	TREMFYA PEN	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1628	TREMFYA PEN INDUCTION PK(2PEN)	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1628	TREMFYA SUBCUTANEOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J8610	<i>methotrexate sodium oral</i>	Methotrexate, oral, 2.5 mg	Non-Specialty	
J8610	TREXALL	Methotrexate, oral, 2.5 mg	Non-Specialty	
J9311	RITUXAN HYCELA	Injection, rituximab 10 mg and hyaluronidase	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9312	RITUXAN	Injection, rituximab, 10 mg	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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Q5115	TRUXIMA	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5119	RUXIENCE	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5123	RIABNI	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Igg1 Monoclonal Antibodies				
C9399	BENLYSTA SUBCUTANEOUS	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J0490	BENLYSTA INTRAVENOUS	Injection, belimumab, 10 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0491	SAPHNELO	Injection, anifrolumab-fnia, 1 mg	Not Covered	
Immunomodulatory Agents (90:00)				
J9071	<i>cyclophosphamide 1 gm/5 ml vl mov, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 1 gm/5 ml vl suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 2 gm/10 ml vl mov, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml mov, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	

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J9072	<i>cyclophosphamide 1 gm/2 ml vl</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9072	<i>cyclophosphamide 2 gm/4 ml vl</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9072	<i>cyclophosphamide 500 mg/ml vl</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J9072	FRINDOVYX	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J9073	<i>cyclophosphamide 1 gm/5 ml vl mov, p/f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 2 gm/10 ml vl mov, p/f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 500 mg/2.5 ml mov, p/f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 1 gm/10 ml vl inner, mov, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 1 gm/10 ml vl outer, mov, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vl inner, mov, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vl outer, mov, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vl inner, mov, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	

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J9074	<i>cyclophosphamide 500 mg/5 ml vl outer, mov, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9075	<i>cyclophosphamide intravenous recon soln</i>	Injection, cyclophosphamide, not otherwise specified, 5mg	Non-Specialty	
J9076	<i>cyclophosphamide 1 gm/5 ml vl mov, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
J9076	<i>cyclophosphamide 500 mg/2.5 ml mov, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
Interferon Gamma Inhibitor Agents, Misc				
J9210	GAMIFANT	Injection, emapalumab-lzsg, 1 mg	Preferred Specialty	PA
Interferons				
J1830	BETASERON SUBCUTANEOUS KIT	Injection, interferon beta-1B, 0.25 mg (code may be used for Medicare when drug administered under direct supervision of a physician; not for use if self-administered)	Pharmacy Only	
J9215	ALFERON N	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	Non-Specialty	
Interleukin Inhibitor Agents, Misc				
J0480	SIMULECT	Injection, basiliximab, 20 mg	Preferred Specialty	
J2357	XOLAIR SUBCUTANEOUS AUTO-INJECTOR	Injection, omalizumab, 5 mg	Pharmacy Only	

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J2357	XOLAIR SUBCUTANEOUS RECON SOLN	Injection, omalizumab, 5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2357	XOLAIR SUBCUTANEOUS SYRINGE	Injection, omalizumab, 5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Interleukin-Mediated Agents, Misc				
C9399	ACTEMRA ACTPEN	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	STARJEMZA INTRAVENOUS	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	STARJEMZA SUBCUTANEOUS SOLUTION	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	STARJEMZA SUBCUTANEOUS SYRINGE	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	

