Priority Health Commercial and MyPriority Plans

Medical Drug List

August 2025

Priority Health

This manual is updated frequently. Last revised: August 14, 2025

Priority Health Medical Drug List

Commercial (Employer Group) and MyPriority (Individual/Family)

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lowercase italics = Generic drugs
UPPERCASE = Brand name drugs

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5153	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	N/A	Not Covered	
J0716	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)	ANASCORP	Preferred Specialty	
J0841	Injection, crotalidae immune f(ab')2 (equine), 120 mg	ANAVIP	Non-Specialty	
J0895	Injection, deferoxamine mesylate, 500 mg	*deferoxamine*	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.

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0895	Injection, deferoxamine mesylate, 500 mg	DESFERAL	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	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN 1 MG HYPOKIT	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	GLUCAGON (HCL) EMERGENCY KIT	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial*	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGON EMERGENCY KIT (HUMAN)	Non-Specialty	
J2311	Injection, naloxone hydrochloride (zimhi), 1 mg (Code deleted effective 6/30/2025)	ZIMHI	Non-Specialty	
J1448	Injection, trilaciclib, 1mg	COSELA	Preferred Specialty	PA
J1190	Injection, dexrazoxane hydrochloride, per 250 mg	*dexrazoxane hcl*	Non-Specialty	
J0207	Injection, amifostine, 500mg (All NDCs Inactive October 2024)	ETHYOL	Preferred Specialty	
J0641	Injection, levoleucovorin, not otherwise specified, 0.5 mg	FUSILEV I.V. 50 MG VIAL	Preferred Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0642	Injection, levoleucovorin (khapzory), 0.5 mg	KHAPZORY	Preferred Specialty	
J0641	Injection, levoleucovorin, not otherwise specified, 0.5 mg	*levoleucovorin calcium*	Preferred Specialty	
J9209	Injection, mesna, 200 mg	*mesna intravenous*	Non-Specialty	
J9209	Injection, mesna, 200 mg	MESNEX INTRAVENOUS	Non-Specialty	
J1190	Injection, dexrazoxane hydrochloride, per 250 mg	TOTECT	Non-Specialty	
J1200	Injection, diphenhydramine HCl, up to 50 mg	*diphenhydramine hcl injection*	Non-Specialty	
J1200	Injection, diphenhydramine HCl, up to 50 mg	*diphenhydramine hcl injection*	Non-Specialty	
J1308	Injection, famotidine, 0.25 mg	*famotidine (pf)*	Non-Specialty	
J1308	Injection, famotidine, 0.25 mg	*famotidine (pf)-nacl (iso-os)*	Non-Specialty	
J1308	Injection, famotidine, 0.25 mg	*famotidine intravenous*	Non-Specialty	
J2550	Injection, promethazine HCl, up to 50 mg	PHENERGAN	Non-Specialty	
J2550	Injection, promethazine HCl, up to 50 mg	*promethazine injection*	Non-Specialty	
J1201	Injection, cetirizine hydrochloride, 0.5 mg	QUZYTTIR	Not Covered	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial 25's, p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial 25's, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial inner, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial inner, suv, p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial inner,sdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial outer, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial outer, suv, p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial outer,sdv*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial p/f, sdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial sdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 1 gm vial suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial inner, mdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial inner, muv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial inner, p/f, mdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial inner,muv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial mdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial outer, mdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial outer, muv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial outer, p/f, mdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial outer,muv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 10 gm vial p/f, mdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 2 gm vial inner, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 2 gm vial outer, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 3 gm vial inner, p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 3 gm vial outer, p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial 10's, outer, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial 25's*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial 25's, p/f*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial 25's, sdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial inner, suv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial p/f, sdv*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin 500 mg vial suv*	Non-Specialty	
J0689	Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg	*cefazolin in dextrose (iso-os)*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin in dextrose (iso-os)*	Non-Specialty	
J0687	Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg	*cefazolin intravenous*	Non-Specialty	
J0688	Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg	*cefazolin intravenous*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin intravenous*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin sod 100 gm bulk bag*	Non-Specialty	
J0690	Injection, cefazolin sodium, 500 mg	*cefazolin sod 300 gm bulk bag*	Non-Specialty	
J0714	Injection, ceftazidime and avibactam, 0.5 g/0.125 g (For billing prior to 1/1/16 use C9399 or J3490)	AVYCAZ	Non-Preferred	
J0712	Injection, ceftaroline fosamil, 10 mg (For billing prior to 1/1/12 use J3490 or C9282)	TEFLARO	Non-Preferred	
J0695	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)	ZERBAXA	Preferred Specialty	
C9399	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)	ZEVTERA	Not Covered	
J3490	Unclassified drugs	ZEVTERA	Not Covered	
J1836	Injection, metronidazole, 10 mg	METRO I.V.	Non-Specialty	
J1836	Injection, metronidazole, 10 mg	*metronidazole in nacl (iso-os)*	Non-Specialty	
J3535	Drug administered through a metered dose inhaler	TOBI PODHALER	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0291	Injection, plazomicin, 5 mg	ZEMDRI	Not Covered	
J0121	Injection, omadacycline, 1 mg	NUZYRA INTRAVENOUS	Not Covered	
J1271	Injection, doxycycline hyclate, 1 mg	DOXY-100	Non-Specialty	
J1271	Injection, doxycycline hyclate, 1 mg	*doxycycline hyclate intravenous*	Non-Specialty	
J2545	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg	NEBUPENT	Non-Specialty	
S0080	Injection, pentamidine isethionate, 300 mg	PENTAM	Non-Specialty	
J2545	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg	*pentamidine*	Non-Specialty	
S0080	Injection, pentamidine isethionate, 300 mg	*pentamidine*	Non-Specialty	
J8499	Prescription drug, oral, non-chemotherapeutic, Not Otherwise Specified	SUNLENCA ORAL	Pharmacy Only	
J1961	Injection, lenacapavir, 1 mg	SUNLENCA SUBCUTANEOUS	Preferred Specialty	PA
J1833	Injection, isavuconazonium sulfate, 1 mg (For billing prior to 1/1/16 use C9456 or J3490)	CRESEMBA INTRAVENOUS	Preferred Specialty	
J3465	Injection, voriconazole, 10 mg	VFEND IV	Preferred Specialty	
J3465	Injection, voriconazole, 10 mg	*voriconazole intravenous*	Preferred Specialty	
J3465	Injection, voriconazole, 10 mg	*voriconazole-hpbcd*	Preferred Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1335	Injection, ertapenem sodium, 500 mg	*ertapenem*	Non-Specialty	
J1335	Injection, ertapenem sodium, 500 mg	INVANZ 1 GM VIAL	Non-Specialty	
J2183	Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg	*meropenem*	Preferred Specialty	
J2185	Injection, meropenem, 100 mg	*meropenem*	Preferred Specialty	
J2184	Injection, meropenem (b. braun), not therapeutically equivalent to j2185, 100 mg	*meropenem-0.9% sodium chloride*	Preferred Specialty	
J0742	Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg	RECARBRIO	Not Covered	
J2186	Injection, meropenem and vaborbactam, 10mg/10mg, (20mg)	VABOMERE	Preferred Specialty	
C9399	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)	PREVYMIS INTRAVENOUS	Preferred Specialty	PA
J3490	Unclassified drugs	PREVYMIS INTRAVENOUS	Preferred Specialty	PA
J0878	Injection, daptomycin, 1 mg	CUBICIN RF 500 MG VIAL	Non-Specialty	
J0872	Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg	*daptomycin*	Non-Specialty	
J0873	Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg	*daptomycin*	Non-Specialty	
J0877	Injection, daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	*daptomycin*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0878	Injection, daptomycin, 1 mg	*daptomycin*	Non-Specialty	
J0874	Injection, daptomycin (baxter), not therapeutically equivalent to j0878, 1 mg	*daptomycin in 0.9 % sod chlor*	Non-Specialty	
J0637	Injection, caspofungin acetate, 5 mg	CANCIDAS	Non-Specialty	
J0637	Injection, caspofungin acetate, 5 mg	*caspofungin*	Non-Specialty	
J2247	Injection, micafungin sodium (par pharm) not thereapeutically equivalent to j2248, 1 mg	*micafungin*	Preferred Specialty	
J2248	Injection, micafungin sodium, 1 mg	*micafungin*	Preferred Specialty	
J2246	Injection, micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1 mg	*micafungin in 0.9 % sodium chl*	Non-Specialty	
J2248	Injection, micafungin sodium, 1 mg	MYCAMINE	Preferred Specialty	
J0349	Injection, rezafungin, 1 mg	REZZAYO	Not Covered	
J2543	Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	*piperacillin-tazobactam*	Non-Specialty	
J2543	Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	ZOSYN IN DEXTROSE (ISO-OSM)	Non-Specialty	
J0122	Injection, eravacycline, 1 mg	XERAVA	Not Covered	
J0875	Injection, dalbavancin, 5 mg (For billing prior to 1/1/16 use C9443 or J3490)	DALVANCE	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2406	Injection, oritavancin (kimyrsa), 10 mg	KIMYRSA	Non-Preferred	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2407	Injection, oritavancin (orbactiv), 10 mg (For billing prior to 1/1/16 use C9444 or J3490)	ORBACTIV	Non-Preferred	PA
J3095	Injection, telavancin, 10 mg (For billing prior to 1/1/11 use J3490 or C9258)	VIBATIV	Non-Preferred	PA
J1746	Injection, ibalizumab-uiyk, 10 mg	TROGARZO	Preferred Specialty	PA
J0739	Injection, cabotegravir, 1 mg	APRETUDE	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, please reference your plan documents and the Priority Health preventive health care guidelines.
J0741	Injection, cabotegravir and rilpivirine, 2mg/3mg	CABENUVA	Preferred Specialty	
J0751	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)	DESCOVY 200-25 MG TABLET	Pharmacy Only	
J0750	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)	*emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab*	Pharmacy Only	
J0750	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)	*emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab inner*	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0750	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)	*emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab outer*	Pharmacy Only	
J0750	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)	TRUVADA 200 MG-300 MG TABLET	Pharmacy Only	
J0750	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)	TRUVADA 200 MG-300 MG TABLET F/C	Pharmacy Only	
J9215	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	ALFERON N	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	CLEOCIN 300 MG-D5W-GALAXY INNER, SINGLE USE	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	CLEOCIN INJECTION	Non-Specialty	
J0737	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg	*clindamycin in 0.9 % sod chlor*	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	*clindamycin in 5 % dextrose*	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	*clindamycin phosphate injection*	Non-Specialty	
J0457	Injection, aztreonam, 100 mg	AZACTAM	Non-Specialty	
J0457	Injection, aztreonam, 100 mg	*aztreonam*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
90380	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use	BEYFORTUS	Covered	PA
90381	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use	BEYFORTUS	Covered	PA
J0638	Injection, canakinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9399)	ILARIS (PF)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q0224	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	PEMGARDA (EUA)	Not Covered	
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	SYNAGIS	Preferred Specialty	PA
J1836	Injection, metronidazole, 10 mg	METRO I.V.	Non-Specialty	
J1836	Injection, metronidazole, 10 mg	*metronidazole in nacl (iso-os)*	Non-Specialty	
J0751	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)	DESCOVY 200-25 MG TABLET	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0750	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)	*emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab*	Pharmacy Only	
J0750	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)	*emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab inner*	Pharmacy Only	
J0750	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)	*emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab outer*	Pharmacy Only	
J1574	Injection, ganciclovir sodium (exela), not therapeutically equivalent to j1570, 500 mg (All NDCs inactive as of 6/18/2025)	*ganciclovir 500 mg/250 ml bag outer, p/f, sdv*	Non-Specialty	
J1574	Injection, ganciclovir sodium (exela), not therapeutically equivalent to j1570, 500 mg (All NDCs inactive as of 6/18/2025)	*ganciclovir 500 mg/250 ml bag sdv, inner, p/f*	Non-Specialty	
J1570	Injection, ganciclovir sodium, 500 mg	*ganciclovir sodium*	Non-Specialty	
J0248	Injection, remdesivir, 1 mg	*remdesivir*	Non-Preferred	
J0750	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)	TRUVADA 200 MG-300 MG TABLET	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0750	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)	TRUVADA 200 MG-300 MG TABLET F/C	Pharmacy Only	