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J3247	COSENTYX INTRAVENOUS	Injection, secukinumab, intravenous, 1 mg	Not Covered	
J3262	ACTEMRA INTRAVENOUS	Injection, tocilizumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9264)	Not Covered	CA (Covered Alternative(s): Q5135 - Tyenne intravenous solution (tocilizumab-aazg). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J3357	STELARA SUBCUTANEOUS	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	Pharmacy Only	
J3357	<i>ustekinumab subcutaneous</i>	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	Pharmacy Only	
J3358	STELARA INTRAVENOUS	Ustekinumab, for intravenous injection, 1 mg (For billing prior to 1/1/18 use Q9989)	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J3358	<i>ustekinumab intravenous</i>	Ustekinumab, for intravenous injection, 1 mg (For billing prior to 1/1/18 use Q9989)	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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J3590	ACTEMRA SUBCUTANEOUS	Unclassified biologics	Pharmacy Only	
J3590	COSENTYX (2 SYRINGES)	Unclassified biologics	Pharmacy Only	
J3590	COSENTYX PEN	Unclassified biologics	Pharmacy Only	
J3590	COSENTYX PEN (2 PENS)	Unclassified biologics	Pharmacy Only	
J3590	COSENTYX SUBCUTANEOUS	Unclassified biologics	Pharmacy Only	
J3590	COSENTYX UNOREADY PEN	Unclassified biologics	Pharmacy Only	
J3590	KEVZARA	Unclassified biologics	Pharmacy Only	
J3590	KINERET	Unclassified biologics	Pharmacy Only	
J3590	STARJEMZA INTRAVENOUS	Unclassified biologics	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	STARJEMZA SUBCUTANEOUS SOLUTION	Unclassified biologics	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	STARJEMZA SUBCUTANEOUS SYRINGE	Unclassified biologics	Pharmacy Only	

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Q0237	AVTOZMA INTRAVENOUS	Injection, tocilizumab-anoh, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, 1 mg	Not Covered	
Q5098	IMULDOSA 130 MG/26 ML VIAL	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5098	IMULDOSA 130 MG/26 ML VIAL	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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Q5098	IMULDOSA SUBCUTANEOUS	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5099	STEQEYMA INTRAVENOUS	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5099	STEQEYMA SUBCUTANEOUS	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	Pharmacy Only	
Q5100	YESINTEK INTRAVENOUS	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5100	YESINTEK SUBCUTANEOUS SOLUTION	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5100	YESINTEK SUBCUTANEOUS SYRINGE	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	Pharmacy Only	
Q5133	TOFIDENCE	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	Not Covered	
Q5135	TYENNE AUTOINJECTOR	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Pharmacy Only	
Q5135	TYENNE INTRAVENOUS	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5135	TYENNE SUBCUTANEOUS	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Pharmacy Only	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5137	WEZLANA SUBCUTANEOUS	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg	Pharmacy Only	
Q5138	WEZLANA INTRAVENOUS	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5156	AVTOZMA INTRAVENOUS	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	Not Covered	
Q9996	PYZCHIVA SUBCUTANEOUS SYRINGE	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	Pharmacy Only	
Q9996	<i>ustekinumab-ttwe subcutaneous</i>	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	Pharmacy Only	
Q9997	PYZCHIVA INTRAVENOUS	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q9997	<i>ustekinumab-ttwe intravenous</i>	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)

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Q9998	SELARSDI INTRAVENOUS	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q9998	SELARSDI SUBCUTANEOUS SOLUTION	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q9998	SELARSDI SUBCUTANEOUS SYRINGE	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Pharmacy Only	
Q9998	<i>ustekinumab-aekn</i>	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Pharmacy Only	
Q9999	OTULFI INTRAVENOUS	Injection, ustekinumab-aaaz (otulfi), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q9999	OTULFI SUBCUTANEOUS	Injection, ustekinumab-aaaz (otulfi), biosimilar, 1 mg	Pharmacy Only	
Monoclonal Antibodies (90:04)				
J0202	LEMTRADA	Injection, alemtuzumab, 1 mg	Not Covered	
J2323	TYSABRI	Injection, natalizumab, 1 mg	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2329	BRIUMVI	Injection, ublituximab-xiyy, 1mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2350	OCREVUS	Injection, ocrelizumab, 1 mg (For billing prior to 1/1/18 use J3590 or C9494 for OPPS billing) (Code re-used by CMS 1/1/18)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J3590	KESIMPTA PEN	Unclassified biologics	Pharmacy Only	
Q5134	TYRUKO	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	Not Covered	
Monoclonal Antibodies (90:10)				
J0174	LEQEMBI	Injection, lecanemab-irmb, 1 mg	Not Covered	
J0175	KISUNLA	Injection, donanemab-azbt, 2 mg	Not Covered	
J3490	LEQEMBI IQLIK	Unclassified drugs	Pharmacy Only	
Monoclonal Antibodies (90:12)				
J1823	UPLIZNA	Injection, inebilizumab-cdon, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Neonatal Fc Receptor Blockers				
C9305	IMAAVY	Injection, nipocalimab-aahu, 3 mg (Code deleted effective 12/31/2025)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9256	IMAAVY	Injection, nipocalimab-aahu, 3 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9332	VYVGART	Injection, efgartigimod alfa-fcab, 2mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9333	RYSTIGGO	Injection, rozanolixizumab-noli, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9334	VYVGART HYTRULO SUBCUTANEOUS SOLUTION	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9334	VYVGART HYTRULO SUBCUTANEOUS SYRINGE	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Pharmacy Only	

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Polyclonal Antibodies, Miscellaneous				
J7504	ATGAM	Lymphocyte immune globulin, anti-thymocyte globulin, equine, parenteral, 250 mg	Non-Specialty	
T-Cell Costimulatory Blockers, Misc				
J0485	NULOJIX	Injection, belatacept, 1 mg (For billing prior to 1/1/13 use C9286 or J3590)	Non-Preferred	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Tumor Necrosis Factor Inhibitors, Misc				
C9399	<i>adalimumab-adaz</i>	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	<i>adalimumab-bwwd subcutaneous auto-injector</i>	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	AMJEVITA(CF)	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	

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C9399	AMJEVITA(CF) AUTOINJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HADLIMA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HADLIMA PUSHTOUCH	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HADLIMA(CF)	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HADLIMA(CF) PUSHTOUCH	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	

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C9399	HYRIMOZ PEN CROHN'S-UC STARTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HYRIMOZ PEN PSORIASIS STARTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HYRIMOZ(CF)	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HYRIMOZ(CF) PEDI CROHN STARTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
C9399	HYRIMOZ(CF) PEN	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	

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C9399	YUSIMRY(CF) PEN	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J0139	HUMIRA	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Pharmacy Only	
J0139	HUMIRA PEN	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Pharmacy Only	
J0139	HUMIRA(CF)	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Pharmacy Only	
J0139	HUMIRA(CF) PEN	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Pharmacy Only	
J0139	HUMIRA(CF) PEN CROHNS-UC-HS	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Pharmacy Only	
J0139	HUMIRA(CF) PEN PSOR-UV-ADOL HS	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Pharmacy Only	

PA-Prior Authorization; **SOS**-Site of Service; **CC**-Coverage Change; **CA**-Covered Alternative(s)

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0717	CIMZIA 2X200 MG/ML SYRINGE KIT	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Pharmacy Only	
J0717	CIMZIA POWDER FOR RECONST	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0717	CIMZIA STARTER KIT	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Pharmacy Only	
J1438	ENBREL	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)	Pharmacy Only	
J1438	ENBREL MINI	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1438	ENBREL SURECLICK	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)	Pharmacy Only	
J1602	SIMPONI ARIA	Injection, golimumab, 1 mg, for intravenous use (For billing prior to 1/1/14 use C9399 or J3590)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1745	<i>infliximab</i>	Injection, infliximab, excludes biosimilar, 10 mg (Code is to be used for Remicade or Infliximab)	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1745	REMICADE	Injection, infliximab, excludes biosimilar, 10 mg (Code is to be used for Remicade or Infliximab)	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J1748	ZYMFENTRA	Injection, infliximab-dyyb (zymfentra), 10 mg	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
J3590	<i>adalimumab-adaz</i>	Unclassified biologics	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J3590	<i>adalimumab-bwwd subcutaneous auto- injector</i>	Unclassified biologics	Pharmacy Only	
J3590	AMJEVITA(CF)	Unclassified biologics	Pharmacy Only	
J3590	AMJEVITA(CF) AUTOINJECTOR	Unclassified biologics	Pharmacy Only	
J3590	HADLIMA	Unclassified biologics	Pharmacy Only	
J3590	HADLIMA PUSHTOUCH	Unclassified biologics	Pharmacy Only	
J3590	HADLIMA(CF)	Unclassified biologics	Pharmacy Only	
J3590	HADLIMA(CF) PUSHTOUCH	Unclassified biologics	Pharmacy Only	
J3590	HYRIMOZ PEN CROHN'S-UC STARTER	Unclassified biologics	Pharmacy Only	
J3590	HYRIMOZ PEN PSORIASIS STARTER	Unclassified biologics	Pharmacy Only	
J3590	HYRIMOZ(CF)	Unclassified biologics	Pharmacy Only	
J3590	HYRIMOZ(CF) PEDI CROHN STARTER	Unclassified biologics	Pharmacy Only	
J3590	HYRIMOZ(CF) PEN	Unclassified biologics	Pharmacy Only	
J3590	SIMPONI	Unclassified biologics	Pharmacy Only	