J0248	Injection, remdesivir, 1 mg	VEKLURY	Non-Preferred	
J0911	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	DEFENCATH	Not Separately Payable	
J2020	Injection, linezolid, 200 mg	*linezolid in dextrose 5%*	Preferred Specialty	
J2021	Injection, linezolid (hospira), not therapeutically equivalent to j2020, 200 mg	*linezolid-0.9% sodium chloride*	Preferred Specialty	
J3090	Injection, tedizolid phosphate, 1 mg (For billing prior to 1/1/16 use C9446 or J3490)	SIVEXTRO INTRAVENOUS	Preferred Specialty	PA
J2020	Injection, linezolid, 200 mg	ZYVOX 200 MG/100 ML-D5W OUTER,SINGLE USE	Preferred Specialty	
J2020	Injection, linezolid, 200 mg	ZYVOX 600 MG/300 ML-D5W P/F, SINGLE USE	Preferred Specialty	
J2020	Injection, linezolid, 200 mg	ZYVOX 600 MG/300 ML-D5W SINGLE USE	Not Covered	
J0691	Injection, lefamulin, 1 mg (All NDCs inactive effective 1/3/2024)	XENLETA INTRAVENOUS	Not Covered	
J0287	Injection, amphotericin B lipid complex, 10 mg	ABELCET	Non-Specialty	
J0285	Injection, amphotericin B, 50mg	*amphotericin b*	Non-Specialty	
C9462	Injection, delafloxacin, 1 mg	BAXDELA INTRAVENOUS	Not Covered	
J3490	Unclassified drugs	BAXDELA INTRAVENOUS	Not Covered	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0699	Injection, cefiderocol, 10 mg	FETROJA	Not Covered	
J1271	Injection, doxycycline hyclate, 1 mg	DOXY-100	Non-Specialty	
J1271	Injection, doxycycline hyclate, 1 mg	*doxycycline hyclate intravenous*	Non-Specialty	
Q2055	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)	ABECMA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9264	Injection, paclitaxel protein-bound particles, 1 mg	ABRAXANE	Preferred Specialty	
J9042	Injection, brentuximab vedotin, 1 mg (For billing prior to 1/1/13 use C9287 or J9999)	ADCETRIS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9000	Injection, doxorubicin hydrochloride, 10 mg	ADRIAMYCIN	Non-Specialty	
J9190	Injection, fluorouracil, 500 mg	ADRUCIL	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	ADSTILADRIN	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9215	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	ALFERON N	Non-Specialty	
J9305	Injection, pemetrexed, not otherwise specified, 10 mg	ALIMTA	Non-Specialty	
J9057	Injection, copanlisib, 1 mg (All NDCs inactive as of 10/16/2024)	ALIQOPA	Preferred Specialty	PA
J9245	Injection, melphalan hydrochloride, not otherwise specified, 50 mg	ALKERAN (AS HCL)	Non-Specialty	
Q5126	Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg	ALYMSYS	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Mvasi or Zirabev)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	AMTAGVI	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	Not otherwise classified, antineoplastic drugs	AMTAGVI	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	ANKTIVA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9302	Injection, ofatumumab, 10 mg (For billing prior to 1/1/11 use J9999 or C9260)	ARZERRA	Non-Preferred	PA
J9118	Injection, calaspargase pegol-mknl, 10 units	ASPARLAS	Non-Preferred	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9301	Obecabtagene autoleucel, up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code deleted effective 6/30/2025)	AUCATZYL	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2058	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)	AUCATZYL	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9035	Injection, bevacizumab, 10 mg	AVASTIN 100 MG/4 ML VIAL P/F, SUV	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Mvasi or Zirabev for non-ophthalmic coverage)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9257	Injection, bevacizumab, 0.25 mg	AVASTIN 100 MG/4 ML VIAL P/F, SUV	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.
J9035	Injection, bevacizumab, 10 mg	AVASTIN 100 MG/4 ML VIAL P/F,SUV	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Mvasi or Zirabev for non-ophthalmic coverage)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9257	Injection, bevacizumab, 0.25 mg	AVASTIN 100 MG/4 ML VIAL P/F,SUV	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.
J9035	Injection, bevacizumab, 10 mg	AVASTIN 400 MG/16 ML VIAL P/F, SUV	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Mvasi or Zirabev for non-ophthalmic coverage)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9257	Injection, bevacizumab, 0.25 mg	AVASTIN 400 MG/16 ML VIAL P/F, SUV	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.
J9035	Injection, bevacizumab, 10 mg	AVASTIN 400 MG/16 ML VIAL P/F,SUV	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Mvasi or Zirabev for non-ophthalmic coverage)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9257	Injection, bevacizumab, 0.25 mg	AVASTIN 400 MG/16 ML VIAL P/F,SUV	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.
C9399	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)	AVGEMSI	Not Covered	
J9999	Not otherwise classified, antineoplastic drugs	AVGEMSI	Not Covered	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9292	Injection, pemetrexed dipotassium, 10 mg	AXTLE	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J9294, J9296, J9297, J9305, J9314, J9322, J9323)
A9590	Iodine i-131, iobenguane, 1 millicurie (All NDCs Inactive as of April 2024)	AZEDRA DOSIMETRIC VIAL	Non-Preferred	PA
A9590	Iodine i-131, iobenguane, 1 millicurie (All NDCs Inactive as of April 2024)	AZEDRA THERAPEUTIC VIAL	Non-Preferred	PA
J9023	Injection, avelumab, 10 mg (For billing prior to 1/1/18 use J9999 or C9491 for OPPS billing)	BAVENCIO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9032	Injection, belinostat, 10 mg (For billing prior to 1/1/16 use C9442 or J9999)	BELEODAQ	Preferred Specialty	PA
J9036	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	BELRAPZO	Non-Specialty	
J9033	Injection, bendamustine hydrochloride, 1 mg	*bendamustine*	Non-Specialty	
J9036	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	*bendamustine*	Non-Specialty	
J9034	Injection, bendamustine HCl (Bendeka), 1 mg	BENDEKA	Non-Specialty	
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	BESPONSA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7999	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	*bevacizumab*	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.
J9050	Injection, carmustine, 100 mg	BICNU	Non-Specialty	
J9382	Injection, zenocutuzumab-zbco, 1 mg	BIZENGRI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9040	Injection, bleomycin sulfate, 15 units	*bleomycin*	Non-Specialty	
J9039	Injection, blinatumomab, 1 microgram (For billing prior to 1/1/16 use C9449 or J9999)	BLINCYTO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9041	Injection, bortezomib, 0.1 mg	*bortezomib injection*	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9049	Injection, bortezomib (hospira), not therapeutically equivalent to j9041, 0.1 mg	*bortezomib injection*	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9046	Injection, bortezomib (dr. reddy's), not therapeutically equivalent to j9041, 0.1 mg (All NDCs inactive effective 1/10/2024)	*bortezomib intravenous recon soln*	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9048	Injection, bortezomib (fresenius kabi), not therapeutically equivalent to j9041, 0.1 mg (All NDCs inactive as of 4/3/2024)	*bortezomib intravenous recon soln*	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9054	Injection, bortezomib (boruzu), 0.1 mg	BORUZU	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
Q2054	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)	BREYANZI	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q2054	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)	BREYANZI CD4 COMPONENT (2OF 2)	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2054	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)	BREYANZI CD8 COMPONENT (1OF 2)	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1952	Leuprolide injectable, camcevi, 1 mg	CAMCEVI (6 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9206	Injection, irinotecan, 20 mg	CAMPTOSAR	Preferred Specialty	
J9045	Injection, carboplatin, 50 mg	*carboplatin intravenous solution*	Non-Specialty	
J9050	Injection, carmustine, 100 mg	*carmustine*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9052	Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg	*carmustine*	Non-Specialty	
Q2056	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)	CARVYKTI	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9060	Injection, cisplatin, powder or solution, per 10 mg	*cisplatin*	Non-Specialty	
J9065	Injection, cladribine, per 1 mg	*cladribine*	Non-Specialty	
J9286	Injection, glofitamab-gxbm, 2.5 mg	COLUMVI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9120	Injection, dactinomycin, 0.5 mg	COSMEGEN	Non-Specialty	
J9071	Injection, cyclophosphamide, (auromedics), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9072	Injection, cyclophosphamide (avyxa), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9073	Injection, cyclophosphamide (dr. reddy's), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9074	Injection, cyclophosphamide (sandoz), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9075	Injection, cyclophosphamide, not otherwise specified, 5mg	*cyclophosphamide intravenous*	Non-Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9076	Injection, cyclophosphamide (baxter), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9308	Injection, ramucirumab, 5 mg (For billing prior to 1/1/16 use C9025 or J9999)	CYRAMZA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9130	Dacarbazine, 100 mg	*dacarbazine*	Non-Specialty	
J9120	Injection, dactinomycin, 0.5 mg	*dactinomycin*	Non-Specialty	
J9348	Injection, naxitamab-gqgk, 1 mg	DANYELZA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9145	Injection, daratumumab, 10 mg (For billing prior to 1/1/17 use J9999 or C9476 for OPPS billing)	DARZALEX	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32 and E85.81.
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	DARZALEX FASPRO	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32 and E85.81.
C9174	Injection, datopotamab deruxtecan-dlnk, 1 mg	DATROWAY	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	Not otherwise classified, antineoplastic drugs	DATROWAY	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0893	Injection, decitabine (sun pharma), not therapeutically equivalent to j0894, 1 mg	*decitabine*	Preferred Specialty	
J0894	Injection, decitabine, 1 mg	*decitabine*	Preferred Specialty	
J9171	Injection, docetaxel, 1 mg	*docetaxel*	Preferred Specialty	
J9172	Injection, docetaxel (docivyx), 1 mg	DOCIVYX	Not Covered	Preferred (Covered) Alternative (Covered Alternative: J9171)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9000	Injection, doxorubicin hydrochloride, 10 mg	*doxorubicin*	Non-Specialty	
J9063	Injection, mirvetuximab soravtansine-gynx, 1 mg	ELAHERE	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD (3 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD (4 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD (6 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9178	Injection, epirubicin HCl, 2 mg	ELLENCE	Preferred Specialty	
J1323	Injection, elranatamab-bcmm, 1 mg	ELREXFIO	Not Covered	
J9269	Injection, tagraxofusp-erzs, 10 micrograms	ELZONRIS	Preferred Specialty	PA
J9176	Injection, elotuzumab, 1 mg (For billing prior to 1/1/17 use J9999 or C9477 for OPPS billing)	EMPLICITI	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	EMRELIS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9999	Not otherwise classified, antineoplastic drugs	EMRELIS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	ENHERTU	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9178	Injection, epirubicin HCl, 2 mg	*epirubicin 200 mg/100 ml vial suv, p/f*	Preferred Specialty	
J9321	Injection, epcoritamab-bysp, 0.16 mg	EPKINLY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9055	Injection, cetuximab, 10 mg	ERBITUX	Preferred Specialty	PA
J9179	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)	*eribulin*	Non-Preferred	
J9019	Injection, asparaginase (Erwinaze), 1,000 IU (For billing prior to 1/1/13 use C9289 or J9999)	ERWINASE	Non-Preferred	PA
J9181	Injection, etoposide, 10 mg	ETOPOPHOS	Non-Specialty	
J9181	Injection, etoposide, 10 mg	*etoposide intravenous*	Non-Specialty	
J9246	Injection, melphalan (evomela), 1 mg	EVOMELA	Preferred Specialty	PA
J9395	Injection, fulvestrant, 25 mg	FASLODEX	Preferred Specialty	
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	FENSOLVI	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9155	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	FIRMAGON	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9155	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	FIRMAGON KIT W DILUENT SYRINGE	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9200	Injection, floxuridine, 500 mg	*floxuridine*	Non-Specialty	
J9190	Injection, fluorouracil, 500 mg	*fluorouracil intravenous*	Non-Specialty	
J9307	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)	FOLOTYN	Preferred Specialty	PA
J9072	Injection, cyclophosphamide (avyxa), 5 mg	FRINDOVYX	Non-Specialty	
J9393	Injection, fulvestrant (teva), not therapeutically equivalent to j9395, 25 mg (All NDCs inactive as of 10/16/2023)	*fulvestrant*	Preferred Specialty	
J9394	Injection, fulvestrant (fresenius kabi) not therapeutically equivalent to j9395, 25 mg	*fulvestrant*	Preferred Specialty	
J9395	Injection, fulvestrant, 25 mg	*fulvestrant*	Preferred Specialty	
J9331	Injection, sirolimus protein-bound particles, 1 mg	FYARRO	Preferred Specialty	PA
J9301	Injection, obinutuzumab, 10 mg (For billing prior to 1/1/15 use C9021 or J9999)	GAZYVA	Preferred Specialty	PA
J9196	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg	*gemcitabine*	Preferred Specialty	
J9201	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg	*gemcitabine*	Preferred Specialty	
C9175	Injection, treosulfan, 50 mg	GRAFAPEX	Preferred Specialty	PA; No PA required if billed with ICD-10 C92.00, C92.02, C92.A0, C92.A2, D46.Z, D46.9

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9999	Not otherwise classified, antineoplastic drugs	GRAFAPEX	Preferred Specialty	PA; No PA required if billed with ICD-10 C92.00, C92.02, C92.A0, C92.A2, D46.Z, D46.9
J9179	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)	HALAVEN	Non-Preferred	
J9248	Injection, melphalan (hepzato), 1 mg	HEPZATO	Preferred Specialty	PA
J9248	Injection, melphalan (hepzato), 1 mg	HEPZATO (50 MM CATHETER)	Preferred Specialty	PA
J9248	Injection, melphalan (hepzato), 1 mg	HEPZATO (62 MM CATHETER)	Preferred Specialty	PA
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg	HERCEPTIN	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ogivri or Trazimera)
J9356	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk	HERCEPTIN HYLECTA	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ogivri or Trazimera)
Q5146	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	HERCESSI	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ogivri or Trazimera)
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg	HERZUMA	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ogivri or Trazimera)
J9351	Injection, topotecan, 0.1 mg	HYCAMTIN 4 MG VIAL P/F,SDV	Preferred Specialty	
J9211	Injection, idarubicin hydrochloride, 5 mg	IDAMYCIN PFS	Non-Specialty	
J9211	Injection, idarubicin hydrochloride, 5 mg	*idarubicin*	Non-Specialty	
J9208	Injection, ifosfamide, 1 gram	IFEX	Non-Specialty	
J9208	Injection, ifosfamide, 1 gram	*ifosfamide*	Non-Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9026	Injection, tarlatamab-dlle, 1 mg	IMDELLTRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9173	Injection, durvalumab, 10 mg	IMFINZI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9347	Injection, tremelimumab-actl, 1 mg	IMJUDO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units (For billing prior to 1/1/17 use J9999 or C9472 for OPPS billing)	IMLYGIC	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9198	Injection, gemcitabine hydrochloride, (infugem), 100 mg (All NDCs inactive as of 8/16/2023)	INFUGEM	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J9196, J9201)
J9206	Injection, irinotecan, 20 mg	*irinotecan*	Preferred Specialty	
J9319	Injection, romidepsin, lyophilized, 0.1 mg	ISTODAX	Preferred Specialty	PA
J9249	Injection, melphalan (apotex), 1 mg	IVRA	Not Covered	
J9207	Injection, ixabepilone, 1 mg	IXEMPRA	Non-Specialty	
J9281	Mitomycin pyelocalyceal instillation, 1 mg	JELMYTO	Non-Preferred	PA

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HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9272	Injection, dostarlimab-gxly, 10 mg	JEMPERLI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9043	Injection, cabazitaxel, 1 mg (For billing prior to 1/1/12 use J9999 or C9276)	JEVTANA	Non-Preferred	PA
J9354	Injection, ado-trastuzumab emtansine, 1 mg (For billing prior to 1/1/14 use C9131 or J9999)	KADCYLA	Preferred Specialty	PA
Q5117	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	KANJINTI	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ogivri or Trazimera)
J9271	Injection, pembrolizumab, 1 mg (For billing prior to 1/1/16 use C9027 or J9999)	KEYTRUDA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9274	Injection, tebentafusp-tebn, 1 microgram	KIMMTRAK	Preferred Specialty	PA
Q2042	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)	KYMRIAH	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9047	Injection, carfilzomib, 1 mg (For billing prior to 1/1/14 use C9295 or J9999)	KYPROLIS	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32.

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9218	Leuprolide acetate, per 1 mg	*leuprolide*	Non-Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg	*leuprolide depot 22.5 mg vial inner, suv*	Not Covered	
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg	*leuprolide depot 22.5 mg vial outer, suv*	Not Covered	
J9119	Injection, cemiplimab-rwlc, 1 mg	LIBTAYO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3263	Injection, toripalimab-tpzi, 1 mg	LOQTORZI	Preferred Specialty	PA
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg (All NDCs inactive as of 12/20/2023)	LUMOXITI 1 MG VIAL	Preferred Specialty	PA
J9350	Injection, mosunetuzumab-axgb, 1 mg (Code reused effective 7/1/2023)	LUNSUMIO	Preferred Specialty	PA
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT (3 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT (3 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT (4 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT (6 MONTH)	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT-PED	Preferred Specialty	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT-PED (3 MONTH)	Preferred Specialty	
A9513	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	LUTATHERA	Preferred Specialty	PA
J9353	Injection, margetuximab-cmkb, 5 mg	MARGENZA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9371	Injection, vincristine sulfate liposome, 1 mg (All NDCs inactive as of 4/3/2024) (Code deleted effective 6/30/2024)	MARQIBO	Non-Preferred	PA
J9245	Injection, melphalan hydrochloride, not otherwise specified, 50 mg	*melphalan hcl*	Non-Specialty	
J8610	Methotrexate, oral, 2.5 mg	*methotrexate sodium oral*	Non-Specialty	
J9280	Injection, mitomycin, 5 mg	*mitomycin intravenous*	Non-Specialty	
J9293	Injection, mitoxantrone hydrochloride, per 5 mg	*mitoxantrone*	Non-Specialty	
J9349	Injection, tafasitamab-cxix, 2 mg	MONJUVI	Preferred Specialty	PA
J9280	Injection, mitomycin, 5 mg	MUTAMYCIN	Non-Specialty	
Q5107	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	MVASI	Preferred Specialty	
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg (For billing prior to 1/1/18 use J9999 or C9399 for OPPS billing)	MYLOTARG	Non-Preferred	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9390	Injection, vinorelbine tartrate, per 10 mg	NAVELBINE	Non-Specialty	
J9268	Injection, pentostatin, per 10 mg	NIPENT	Preferred Specialty	
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	OGIVRI	Preferred Specialty	
J9266	Injection, pegaspargase, per single dose vial	ONCASPAR	Preferred Specialty	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
J9205	Injection, irinotecan liposome, 1 mg (For billing prior to 1/1/17 use J9999 or C9474 for OPPS billing)	ONIVYDE	Preferred Specialty	PA
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg	ONTRUZANT	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ogivri or Trazimera)
C9453	Injection, nivolumab, 1 mg (For billing OPPS prior to 7/1/15 use C9399) - see also J9999 (Code deleted effective 12/31/15) - see J9299	OPDIVO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9299	Injection, nivolumab, 1 mg (For billing prior to 1/1/16 use C9453 or J9999)	OPDIVO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy	OPDIVO QVANTIG	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	OPDUALAG	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9264	Injection, paclitaxel protein-bound particles, 1 mg	*paclitaxel protein-bound*	Preferred Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg	PADCEV	Preferred Specialty	PA
J9045	Injection, carboplatin, 50 mg	PARAPLATIN	Non-Specialty	
J9314	Injection, pemetrexed (teva), not therapeutically equivalent to j9305, 10 mg	*pemetrexed*	Non-Specialty	
J9323	Injection, pemetrexed ditromethamine, 10 mg (All NDCs inactive as of 7/14/2025)	*pemetrexed 1 gram vial*	Non-Specialty	
J9323	Injection, pemetrexed ditromethamine, 10 mg (All NDCs inactive as of 7/14/2025)	*pemetrexed 100 mg vial*	Non-Specialty	
J9323	Injection, pemetrexed ditromethamine, 10 mg (All NDCs inactive as of 7/14/2025)	*pemetrexed 500 mg vial*	Non-Specialty	
J9294	Injection, pemetrexed (hospira), not therapeutically equivalent to j9305, 10 mg	*pemetrexed disodium*	Non-Specialty	
J9296	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg	*pemetrexed disodium*	Non-Specialty	
J9297	Injection, pemetrexed (sandoz), not therapeutically equivalent to j9305, 10 mg	*pemetrexed disodium*	Non-Specialty	
J9305	Injection, pemetrexed, not otherwise specified, 10 mg	*pemetrexed disodium*	Non-Specialty	
J9322	Injection, pemetrexed (bluepoint), not therapeutically equivalent to j9305, 10 mg	*pemetrexed disodium*	Non-Specialty	
J9304	Injection, pemetrexed (pemfexy), 10 mg	PEMFEXY	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J9294, J9296, J9297, J9305, J9314, J9322, J9323)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9324	Injection, pemetrexed (pemrydi rtu), 10 mg	PEMRYDI RTU	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J9294, J9296, J9297, J9305, J9314, J9322, J9323)
J9306	Injection, pertuzumab, 1 mg (For billing prior to 1/1/14 use C9292 or J9999)	PERJETA	Preferred Specialty	PA; No PA required for ICD-10 code C50.
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	PHESGO	Preferred Specialty	PA; No PA required if billed with ICD-10 C50
J9600	Injection, porfimer sodium, 75 mg	PHOTOFRIN	Preferred Specialty	
A9607	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	PLUVICTO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9309	Injection, polatuzumab vedotin-piiq, 1 mg	POLIVY	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9295	Injection, necitumumab, 1 mg (For billing prior to 1/1/17 use J9999 or C9475 for OPPS billing) (NDC inactive since 7/15/2025)	PORTRAZZA 800 MG/50 ML VIAL	Not Covered	
J9204	Injection, mogamulizumab-kpkc, 1 mg	POTELIGEO	Non-Preferred	PA
J9307	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)	*pralatrexate*	Preferred Specialty	PA
J9015	Injection, aldesleukin, per single-use vial	PROLEUKIN	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q2043	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)	PROVENGE	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5123	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg	RIABNI	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ruxience or Truxima)
J9312	Injection, rituximab, 10 mg	RITUXAN	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ruxience or Truxima)
J9311	Injection, rituximab 10 mg and hyaluronidase	RITUXAN HYCELA	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ruxience or Truxima)
J9318	Injection, romidepsin, non-lyophilized, 0.1 mg	*romidepsin*	Preferred Specialty	PA
J9319	Injection, romidepsin, lyophilized, 0.1 mg	*romidepsin*	Preferred Specialty	PA
Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	RUXIENCE	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9061	Injection, amivantamab-vmjw, 2 mg	RYBREVANT	Preferred Specialty	PA
J9021	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	RYLAZE	Preferred Specialty	PA