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J3590	YUSIMRY(CF) PEN	Unclassified biologics	Pharmacy Only	
Q5103	INFLECTRA	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.)
Q5104	RENFLEXIS	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5121	AVSOLA	Injection, infliximab-axxq, biosimilar, (avsola), 10 mg	Preferred Specialty	Site of Service (Site of Service applies. See Medical Policy Infusion Services and Equipment Policy 91414 for details)
Q5140	<i>adalimumab-fkjp</i>	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5140	HULIO(CF)	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5140	HULIO(CF) PEN	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5141	<i>adalimumab-aaty</i>	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5141	ADALIMUMAB- AATY(CF) AI CROHNS	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	

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Q5141	YUFLYMA(CF)	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5141	YUFLYMA(CF) AI CROHN'S-UC-HS	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5141	YUFLYMA(CF) AUTOINJECTOR	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5142	<i>adalimumab-ryvk</i>	Injection, adalimumab-ryvk biosimilar, 1 mg	Pharmacy Only	
Q5142	SIMLANDI(CF)	Injection, adalimumab-ryvk biosimilar, 1 mg	Pharmacy Only	
Q5142	SIMLANDI(CF) AUTOINJECTOR	Injection, adalimumab-ryvk biosimilar, 1 mg	Pharmacy Only	
Q5143	<i>adalimumab-adbm</i>	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5143	CYLTEZO(CF)	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5143	CYLTEZO(CF) PEN	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5143	CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5143	CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.8 ML	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5144	<i>adalimumab-aacf</i>	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Pharmacy Only	
Q5144	ADALIMUMAB- AACF(CF) PEN CROHNS	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Pharmacy Only	
Q5144	ADALIMUMAB- AACF(CF) PEN PS-UV	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Pharmacy Only	
Q5145	ABRILADA(CF)	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Q5145	ABRILADA(CF) PEN	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Recommend NDC Level Pricing)	Pharmacy Only	
Local Anesthetics				
<i>Local Anesthetics</i>				
C9089	XARACOLL	Bupivacaine, collagen-matrix implant, 1 mg (Code deleted effective 12/31/2025)	Not Covered	
J0665	<i>bupivacaine (pf)</i>	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	<i>bupivacaine hcl</i>	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	<i>bupivacaine-dextrose- water(pf)</i>	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0665	MARCAINE	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	MARCAINE (PF)	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	MARCAINE SPINAL (PF)	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	SENSORCAINE	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	SENSORCAINE-MPF	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	SENSORCAINE-MPF SPINAL	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0666	<i>bupivacaine liposome (pf)</i>	Injection, bupivacaine liposome, 1 mg	Non-Specialty	
J0666	EXPAREL (PF)	Injection, bupivacaine liposome, 1 mg	Non-Specialty	
J0668	ZYNRELEF	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	Not Covered	
J2403	IHEEZO (PF)	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	Not Covered	
J2795	<i>ropivacaine (pf) injection solution</i>	Injection, ropivacaine hydrochloride, 1 mg	Non-Specialty	
J2795	<i>ropivacaine (pf)-nacl, iso-osm injection</i>	Injection, ropivacaine hydrochloride, 1 mg	Non-Specialty	
J3490	POSIMIR	Unclassified drugs	Non-Specialty	
J3490	XARACOLL	Unclassified drugs	Not Covered	