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HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0870	Injection, imetelstat, 1 mg	RYTELO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9227	Injection, isatuximab-irfc, 10 mg	SARCLISA	Preferred Specialty	PA
J9226	Histrelin implant (Supprelin LA), 50 mg	SUPPRELIN LA	Non-Preferred	PA
J2860	Injection, siltuximab, 10 mg (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9455 or J3590)	SYLVANT	Preferred Specialty	PA
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg (For billing prior to 1/1/14 use C9297, J9999) (NDC inactive as of 12/27/2023)	SYNRIBO 3.5 MG/ML VIAL	Non-Preferred	PA
J3055	Injection, talquetamab-tgvs, 0.25 mg	TALVEY	Non-Preferred	PA
Q2053	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)	TECARTUS	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9022	Injection, atezolizumab, 10 mg (For billing prior to 1/1/18 use J9999 or C9483 for OPPS billing)	TECENTRIQ	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	TECENTRIQ HYBREZA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9380	Injection, teclistamab-cqyv, 0.5 mg (Code reused effective 7/1/2023)	TECVAYLI	Non-Preferred	PA
Q2017	Injection, teniposide, 50 mg (All NDCs inactive as of 7/23/2024)	*teniposide*	Non-Specialty	
J9340	Injection, thiotepa, 15 mg (Code deleted effective 6/30/2025)	TEPADINA INJECTION RECON SOLN	Non-Specialty	
J9341	Injection, thiotepa (tepylute), 1 mg	TEPYLUTE	Non-Specialty	
J9329	Injection, tislelizumab-jsgr, 1mg	TEVIMBRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9340	Injection, thiotepa, 15 mg (Code deleted effective 6/30/2025)	*thiotepa*	Non-Specialty	
J9030	BCG live intravesical instillation, 1 mg	TICE BCG	Non-Specialty	
J9273	Injection, tisotumab vedotin-tftv, 1 mg	TIVDAK	Preferred Specialty	PA
J9181	Injection, etoposide, 10 mg	TOPOSAR 1,000 MG/50 ML VIAL MDV,POLYMER	Non-Specialty	
J9181	Injection, etoposide, 10 mg	TOPOSAR 100 MG/5 ML VIAL MDV,POLYMER	Non-Specialty	
J9181	Injection, etoposide, 10 mg	TOPOSAR 500 MG/25 ML VIAL MDV,POLYMER	Non-Specialty	
J9351	Injection, topotecan, 0.1 mg	*topotecan*	Preferred Specialty	
Q5116	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg	TRAZIMERA	Preferred Specialty	
J9033	Injection, bendamustine hydrochloride, 1 mg	TREANDA	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3315	Injection, triptorelin pamoate, 3.75 mg	TRELSTAR	Non-Specialty	
J8610	Methotrexate, oral, 2.5 mg	TREXALL	Non-Specialty	
J3316	Injection, triptorelin, extended-release, 3.75 mg	TRIPTODUR	Non-Preferred	
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg	TRODELVY	Preferred Specialty	PA
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	TRUXIMA	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	UNITUXIN	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	Not otherwise classified, antineoplastic drugs	UNITUXIN	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9303	Injection, panitumumab, 10 mg	VECTIBIX	Preferred Specialty	PA
Q5129	Injection, bevacizumab-adcd (vegzelma), biosimilar, 10 mg	VEGZELMA	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Mvasi or Zirabev)
J9041	Injection, bortezomib, 0.1 mg	VELCADE	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9360	Injection, vinblastine sulfate, 1 mg	*vinblastine*	Non-Specialty	
J9370	Vincristine sulfate, 1 mg	VINCASAR PFS	Non-Specialty	
J9370	Vincristine sulfate, 1 mg	*vincristine*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9390	Injection, vinorelbine tartrate, per 10 mg	*vinorelbine*	Non-Specialty	
J9056	Injection, bendamustine hydrochloride (vivimusta), 1 mg	VIVIMUSTA	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J9033, J9034, J9036)
C9303	Injection, zolbetuximab-clzb, 1 mg (Code deleted 6/30/2025)	VYLOY	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1326	Injection, zolbetuximab-clzb, 2 mg	VYLOY	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	VYXEOS	Preferred Specialty	PA
J9228	Injection, ipilimumab, 1 mg (For billing prior to 1/1/12 use J9999 or C9284)	YERVOY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2041	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 OPPS billing) (Code Price is for drug ONLY) (Code re-used by CMS)	YESCARTA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9352	Injection, trabectedin, 0.1 mg (For billing prior to 1/1/17 use J9999 or C9480 for OPPS billing)	YONDELIS	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9400	Injection, ziv-aflibercept, 1 mg (For billing prior to 1/1/14 use C9296 or J9999)	ZALTRAP	Non-Preferred	
J9320	Injection, streptozocin, 1 gram	ZANOSAR	Non-Specialty	
J9223	Injection, lurbinectedin, 0.1 mg	ZEPZELCA	Non-Specialty	PA
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries (Code Price is per dose)	ZEVALIN (Y-90)	Preferred Specialty	PA
C9302	Injection, zanidatamab-hrii, 2 mg (Code deleted effective 6/30/2025)	ZIIHERA	Non-Preferred	PA
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg	ZIRABEV	Preferred Specialty	
J9202	Goserelin acetate implant, per 3.6 mg	ZOLADEX	Preferred Specialty	
C9399	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)	ZUSDURI	New to Market	
J9999	Not otherwise classified, antineoplastic drugs	ZUSDURI	New to Market	
J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg	ZYNLONTA	Preferred Specialty	PA
J9345	Injection, retifanlimab-dlwr, 1 mg	ZYNYZ	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PALFORZIA (LEVEL 0)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 0)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 1)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 1)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 2)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 2)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 3)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 3)	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PALFORZIA (LEVEL 4)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 4)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 5)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 5)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 6)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 6)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 7)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 7)	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PALFORZIA (LEVEL 8)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 8)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 9)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 9)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 10)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 10)	Preferred Specialty	PA
C9399	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)	PALFORZIA (LEVEL 11 UP-DOSE)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA (LEVEL 11 UP-DOSE)	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PALFORZIA INITIAL (1-3 YRS)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA INITIAL (1-3 YRS)	Preferred Specialty	PA
C9399	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)	PALFORZIA INITIAL (4-17 YRS)	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA INITIAL (4-17 YRS)	Preferred Specialty	PA
C9399	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)	PALFORZIA LEVEL 11 MAINTENANCE	Preferred Specialty	PA
J3590	Unclassified biologics	PALFORZIA LEVEL 11 MAINTENANCE	Preferred Specialty	PA
J1552	Injection, immune globulin (alyglo), 500 mg	ALYGLO	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J1459, J1557, J1561, J1568, J1569, J1572)
J0716	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)	ANASCORP	Preferred Specialty	
J0841	Injection, crotalidae immune f(ab')2 (equine), 120 mg	ANAVIP	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1554	Injection, immune globulin (asceniv), 500 mg	ASCENIV	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J1459, J1557, J1561, J1568, J1569, J1572)
J1556	Injection, immune globulin (Bivigam), 500 mg (For billing prior to 1/1/14 see C9130 or J1599)	BIVIGAM	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J1459, J1557, J1561, J1568, J1569, J1572)
90284	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)	CUTAQUIG	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1551	Injection, immune globulin (cutaquig), 100 mg	CUTAQUIG	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
90284	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)	CUVITRU	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1555	Injection, immune globulin (Cuvitru), 100 mg (For billing prior to 1/1/18 use J3590 or C9399 for OPPS billing)	CUVITRU	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	FLEBOGAMMA DIF	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
90284	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)	GAMMAGARD LIQUID	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1569	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg	GAMMAGARD LIQUID	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1566	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)	GAMMAGARD S-D (IGA < 1 MCG/ML)	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J1459, J1557, J1561, J1568, J1569, J1572)
90284	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)	GAMMAKED	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg	GAMMAKED	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)	GAMMAPLEX	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)	GAMMAPLEX (WITH SORBITOL)	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
90284	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)	GAMUNEX-C	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg	GAMUNEX-C	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1573	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5 mL (see J1571 for IM use)	HEPAGAM B	Non-Specialty	
90284	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)	HIZENTRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1559	Injection, immune globulin (Hizentra), 100 mg (For billing prior to 1/1/11 use J3590 or C9399) (see also 90284 for CPT billing requirements)	HIZENTRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2790	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	HYPERRHO S-D 1,500 UNIT SYRING P/F,INNER,SDV	Non-Specialty	
J2790	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	HYPERRHO S-D 1,500 UNIT SYRING P/F,OUTER,SDV	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1575	Injection, immune globulin/hyaluronidase, (Hyqvia), 100 mg immune globulin (For billing prior to 1/1/16 use C9399 or J3590)	HYQVIA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1568	Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg	OCTAGAM	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	PANZYGA	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: J1459, J1557, J1561, J1568, J1569, J1572)
J1459	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g liquid), 500 mg	PRIVIGEN	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2790	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	RHOGAM ULTRA-FILTERED PLUS	Non-Specialty	
J2791	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU (see also 90384 and 90386 for CPT billing requirements)	RHOPHYLAC	Non-Specialty	
90284	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)	XEMBIFY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1558	Injection, immune globulin (xembify), 100 mg	XEMBIFY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0565	Injection, bezlotoxumab, 10 mg (For billing prior to 1/1/18 use J3590 or C9490 for OPPS billing)	ZINPLAVA	Not Covered	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADRENALIN	Non-Specialty	
J3490	Unclassified drugs	ADRENALIN 4 MG/250 ML-0.9% NACL SUV, INNER	Non-Specialty	
J3490	Unclassified drugs	ADRENALIN 4 MG/250 ML-0.9% NACL SUV, OUTER	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADYPHREN	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADYPHREN AMP	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADYPHREN II	Non-Specialty	
J3490	Unclassified drugs	*epineph bitart in 0.9% sod chl intravenous solution*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 0.1 mg/ml syringe suv*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 1 mg/10 ml abbojct suv, inner*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 1 mg/10 ml abbojct suv, outer*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 1 mg/10 ml luerjet suv*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine hcl (pf)*	Non-Specialty	
J0173	Injection, epinephrine (belcher), not therapeutically equivalent to j0171, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine hcl (pf)*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine injection solution*	Non-Specialty	
J0173	Injection, epinephrine (belcher), not therapeutically equivalent to j0171, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine injection solution*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINE PROFESSIONAL	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINE PROFESSIONL EMS KT	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINESNAP	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINESNAP-EMS	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINESNAP-V	Non-Specialty	
J3490	Unclassified drugs	REZIPRES	Non-Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2372	Injection, phenylephrine hydrochloride (biorphen), 20 micrograms	BIORPHEN	Non-Specialty	
J2373	Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms	IMMPHENTIV	Non-Specialty	
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	*phenylephrine hcl injection*	Non-Specialty	
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	VAZCULEP	Non-Specialty	
J7677	Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram	YUPELRI	Not Covered	
J0515	Injection, benztropine mesylate, per 1mg	*benztropine injection*	Non-Specialty	
J0585	Injection, onabotulinumtoxinA, 1 unit	BOTOX	Preferred Specialty	PA
J0585	Injection, onabotulinumtoxinA, 1 unit	BOTOX COSMETIC	Not Covered	
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	DAXXIFY	Preferred Specialty	PA
J0586	Injection, abobotulinumtoxinA, 5 units (For billing prior to 1/1/10 use J3590 or C9399)	DYSPORT	Preferred Specialty	PA
C9399	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)	JEUVEAU	Not Covered	
J3590	Unclassified biologics	JEUVEAU	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0587	Injection, rimabotulinumtoxinB, 100 units	MYOBLOC	Preferred Specialty	PA
J0588	Injection, incobotulinumtoxinA, 1 unit	XEOMIN	Preferred Specialty	PA
J0475	Injection, baclofen, 10 mg	*baclofen intrathecal kit*	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	*baclofen intrathecal solution*	Preferred Specialty	
J0476	Injection, baclofen, 50 mcg, for intrathecal trial	*baclofen intrathecal syringe*	Non-Specialty	
J0475	Injection, baclofen, 10 mg	GABLOFEN 10,000 MCG/20 ML SYRG P/F, SUV	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	GABLOFEN 20,000 MCG/20 ML SYRG P/F, SUV	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	GABLOFEN 40,000 MCG/20 ML SYRG P/F, SUV	Preferred Specialty	
J0476	Injection, baclofen, 50 mcg, for intrathecal trial	GABLOFEN 50 MCG/ML SYRINGE P/F, SUV	Non-Specialty	
J0475	Injection, baclofen, 10 mg	GABLOFEN INTRATHECAL SOLUTION	Preferred Specialty	
J0476	Injection, baclofen, 50 mcg, for intrathecal trial	LIORESAL IT 0.05 MG/ML AMPULE INNER, SUV, P/F	Non-Specialty	
J0476	Injection, baclofen, 50 mcg, for intrathecal trial	LIORESAL IT 0.05 MG/ML AMPULE OUTER, SUV, P/F	Non-Specialty	
J0476	Injection, baclofen, 50 mcg, for intrathecal trial	LIORESAL IT 0.05 MG/ML AMPULE SUV, P/F	Non-Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/20 ML AMPULE INNER, P/F, SUV	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/20 ML KIT OUTER, P/F, SUV	Preferred Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/20 ML KIT SUV, P/F	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/5 ML AMPULE INNER, P/F, SUV	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/5 ML AMPULE SUV, P/F, INNER	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/5 ML KIT OUTER, P/F, SUV	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 10 MG/5 ML KIT SUV, P/F, OUTER	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 40 MG/20 ML AMPULE INNER, SUV, P/F	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 40 MG/20 ML AMPULE INNER,SUV	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 40 MG/20 ML KIT OUTER, SUV, P/F	Preferred Specialty	
J0475	Injection, baclofen, 10 mg	LIORESAL IT 40 MG/20 ML KIT OUTER,SUV	Preferred Specialty	
J0330	Injection, succinylcholine chloride, up to 20mg	*succinylcholine 100 mg/5 ml syringe suv, p/f, inner*	Non-Specialty	
J0330	Injection, succinylcholine chloride, up to 20mg	*succinylcholine 100 mg/5 ml syringe suv, p/f, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, inner*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng inner, suv, p/f*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng outer, suv, p/f*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, inner*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, outer*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol intravenous solution*	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	BLOXIVERZ	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	*neostigmine 3 mg/3 ml syringe inner, suv*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	*neostigmine 3 mg/3 ml syringe outer, suv*	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	*neostigmine methylsulfate intravenous solution*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng inner, suv, p/f*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng outer, suv, p/f*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, inner*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, outer*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol intravenous solution*	Non-Specialty	
J7611	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg (Code reinstated effective 4/1/2008)	*albuterol sulfate inhalation solution for nebulization*	Non-Specialty	
J7613	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	*albuterol sulfate inhalation solution for nebulization*	Non-Specialty	
J3105	Injection, terbutaline sulfate, up to 1 mg	*terbutaline subcutaneous*	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	BREVIBLOC	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	BREVIBLOC IN NACL (ISO-OSM)	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	*esmolol*	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	*esmolol in nacl (iso-osm)*	Non-Specialty	
J1806	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	*esmolol in sterile water*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2315	Injection, naltrexone, depot form, 1 mg	VIVITROL	Preferred Specialty	
J0256	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	ARALAST NP	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0257	Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg (For billing prior to 1/1/12 use J3590 or C9399)	GLASSIA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0256	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	PROLASTIN C 1,000 MG VIAL P/F,SUV,PRICE/MG	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0256	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	PROLASTIN C 1,000 MG VIAL PRICE/MG,SDV	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0256	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	PROLASTIN-C	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2998	Injection, plasminogen, human-tvmh, 1 mg	RYPLAZIM	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0256	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	ZEMAIRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0881	Injection, darbepoetin alfa, 1 microgram (non-ESRD use)	ARANESP (IN POLYSORBATE)	Preferred Specialty	
J0882	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	ARANESP (IN POLYSORBATE)	Preferred Specialty	
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	MIRCERA	Preferred Specialty	
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	MIRCERA	Preferred Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0896	Injection, luspatercept-aamt, 0.25 mg	REBLOZYL	Preferred Specialty	PA
J0901	Vadadustat, oral, 1 mg (for esrd on dialysis)	VAFSEO	Not Covered	
J0911	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	DEFENCATH	Not Separately Payable	
J0791	Injection, crizanlizumab-tmca, 5 mg	ADAKVEO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2277	Injection, motixafortide, 0.25 mg	APHEXDA	Non-Preferred	
J0881	Injection, darbepoetin alfa, 1 microgram (non-ESRD use)	ARANESP (IN POLYSORBATE)	Preferred Specialty	
J0882	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	ARANESP (IN POLYSORBATE)	Preferred Specialty	
Q5108	Injection, pegfilgrastim-jmdb (fulphila), biosimilar, 0.5 mg	FULPHILA	Preferred Specialty	
Q5130	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	FYLNETRA	Not Covered	
J2820	Injection, sargramostim (GM-CSF), 50 mcg	LEUKINE	Preferred Specialty	
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	MIRCERA	Preferred Specialty	
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	MIRCERA	Preferred Specialty	
J2562	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)	MOZOBIL	Non-Preferred	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	NEULASTA	Preferred Specialty	