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Miscellaneous Therapeutic Agents				
Antigout Agents				
J0206	<i>allopurinol sodium</i>	Injection, allopurinol sodium, 1 mg	Non-Specialty	
J0206	ALOPRIM	Injection, allopurinol sodium, 1 mg	Non-Specialty	
J2507	KRYSTEXXA	Injection, pegloticase, 1 mg (For billing prior to 1/1/12 use J3590 or C9281)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Antisense Oligonucleotides				
J1426	AMONDYS-45	Injection, casimersen, 10 mg	Not Covered	
J1427	VILTEPSO	Injection, viltolarsen, 10 mg	Not Covered	
J1428	EXONDYS-51	Injection, eteplirsen, 10 mg (For billing prior to 1/1/18 use J3490 or C9484 for OPPS billing)	Not Covered	
J1429	VYONDYS-53	Injection, golodirsen, 10 mg	Not Covered	
J2326	SPINRAZA (PF)	Injection, nusinersen, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9489 for OPPS billing)	Preferred Specialty	PA
Bone Anabolic Agents				
J3110	FORTEO	Injection, teriparatide, 10 mcg	Pharmacy Only	
J3110	<i>teriparatide</i>	Injection, teriparatide, 10 mcg	Pharmacy Only	
Bone Resorption Inhibitors				
J1000	DEPO-ESTRADIOL	Injection, depo-estradiol cypionate, up to 5 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J1740	<i>ibandronate intravenous syringe</i>	Injection, ibandronate sodium, 1 mg	Preferred Specialty	
J2430	<i>pamidronate intravenous solution</i>	Injection, pamidronate disodium, per 30 mg	Non-Specialty	
J3489	RECLAST	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid intravenous solution</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid-mannitol-water</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic ac-mannitol-0.9nacl</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
Bradykinin Receptor Antagonists				
J1744	FIRAZYR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Pharmacy Only	
J1744	<i>icatibant</i>	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Pharmacy Only	
J1744	SAJAZIR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Pharmacy Only	
Complement Inhibitors (92:32)				
J0596	RUCONEST	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units (For billing prior to 1/1/16 use C9445 or J3590)	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0597	BERINERT	Injection, C-1 esterase inhibitor (human), Berinert, 10 units (For billing prior to 1/1/11 use J3590 or C9269)	Pharmacy Only	
J0598	CINRYZE	Injection, C1 esterase inhibitor (human), Cinryze, 10 units	Not Covered	
J0599	HAEGARDA	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	Pharmacy Only	
J9376	VEOPOZ	Injection, pozelimab-bbfg, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Complement Inhibitors				
Q5151	EPYSQLI	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Immunomodulatory Agents				
J2351	OCREVUS ZUNOVO	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9015	PROLEUKIN	Injection, aldesleukin, per single-use vial	Non-Specialty	
Other Miscellaneous Therapeutic Agents				
C9399	FORZINITY	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J0222	ONPATTRO	Injection, Patisiran, 0.1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0223	GIVLAARI	Injection, givosiran, 0.5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J0224	OXLUMO	Injection, lumasiran, 0.5 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0225	AMVUTTRA	Injection, vutrisiran, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0591	KYBELLA	Injection, deoxycholic acid, 1 mg	Not Covered	
J1809	NULIBRY	Injection, fosdenopterin, 0.1 mg	Preferred Specialty	PA
J1955	CARNITOR INTRAVENOUS	Injection, levocarnitine, per 1 g	Non-Specialty	
J1955	<i>levocarnitine intravenous</i>	Injection, levocarnitine, per 1 g	Non-Specialty	
J3490	FORZINITY	Unclassified drugs	Pharmacy Only	
J3490	RIVFLOZA	Unclassified drugs	Not Covered	
J9038	NIKTIMVO	Injection, axatilimab-csfr, 0.1 mg	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Protective Agents				
J7352	SCENESSE	Afamelanotide implant, 1 mg	Preferred Specialty	PA
Oxytocics				
Oxytocics				
J0675	<i>carboprost tromethamine</i>	Injection, carboprost tromethamine, 0.1 mg	Not Covered	
J0675	HEMABATE	Injection, carboprost tromethamine, 0.1 mg	Not Covered	
J2210	<i>methylergonovine injection</i>	Injection, methylergonovine maleate, up to 0.2 mg	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
Radioactive Agents				
<i>Radioactive Agents</i>				
A9601	TAUVID	Flortaucipir f 18 injection, diagnostic, 1 millicurie	Non-Specialty	
A9606	XOFIGO	Radium Ra-223 dichloride, therapeutic, per microcurie (For billing prior to 1/1/15 use C9399 or A9699)	Non-Preferred	PA