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HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	NEULASTA ONPRO	Preferred Specialty	
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram	NIVESTYM	Preferred Specialty	
J2802	Injection, romiplostim, 1 microgram	NPLATE	Preferred Specialty	PA
Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	NYPOZI	Not Covered	
Q5122	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	NYVEPRIA	Preferred Specialty	
J2562	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)	*plerixafor*	Non-Preferred	
J0896	Injection, luspatercept-aamt, 0.25 mg	REBLOZYL	Preferred Specialty	PA
Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	RELEUKO	Preferred Specialty	
Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	RELEUKO 300 MCG/ML VIAL P/F, SUV, INNER	Preferred Specialty	
Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	RELEUKO 300 MCG/ML VIAL P/F, SUV, OUTER	Preferred Specialty	
Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	RELEUKO 480 MCG/1.6 ML VIAL P/F, SUV, INNER	Preferred Specialty	
Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	RELEUKO 480 MCG/1.6 ML VIAL P/F, SUV, OUTER	Preferred Specialty	
J1449	Injection, eflapegrastim-xnst, 0.1 mg	ROLVEDON	Not Covered	
Q5127	Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg	STIMUFEND	Not Covered	
Q5111	Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg	UDENYCA	Not Covered	
Q5111	Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg	UDENYCA AUTOINJECTOR	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5111	Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg	UDENYCA ONBODY	Not Covered	
J0901	Vadadustat, oral, 1 mg (for esrd on dialysis)	VAFSEO	Not Covered	
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio), 1 microgram	ZARXIO	Preferred Specialty	
Q5120	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg	ZIEXTENZO	Not Covered	
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	ADVATE	Pharmacy Only	
J7207	Injection, factor VIII, (antihemophilic factor, recombinant), pegylated, 1 IU (For billing prior to 1/1/17 use J7199 or C9137 for OPPS billing)	ADYNOVATE	Pharmacy Only	
J7210	Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU (For billing prior to 1/1/18 use J7199 or C9140 for OPPS billing)	AFSTYLA	Pharmacy Only	
C9399	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)	ALHEMO PEN	Pharmacy Only	
J3590	Unclassified biologics	ALHEMO PEN	Pharmacy Only	
J7186	Injection, antihemophilic factor VIII/Von Willebrand factor complex (human), per factor VIII I.U.	ALPHANATE	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU	ALPHANINE SD	Pharmacy Only	
J7201	Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1 IU	ALPROLIX	Pharmacy Only	
J7214	Injection, factor viii/von willebrand factor complex, recombinant (altuviiio), per factor viii i.u.	ALTUVIIIO	Pharmacy Only	
J7165	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	BALFAXAR	Non-Specialty	
J7195	Injection factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified	BENEFIX	Pharmacy Only	
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (Code deleted effective 12/31/2024)	BEQVEZ 4 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 4 VIAL KIT SUV, P/F, OUTER	Not Covered	
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (Code deleted effective 12/31/2024)	BEQVEZ 5 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 5 VIAL KIT SUV, P/F, OUTER	Not Covered	
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (Code deleted effective 12/31/2024)	BEQVEZ 6 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 6 VIAL KIT SUV, P/F, OUTER	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (Code deleted effective 12/31/2024)	BEQVEZ 7 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 7 VIAL KIT SUV, P/F, OUTER	Not Covered	
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (Code deleted effective 12/31/2024)	BEQVEZ VIAL SUV, P/F, INNER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ VIAL SUV, P/F, INNER	Not Covered	
J7175	Injection, factor X, (human), 1 IU (For billing prior to 1/1/17 use J3590 or C9399 for OPPS billing)	COAGADEX	Pharmacy Only	
J7180	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)	CORIFACT	Pharmacy Only	
J2597	Injection, desmopressin acetate, per 1 mcg	DDAVP INJECTION	Non-Specialty	
J2597	Injection, desmopressin acetate, per 1 mcg	*desmopressin injection*	Non-Specialty	
J7205	Injection, factor VIII, Fc fusion protein (recombinant), per IU	ELOCTATE	Pharmacy Only	
J7204	Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu	ESPEROCT	Pharmacy Only	
J7198	Anti-inhibitor, per IU	FEIBA NF	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7177	Injection, human fibrinogen concentrate (fibryga), 1 mg (Price is per 1mg. Product contains approximately 1 gram (900-1300mg))	FIBRYGA	Not Separately Payable	
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	HEMGENIX	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -** Coverage is dependent on member's benefit plan documents. This product is defined by the FDA's Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA's website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7170	Injection, emicizumab-kxwh, 0.5 mg	HEMLIBRA	Pharmacy Only	
J7190	Factor VIII (antihemophilic factor [human]) per IU	HEMOFIL M HIGH	Pharmacy Only	
J7190	Factor VIII (antihemophilic factor [human]) per IU	HEMOFIL M LOW	Pharmacy Only	
J7190	Factor VIII (antihemophilic factor [human]) per IU	HEMOFIL M MID	Pharmacy Only	
J7190	Factor VIII (antihemophilic factor [human]) per IU	HEMOFIL M SUPER HIGH	Pharmacy Only	
J7187	Injection, Von Willebrand factor complex (Humate-P), per IU, VWF:RCO	HUMATE-P	Pharmacy Only	
C9304	Injection, marstacimab-hncq, 0.5 mg (Code deleted effective 6/30/2025)	HYMPAVZI PEN	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7172	Injection, marstacimab-hncq, 0.5 mg	HYMPAVZI PEN	Pharmacy Only	
J7202	Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, 1 IU (For billing prior to 1/1/17 use J7199 or C9139 for OPPS billing)	IDELVION	Pharmacy Only	
J7213	Injection, coagulation factor ix (recombinant), ixinity, 1 i.u.	IXINITY	Pharmacy Only	
J7208	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	JIVI	Pharmacy Only	
J7190	Factor VIII (antihemophilic factor [human]) per IU	KOATE	Pharmacy Only	
J7190	Factor VIII (antihemophilic factor [human]) per IU	KOATE-DVI	Pharmacy Only	
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	KOGENATE FS	Pharmacy Only	
J7211	Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU (For billing prior to 1/1/18 use J7192)	KOVALTRY	Pharmacy Only	
J7182	Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU	NOVOEIGHT	Pharmacy Only	
J7189	Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram	NOVOSEVEN RT	Pharmacy Only	
J7209	Injection, factor VIII, (antihemophilic factor, recombinant), (Nuwiq), 1 IU (For billing prior to 1/1/17 use J7199 or C9138 for OPPS billing)	NUWIQ	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7188	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)	OBIZUR	Pharmacy Only	
J7194	Factor IX, complex, per IU	PROFILNINE	Pharmacy Only	
C9399	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)	QFITLIA	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3490	Unclassified drugs	QFITLIA	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	QFITLIA PEN	Not Covered	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3490	Unclassified drugs	QFITLIA PEN	Not Covered	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7203	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	REBINYN	Pharmacy Only	
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	RECOMBINATE	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7200	Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU (For billing prior to 1/1/15 use C9133 or J7195)	RIXUBIS	Pharmacy Only	
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	ROCTAVIAN	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -** Coverage is dependent on member's benefit plan documents. This product is defined by the FDA's Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA's website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	SEVENFACT	Pharmacy Only	
J3490	Unclassified drugs	*tranexamic acid in nacl,iso-os*	Non-Specialty	
J7181	Injection, factor XIII A-subunit, (recombinant), per IU For billing prior to 1/1/15 use C9134 or J3590)	TRETTEN	Pharmacy Only	
J7179	Injection, Von Willebrand factor (recombinant), (Vonvendi), 1 IU VWF:RCo (For billing prior to 1/1/17 use J7199 or C9399 for OPPS billing)	VONVENDI	Pharmacy Only	
J7183	Injection, Von Willebrand factor complex (human), Wilate, 1 IU VWF:RCO	WILATE	Pharmacy Only	
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU	XYNTHA	Pharmacy Only	

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HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU	XYNTHA SOLOFUSE	Pharmacy Only	
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) (For billing prior to 1/1/10 use J3490 or C9399)	FERAHEME	Non-Specialty	
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	FERRLECIT	Non-Specialty	
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) (For billing prior to 1/1/10 use J3490 or C9399)	*ferumoxytol*	Non-Specialty	
J1750	Injection, iron dextran, 50 mg (Code reinstated effective 1/1/09)	INFED	Non-Specialty	
J1439	Injection, ferric carboxymaltose, 1 mg	INJECTAFER	Non-Preferred	
J1437	Injection, ferric derisomaltose, 10 mg	MONOFERRIC	Non-Preferred	
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	*sodium ferric gluconat-sucrose*	Non-Specialty	
J1756	Injection, iron sucrose, 1 mg	VENOFER	Non-Specialty	
C9047	Injection, caplacizumab-yhdp, 1 mg	CABLIVI INJECTION KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	Unclassified biologics	CABLIVI INJECTION KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, inner*	Non-Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng inner, suv, p/f*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng outer, suv, p/f*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, inner*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, outer*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol intravenous solution*	Non-Specialty	
J1305	Injection, evinacumab-dgnb, 5mg	EVKEEZA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1306	Injection, inclisiran, 1 mg	LEQVIO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	TRYNGOLZA	Not Covered	
J3490	Unclassified drugs	TRYNGOLZA	Not Covered	
J1805	Injection, esmolol hydrochloride, 10 mg	BREVIBLOC	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	BREVIBLOC IN NACL (ISO-OSM)	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	*esmolol*	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	*esmolol in nacl (iso-osm)*	Non-Specialty	
J1806	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	*esmolol in sterile water*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, outer*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng inner, suv, p/f*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng outer, suv, p/f*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, inner*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, outer*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol intravenous solution*	Non-Specialty	
J1744	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	FIRAZYR	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1744	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	*icatibant*	Pharmacy Only	
J1744	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	SAJAZIR	Pharmacy Only	
J1160	Injection, digoxin, up to 0.5 mg	*digoxin injection*	Non-Specialty	
J1160	Injection, digoxin, up to 0.5 mg	LANOXIN INJECTION	Non-Specialty	
J1160	Injection, digoxin, up to 0.5 mg	LANOXIN PEDIATRIC	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	BREVIBLOC	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	BREVIBLOC IN NACL (ISO-OSM)	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	*esmolol*	Non-Specialty	
J1805	Injection, esmolol hydrochloride, 10 mg	*esmolol in nacl (iso-osm)*	Non-Specialty	
J1806	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	*esmolol in sterile water*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 100 mg/100 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-dextrose p/f, suv, outer*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 200 mg/200 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, inner*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol 300 mg/300 ml-nacl p/f, suv, outer*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng inner, suv, p/f*	Non-Specialty	
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	*labetalol hcl 10 mg/2 ml syrng outer, suv, p/f*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, inner*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol hcl 20 mg/4 ml crpjt suv, outer*	Non-Specialty	
J1920	Injection, labetalol hydrochloride, 5 mg	*labetalol intravenous solution*	Non-Specialty	
J3490	Unclassified drugs	RAPIBLYK	New to Market	
J1290	Injection, ecallantide, 1 mg (For billing prior to 1/1/11 use J3590 or C9263)	KALBITOR	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0593	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)	TAKHZYRO	Pharmacy Only	
J1941	Injection, furosemide (furoscix), 20 mg	FUROSCIX	Not Covered	
J1938	Injection, furosemide, 1 mg	*furosemide 100 mg/10 ml syring inner, sdv*	Non-Specialty	
J1938	Injection, furosemide, 1 mg	*furosemide 100 mg/10 ml syring outer, sdv*	Non-Specialty	
J1938	Injection, furosemide, 1 mg	*furosemide injection*	Non-Specialty	
J2305	Injection, nitroglycerin, 5 mg	*nitroglycerin in 5 % dextrose*	Non-Specialty	
J2305	Injection, nitroglycerin, 5 mg	*nitroglycerin intravenous*	Non-Specialty	
J1749	Injection, iloprost, 0.1 mcg	AURLUMYN	Not Covered	
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	*epoprostenol*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	*epoprostenol sodium 0.5 mg vl*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	*epoprostenol sodium 1.5 mg vl*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	FLOLAN	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 100 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 20 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3285	Injection, treprostinil, 1 mg	REMODULIN 200 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 50 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	*treprostinil sodium*	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	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)	TYVASO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	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)	TYVASO INSTITUTIONAL START KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	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)	TYVASO REFILL KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	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)	TYVASO STARTER KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	VELETRI	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	AMTAGVI	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9999	Not otherwise classified, antineoplastic drugs	AMTAGVI	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	LANTIDRA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	Unclassified biologics	LANTIDRA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	OMISIRGE	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	Unclassified biologics	OMISIRGE	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2043	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)	PROVENGE	Gene/Cellular Therapy	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3590	Unclassified biologics	RETHYMIC	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	RYONCIL	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3590	Unclassified biologics	RYONCIL	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2055	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)	ABECMA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	ADSTILADRIN	Gene/Cellular Therapy	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9301	Obecabtagene autoleucel, up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code deleted effective 6/30/2025)	AUCATZYL	Gene/Cellular Therapy	PA
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 4 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 5 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 6 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ 7 VIAL KIT SUV, P/F, OUTER	Not Covered	
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose (All NDCs inactive as of 6/18/2025)	BEQVEZ VIAL SUV, P/F, INNER	Not Covered	
Q2054	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)	BREYANZI	Gene/Cellular Therapy	PA
Q2054	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)	BREYANZI CD4 COMPONENT (2OF 2)	Gene/Cellular Therapy	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q2054	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)	BREYANZI CD8 COMPONENT (1OF 2)	Gene/Cellular Therapy	PA
Q2056	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)	CARVYKTI	Gene/Cellular Therapy	PA
J3392	Injection, exagamglogene autotemcel, per treatment	CASGEVY	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 10.5-11.4 KG (10 ML X 11) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 10-10.4 KG (10 ML X 10) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -** Coverage is dependent on member's benefit plan documents. This product is defined by the FDA's Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA's website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 11.5-12.4 KG (10 ML X 12) OUTER, SUV. P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 12.5-13.4 KG (10 ML X 13) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 13.5-14.4 KG (10 ML X 14) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 14.5-15.4 KG (10 ML X 15) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 15.5-16.4 KG (10 ML X 16) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 16.5-17.4 KG (10 ML X 17) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 17.5-18.4 KG (10 ML X 18) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 18.5-19.4 KG (10 ML X 19) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 19.5-20.4 KG (10 ML X 20) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 20.5-21.4 KG (10 ML X 21) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 21.5-22.4 KG (10 ML X 22) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 22.5-23.4 KG (10 ML X 23) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 23.5-24.4 KG (10 ML X 24) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 24.5-25.4 KG (10 ML X 25) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 25.5-26.4 KG (10 ML X 26) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 26.5-27. 4KG (10 ML X 27) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 27.5-28.4 KG (10 ML X 28) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 28.5-29.4 KG (10 ML X 29) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 29.5-30.4 KG (10 ML X 30) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 30.5-31.4 KG (10 ML X 31) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 31.5-32.4 KG (10 ML X 32) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 32.5-33.4 KG (10 ML X 33) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 33.5-34.4 KG (10 ML X 34) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 34.5-35.4 KG (10 ML X 35) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 35.5-36.4 KG (10 ML X 36) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 36.5-37.4 KG (10 ML X 37) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 37.5-38.4 KG (10 ML X 38) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 38.5-39.4 KG (10 ML X 39) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 39.5-40.4 KG (10 ML X 40) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 40.5-41.4 KG (10 ML X 41) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 41.5-42.4 KG (10 ML X 42) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 42.5-43.4 KG (10 ML X 43) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 43.5-44.4 KG (10 ML X 44) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 44.5-45.4 KG (10 ML X 45) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 45.5-46.4 KG (10 ML X 46) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 46.5-47.4 KG (10 ML X 47) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 47.5-48.4 KG (10 ML X 48) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 48.5-49.4 KG (10 ML X 49) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 49.5-50.4 KG (10 ML X 50) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 50.5-51.4 KG (10 ML X 51) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 51.5-52.4 KG (10 ML X 52) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 52.5-53.4 KG (10 ML X 53) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 53.5-54.4 KG (10 ML X 54) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 54.5-55.4 KG (10 ML X 55) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 55.5-56.4 KG (10 ML X 56) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 56.5-57.4 KG (10 ML X 57) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 57.5-58.4 KG (10 ML X 58) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 58.5-59.4 KG (10 ML X 59) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 59.5-60.4 KG (10 ML X 60) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 60.5-61.4 KG (10 ML X 61) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 61.5-62.4 KG (10 ML X 62) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 62.5-63.4 KG (10 ML X 63) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 63.5-64.4 KG (10 ML X 64) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 64.5-65.4 KG (10 ML X 65) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 65.5-66.4 KG (10 ML X 66) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 66.5-67.4 KG (10 ML X 67) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 67.5-68.4 KG (10 ML X 68) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 68.5-69.4 KG (10 ML X 69) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS 69.5 KG-ABOVE (10 ML X 70) OUTER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	ELEVIDYS VIAL INNER, SUV, P/F	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	ENCELTO	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -** Coverage is dependent on member's benefit plan documents. This product is defined by the FDA's Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA's website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	Unclassified biologics	ENCELTO	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -** Coverage is dependent on member's benefit plan documents. This product is defined by the FDA's Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA's website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	HEMGENIX	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -** Coverage is dependent on member's benefit plan documents. This product is defined by the FDA's Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA's website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units (For billing prior to 1/1/17 use J9999 or C9472 for OPPS billing)	IMLYGIC	Gene/Cellular Therapy	PA
C9399	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)	KEBILIDI	Not Covered	
J3590	Unclassified biologics	KEBILIDI	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q2042	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)	KYMRIAH	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3391	Injection, atidarsagene autotemcel, per treatment	LENMELDY	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	LUXTURNA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3394	Injection, lovotibeglogene autotemcel, per treatment	LYFGENIA	Not Covered	
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	ROCTAVIAN	Gene/Cellular Therapy	PA
C9399	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)	SKYSONA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3590	Unclassified biologics	SKYSONA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q2053	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)	TECARTUS	Gene/Cellular Therapy	PA
Q2057	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	TECELRA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	VYJUVEK	Gene/Cellular Therapy	PA
Q2041	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 OPPS billing) (Code Price is for drug ONLY) (Code re-used by CMS)	YESCARTA	Gene/Cellular Therapy	PA
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	ZOLGENSMA	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3393	Injection, betibeglogene autotemcel, per treatment	ZYNTEGLO	Not Covered	
J1301	Injection, edaravone, 1 mg	*edaravone*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1304	Injection, tofersen, 1 mg	QALSODY	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1301	Injection, edaravone, 1 mg	RADICAVA	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0515	Injection, benztropine mesylate, per 1mg	*benztropine injection*	Non-Specialty	
J3490	Unclassified drugs	KETALAR	Not Covered	
J3490	Unclassified drugs	*ketamine injection*	Not Covered	
J0402	Injection, aripiprazole (abilify asimtufii), 1 mg	ABILIFY ASIMTUFII	Preferred Specialty	
J0401	Injection, aripiprazole (abilify maintena), 1 mg	ABILIFY MAINTENA	Non-Preferred	
J1944	Injection, aripiprazole lauroxil, (aristada), 1 mg	ARISTADA	Non-Preferred	
J1943	Injection, aripiprazole lauroxil, (aristada initio), 1 mg	ARISTADA INITIO	Non-Preferred	
J3486	Injection, ziprasidone mesylate, 10 mg	GEODON INTRAMUSCULAR	Non-Specialty	
J2359	Injection, olanzapine, 0.5 mg	*olanzapine intramuscular*	Preferred Specialty	
J2798	Injection, risperidone, (perseris), 0.5 mg	PERSERIS	Non-Preferred	
J2794	Injection, risperidone (risperdal consta), 0.5 mg	RISPERDAL CONSTA	Preferred Specialty	
J2794	Injection, risperidone (risperdal consta), 0.5 mg	*risperidone microspheres*	Preferred Specialty	
J2799	Injection, risperidone (uzedy), 1 mg	UZEDY	Preferred Specialty	
J3490	Unclassified drugs	*valproate sodium*	Non-Specialty	
J3486	Injection, ziprasidone mesylate, 10 mg	*ziprasidone mesylate*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2359	Injection, olanzapine, 0.5 mg	ZYPREXA 10 MG VIAL	Preferred Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 210 MG VIAL INNER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 210 MG VL KIT OUTER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 210 MG VL KIT SDV, OUTER	Preferred Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 300 MG VIAL INNER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 300 MG VL KIT OUTER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 300 MG VL KIT SDV, OUTER	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 405 MG VIAL INNER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 405 MG VL KIT OUTER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 405 MG VL KIT SUV, OUTER	Non-Specialty	
J0137	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag inner, single use*	Non-Specialty	
J0137	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag outer, single use*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, single use*	Non-Specialty	
J0136	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, suv*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0134	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, suv, inner*	Non-Specialty	
J0134	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, suv, outer*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml bag single-use, p/f*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl inner, suv*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl inner, suv, p/f*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl inner,suv*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl outer, suv*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl outer, suv, p/f*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl outer,suv*	Non-Specialty	
J0136	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 500 mg/50 ml bag single use, p/f*	Non-Specialty	
J0138	Injection, acetaminophen 10 mg and ibuprofen 3 mg	COMBOGESIC IV	Not Covered	
J3490	Unclassified drugs	*valproate sodium*	Non-Specialty	
J2550	Injection, promethazine HCl, up to 50 mg	PHENERGAN	Non-Specialty	