A9607	PLUVICTO	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Respiratory Tract Agents				
<i>Alpha And Beta Adrenergic Agonist(Respr)</i>				
J0163	ADRENALIN IN 0.9 % SOD CHLOR	Injection, epinephrine in sodium chloride (endo), 0.1 mg	Non-Specialty	
J0164	<i>epineph bitart in 0.9% sod chl intravenous solution</i>	Injection, epinephrine in sodium chloride (baxter), 0.1 mg	Non-Specialty	
J3490	REZIPRES	Unclassified drugs	Non-Specialty	
<i>Anticholinergic Agents (Respir.Tract)</i>				
J7677	YUPELRI	Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram	Not Covered	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Dual Phosphodiesterase Inhibitor (48:34)				
J7601	OHTUVAYRE	Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg	Pharmacy Only	
First Generation Antihist.(Respir Tract)				
J1200	<i>diphenhydramine hcl injection</i>	Injection, diphenhydramine HCl, up to 50 mg	Non-Specialty	
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
Interleukin Antagonists				
C9399	EXDENSUR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
J0517	FASENRA	Injection, benralizumab, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0517	FASENRA PEN	Injection, benralizumab, 1 mg	Pharmacy Only	
J0638	ILARIS (PF)	Injection, canakinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9399)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2182	NUCALA SUBCUTANEOUS AUTO-INJECTOR	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPPS billing)	Pharmacy Only	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J2182	NUCALA SUBCUTANEOUS RECON SOLN	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPSS billing)	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2182	NUCALA SUBCUTANEOUS SYRINGE	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPSS billing)	Pharmacy Only	
J2356	TEZSPIRE SUBCUTANEOUS PEN INJECTOR	Injection, tezepelumab-ekko, 1 mg	Pharmacy Only	
J2356	TEZSPIRE SUBCUTANEOUS SYRINGE	Injection, tezepelumab-ekko, 1 mg	Not Covered	
J2786	CINQAIR	Injection, reslizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9481 for OPSS billing)	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	EXDENSUR	Unclassified biologics	Not Covered	
Mucolytic Agents				
J7639	PULMOZYME	Dornase alfa, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose form, per milligram	Pharmacy Only	
Prostacyclin & Prostacyclin Derivatives				
Q4074	VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F	Iloprost, inhalation solution, FDA- approved final product, non- compounded, administered through DME, unit dose form, up to 20 micrograms (All NDCs Inactive as of 10/15/2025)	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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Q4074	VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F,30'S	Iloprost, inhalation solution, FDA- approved final product, non- compounded, administered through DME, unit dose form, up to 20 micrograms (All NDCs Inactive as of 10/15/2025)	Non- Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Respiratory Tract Agents, Miscellaneous				
J3590	WINREVAIR	Unclassified biologics	Preferred Specialty	PA
Second Generation Antihist(Respir Tract)				
J1201	QUZYTIR	Injection, cetirizine hydrochloride, 0.5 mg	Not Covered	
Select.Beta-2-Adrenergic Agonist(Respir)				
J3105	<i>terbutaline subcutaneous</i>	Injection, terbutaline sulfate, up to 1 mg	Non-Specialty	
J7611	<i>albuterol sulfate inhalation solution for nebulization</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, concentrated form, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sulfate inhalation solution for nebulization</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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Vasodilating Agents (Respiratory Tract)				
J1325	<i>epoprostenol</i>	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	FLOLAN	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	VELETRI	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1749	AURLUMYN	Injection, iloprost, 0.1 mcg	Not Covered	CC (No PA Required - Inpatient Use Only)
J3285	REMODULIN 100 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	REMODULIN 20 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	REMODULIN 200 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	REMODULIN 50 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	<i>treprostinil sodium</i>	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	TYVASO	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

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J7686	TYVASO INSTITUTIONAL START KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	TYVASO REFILL KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	TYVASO STARTER KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Skin And Mucous Membrane Agents				
Antibacterials (84:04)				
J0736	CLEOCIN INJECTION	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin in 5 % dextrose</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin phosphate injection</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0737	<i>clindamycin in 0.9 % sod chlor</i>	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg	Non-Specialty	

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J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
J2280	<i>moxifloxacin-sod.chloride(iso)</i>	Injection, moxifloxacin, 100 mg	Non-Specialty	
J2281	<i>moxifloxacin-sod.ace,sul-water</i>	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg	Non-Specialty	
Antiproliferants				
J7308	LEVULAN	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)	Non-Specialty	
J9190	ADRUCIL	Injection, fluorouracil, 500 mg	Non-Specialty	
J9190	<i>fluorouracil intravenous</i>	Injection, fluorouracil, 500 mg	Non-Specialty	
Antipruritics And Local Anesthetics				
J0879	KORSUVA	Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis)	Preferred Specialty	PA
Antivirals (Skin And Mucous Membrane)				
J7354	YCANTH	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	Non-Specialty	
Cell Stimulants And Proliferants				
J2425	KEPIVANCE	Injection, palifermin, 50 micrograms	Non-Specialty	

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Corticosteroids (Skin, Mucous Membrane)				
J7311	RETISERT	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	Not Covered	
J7313	ILUVIEN	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211- E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311, E10.321 -E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.039, H30.20-H30.23,H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7314	YUTIQ	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes H30.001-H30.039, H30.20-H30.23,H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7402	SINUVA	Mometasone furoate sinus implant, (sinuva), 10 micrograms	Not Covered	
Immunomodulatory Agents (84:06)				
C9399	BIMZELX	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	

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C9399	BIMZELX AUTOINJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Pharmacy Only	
J1628	TREMFYA INTRAVENOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Not Covered	
J1628	TREMFYA ONE-PRESS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1628	TREMFYA PEN	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1628	TREMFYA PEN INDUCTION PK(2PEN)	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1628	TREMFYA SUBCUTANEOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Pharmacy Only	
J1747	SPEVIGO 150 MG/ML SYRINGE INNER, SUV, P/F	Injection, spesolimab-sbzo, 1 mg	Not Covered	
J1747	SPEVIGO 150 MG/ML SYRINGE OUTER, SUV, P/F	Injection, spesolimab-sbzo, 1 mg	Not Covered	
J1747	SPEVIGO INTRAVENOUS	Injection, spesolimab-sbzo, 1 mg	Not Covered	

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J2327	SKYRIZI INTRAVENOUS	Injection, risankizumab-rzaa, intravenous, 1 mg	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3245	ILUMYA	Injection, tildrakizumab, 1 mg (Code reused by CMS 1/1/2019)	Non- Preferred	PA
J3590	BIMZELX	Unclassified biologics	Pharmacy Only	
J3590	BIMZELX AUTOINJECTOR	Unclassified biologics	Pharmacy Only	
J3590	SILIQ	Unclassified biologics	Pharmacy Only	
J3590	SKYRIZI SUBCUTANEOUS	Unclassified biologics	Pharmacy Only	
J7525	PROGRAF INTRAVENOUS	Tacrolimus, parenteral, 5 mg	Non-Specialty	
J7525	<i>tacrolimus intravenous</i>	Tacrolimus, parenteral, 5 mg	Non-Specialty	
<i>Skin And Mucous Membrane Agents, Misc.</i>				
J3389	ZEVASKYN	Topical administration, prademagene zamikeracel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3401	VYJUVEK	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 ⁹ pfu/ml vector genomes, per 0.1 ml	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7336	QUTENZA	Capsaicin 8% patch, per square centimeter	Non- Preferred	PA
<i>Sunscreen Agents</i>				
J7352	SCENESSE	Afamelanotide implant, 1 mg	Preferred Specialty	PA

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Vitamins				
<i>Vitamin D</i>				
J0636	<i>calcitriol intravenous</i>	Injection, calcitriol, 0.1 mcg	Non-Specialty	

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