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C9399	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)	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, INNER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, INNER	Non-Specialty	
C9399	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)	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, OUTER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, OUTER	Non-Specialty	
C9399	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)	PRECEDEX 1,000 MCG/250 ML BTL SINGLE USE, P/F	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 1,000 MCG/250 ML BTL SINGLE USE, P/F	Non-Specialty	
C9399	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)	PRECEDEX 1,000 MCG/250 ML BTL SINGLE-USE, P/F	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 1,000 MCG/250 ML BTL SINGLE-USE, P/F	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, INNER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, INNER	Non-Specialty	
C9399	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)	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, OUTER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, OUTER	Non-Specialty	
C9399	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)	PRECEDEX 200 MCG/50 ML BOTTLE INNER, SUV, P/F	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 200 MCG/50 ML BOTTLE INNER, SUV, P/F	Non-Specialty	
C9399	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)	PRECEDEX 200 MCG/50 ML BOTTLE OUTER, SUV, P/F	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 200 MCG/50 ML BOTTLE OUTER, SUV, P/F	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, INNER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, INNER	Non-Specialty	
C9399	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)	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, OUTER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, OUTER	Non-Specialty	
C9399	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)	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, INNER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, INNER	Non-Specialty	
C9399	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)	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, OUTER	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, OUTER	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	PRECEDEX 400 MCG/100 ML BOTTLE INNER, SUV, P/F	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 400 MCG/100 ML BOTTLE INNER, SUV, P/F	Non-Specialty	
C9399	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)	PRECEDEX 400 MCG/100 ML BOTTLE OUTER, SUV, P/F	Non-Specialty	
J3490	Unclassified drugs	PRECEDEX 400 MCG/100 ML BOTTLE OUTER, SUV, P/F	Non-Specialty	
J2550	Injection, promethazine HCl, up to 50 mg	*promethazine injection*	Non-Specialty	
J0402	Injection, aripiprazole (abilify asimtufii), 1 mg	ABILIFY ASIMTUFII	Preferred Specialty	
J0401	Injection, aripiprazole (abilify maintena), 1 mg	ABILIFY MAINTENA	Non-Preferred	
J1944	Injection, aripiprazole lauroxil, (aristada), 1 mg	ARISTADA	Non-Preferred	
J1943	Injection, aripiprazole lauroxil, (aristada initio), 1 mg	ARISTADA INITIO	Non-Preferred	
J2428	Injection, paliperidone palmitate extended release (erzofri), 1 mg	ERZOFRI	Not Covered	
J3486	Injection, ziprasidone mesylate, 10 mg	GEODON INTRAMUSCULAR	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2427	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg	INVEGA HAFYERA	Preferred Specialty	
J2426	Injection, paliperidone palmitate extended release (invega sustenna), 1 mg	INVEGA SUSTENNA	Preferred Specialty	
J2427	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg	INVEGA TRINZA	Preferred Specialty	
J2359	Injection, olanzapine, 0.5 mg	*olanzapine intramuscular*	Preferred Specialty	
J2798	Injection, risperidone, (perseris), 0.5 mg	PERSERIS	Non-Preferred	
J2794	Injection, risperidone (risperdal consta), 0.5 mg	RISPERDAL CONSTA	Preferred Specialty	
J2794	Injection, risperidone (risperdal consta), 0.5 mg	*risperidone microspheres*	Preferred Specialty	
J2799	Injection, risperidone (uzedy), 1 mg	UZEDY	Preferred Specialty	
J3486	Injection, ziprasidone mesylate, 10 mg	*ziprasidone mesylate*	Non-Specialty	
J2359	Injection, olanzapine, 0.5 mg	ZYPREXA 10 MG VIAL	Preferred Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV	Non-Specialty	
J2560	Injection, phenobarbital sodium, up to 120 mg	*phenobarbital sodium*	Non-Specialty	
J2561	Injection, phenobarbital sodium (sezaby), 1 mg	SEZABY	Not Covered	
J2560	Injection, phenobarbital sodium, up to 120 mg	*phenobarbital sodium*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2561	Injection, phenobarbital sodium (sezaby), 1 mg	SEZABY	Not Covered	
J2060	Injection, lorazepam, 2 mg	ATIVAN INJECTION	Non-Specialty	
J3360	Injection, diazepam, up to 5 mg	*diazepam injection*	Non-Specialty	
J2060	Injection, lorazepam, 2 mg	*lorazepam injection*	Non-Specialty	
J2060	Injection, lorazepam, 2 mg	ATIVAN INJECTION	Non-Specialty	
J3360	Injection, diazepam, up to 5 mg	*diazepam injection*	Non-Specialty	
J2060	Injection, lorazepam, 2 mg	*lorazepam injection*	Non-Specialty	
J1631	Injection, haloperidol decanoate, per 50 mg	HALDOL DECANOATE	Non-Specialty	
J1631	Injection, haloperidol decanoate, per 50 mg	*haloperidol decanoate*	Non-Specialty	
J1630	Injection, haloperidol, up to 5 mg	*haloperidol lactate injection*	Non-Specialty	
J1630	Injection, haloperidol, up to 5 mg	*haloperidol lactate intramuscular*	Non-Specialty	
J3031	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)	AJOVY AUTOINJECTOR	Pharmacy Only	
J3031	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)	AJOVY SYRINGE	Pharmacy Only	
J3032	Injection, eptinezumab-jjmr, 1 mg	VYEPTI	Non-Preferred	PA
J2062	Loxapine for inhalation, 1 mg	ADASUVE	Not Covered	
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 mL	DUOPA	Non-Preferred	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1632	Injection, brexanolone, 1 mg (All NDCs inactive as of 12/31/2024)	ZULRESSO 100 MG/20 ML VIAL	Non-Preferred	PA; No PA required for ICD-10 code F53.0.
J3490	Unclassified drugs	*valproate sodium*	Non-Specialty	
S0013	Esketamine, nasal spray, 1 mg	SPRAVATO	Non-Preferred	PA
J3490	Unclassified drugs	KETALAR	Not Covered	
J3490	Unclassified drugs	*ketamine injection*	Not Covered	
J0364	Injection, apomorphine hydrochloride, 1 mg	APOKYN	Pharmacy Only	
J0364	Injection, apomorphine hydrochloride, 1 mg	*apomorphine*	Pharmacy Only	
C9399	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)	ONAPGO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3490	Unclassified drugs	ONAPGO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0137	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag inner, single use*	Non-Specialty	
J0137	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag outer, single use*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, single use*	Non-Specialty	
J0136	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, suv*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0134	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, suv, inner*	Non-Specialty	
J0134	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 1,000 mg/100 ml bag p/f, suv, outer*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml bag single-use, p/f*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl inner, suv*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl inner, suv, p/f*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl inner,suv*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl outer, suv*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl outer, suv, p/f*	Non-Specialty	
J0131	Injection, acetaminophen, not otherwise specified, 10 mg	*acetaminophen 1,000 mg/100 ml vl outer,suv*	Non-Specialty	
J0136	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	*acetaminophen 500 mg/50 ml bag single use, p/f*	Non-Specialty	
J0138	Injection, acetaminophen 10 mg and ibuprofen 3 mg	COMBOGESIC IV	Not Covered	
J2278	Injection, ziconotide, 1 microgram	PRIALT	Preferred Specialty	
J0216	Injection, alfentanil hydrochloride, 500 micrograms	*alfentanil 500 mcg/ml ampule p/f*	Non-Specialty	
J2175	Injection, meperidine hydrochloride, per 100 mg	DEMEROL	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2175	Injection, meperidine hydrochloride, per 100 mg	DEMEROL (PF)	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 0.2 MG/ML SYRINGE SUV, P/F, INNER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 0.2 MG/ML SYRINGE SUV, P/F, OUTER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 0.5 MG/0.5 ML SYRINGE SUV, P/F, INNER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 0.5 MG/0.5 ML SYRINGE SUV, P/F, OUTER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 1 MG/ML SYRINGE SUV, P/F, INNER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 1 MG/ML SYRINGE SUV, P/F, OUTER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 2 MG/ML SYRINGE SUV, P/F, INNER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	DILAUDID 2 MG/ML SYRINGE SUV, P/F, OUTER	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	*hydromorphone (pf)*	Non-Specialty	
J1171	Injection, hydromorphone, 0.1 mg	*hydromorphone injection*	Non-Specialty	
J2175	Injection, meperidine hydrochloride, per 100 mg	*meperidine (pf)*	Non-Specialty	
J2315	Injection, naltrexone, depot form, 1 mg	VIVITROL	Preferred Specialty	
J2311	Injection, naloxone hydrochloride (zimhi), 1 mg (Code deleted effective 6/30/2025)	ZIMHI	Non-Specialty	
J0577	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	BRIXADI	Preferred Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0578	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	BRIXADI	Preferred Specialty	
J0592	Injection, buprenorphine hydrochloride, 0.1 mg	BUPRENEX 0.3 MG/ML AMPUL INNER	Non-Specialty	
J0592	Injection, buprenorphine hydrochloride, 0.1 mg	BUPRENEX 0.3 MG/ML AMPUL OUTER	Non-Specialty	
J0592	Injection, buprenorphine hydrochloride, 0.1 mg	*buprenorphine hcl injection*	Non-Specialty	
Q9991	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)	SUBLOCADE	Preferred Specialty	
Q9992	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)	SUBLOCADE	Preferred Specialty	
J3230	Injection, chlorpromazine HCl, up to 50 mg	*chlorpromazine injection*	Non-Specialty	
J2680	Injection, fluphenazine decanoate, up to 25 mg	*fluphenazine decanoate*	Non-Specialty	
J2679	Injection, fluphenazine hcl, 1.25 mg	*fluphenazine hcl injection*	Non-Specialty	
J0138	Injection, acetaminophen 10 mg and ibuprofen 3 mg	COMBOGESIC IV	Not Covered	
C9088	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	ZYNRELEF	Not Covered	
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	DUROLANE	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose (20 mg/2 mL) (Note: Total dose regimen = 3 injections)	EUFLEXXA	Not Covered	
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	GEL-ONE	Not Covered	
J7328	Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg	GELSYN-3	Not Covered	
J7320	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)	GENVISC 850	Not Covered	
J7321	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)	HYALGAN	Not Covered	
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg (Code re-used by CMS effective 1/1/17) (For billing prior to 1/1/17 use J3490 or C9471 for OPPS billing) (Hymovis dose is 24 mg/3 mL) (Note: Total dose regimen = 2 injections)	HYMOVIS	Not Covered	
J7327	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)	MONOVISC	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL) (Note: Total dose regimen = 3 - 4 injections)	ORTHOVISC	Not Covered	
J7321	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)	SUPARTZ FX	Not Covered	
J7331	Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg	SYNOJOYNT	Not Covered	
J7325	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)	SYNVISC	Not Covered	
J7325	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)	SYNVISC-ONE	Not Covered	
J7332	Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg	TRILURON	Not Covered	
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	TRIVISC	Not Covered	
J7321	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)	VISCO-3	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0801	Injection, corticotropin (acthar gel), up to 40 units	ACTHAR	Pharmacy Only	
J0801	Injection, corticotropin (acthar gel), up to 40 units	ACTHAR SELFJECT	Pharmacy Only	
J0802	Injection, corticotropin (ani), up to 40 units	CORTROPHIN GEL	Pharmacy Only	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN DIAGNOSTIC 1 MG VIAL INNER, SUV	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN DIAGNOSTIC 1 MG VIAL OUTER, SUV	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN DIAGNOSTIC 1 MG VIAL SUV	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial inner, suv*	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial outer, suv*	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial suv, inner*	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial suv, outer*	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial suv,inner*	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon 1 mg vial suv,outer*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
A9596	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie (NDC Unit Pricing is based on 5 mCi dose)	ILLUCCIX	Non-Specialty	
J2805	Injection, sincalide, 5 micrograms	KINEVAC	Non-Specialty	
J2805	Injection, sincalide, 5 micrograms	*sincalide*	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	BLOXIVERZ	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	*neostigmine 3 mg/3 ml syringe inner, suv*	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	*neostigmine 3 mg/3 ml syringe outer, suv*	Non-Specialty	
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	*neostigmine methylsulfate intravenous solution*	Non-Specialty	
J3240	Injection,thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial (Code Price is per 1 vial)	THYROGEN	Preferred Specialty	
J0584	Injection, burosumab-twza 1 mg	CRYSVITA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1941	Injection, furosemide (furoscix), 20 mg	FUROSCIX	Not Covered	
J1938	Injection, furosemide, 1 mg	*furosemide 100 mg/10 ml syring inner, sdv*	Non-Specialty	
J1938	Injection, furosemide, 1 mg	*furosemide 100 mg/10 ml syring outer, sdv*	Non-Specialty	
J1938	Injection, furosemide, 1 mg	*furosemide injection*	Non-Specialty	
J0609	Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis)	AURYXIA	Pharmacy Only	
J0615	Calcium acetate, oral, 23 mg (for esrd on dialysis)	*calcium acetate*	Pharmacy Only	
J0615	Calcium acetate, oral, 23 mg (for esrd on dialysis)	*calcium acetate(phosphat bind)*	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0607	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)	FOSRENOL	Pharmacy Only	
J0608	Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to j0607 (for esrd on dialysis)	FOSRENOL	Pharmacy Only	
J0607	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)	*lanthanum*	Pharmacy Only	
J3490	Unclassified drugs	*potassium phos in 0.9 % nacl intravenous piggyback*	Non-Specialty	
J1202	Miglustat, oral, 65 mg	OPFOLDA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7171	Injection, adamts13, recombinant-krhn, 10 iu	ADZYNMA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1931	Injection, laronidase, 0.1 mg	ALDURAZYME	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9118	Injection, calaspargase pegol-mknl, 10 units	ASPARLAS	Non-Preferred	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
J0567	Injection, cerliponase alfa, 1 mg	BRINEURA INTRAVENTRICULAR KIT	Preferred Specialty	PA
J1786	Injection, imiglucerase, 10 units	CEREZYME	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1743	Injection, idursulfase, 1 mg	ELAPRASE	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3060	Injection, taliglucerase alfa, 10 units	ELELYSO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	ELFABRIO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2783	Injection, rasburicase, 0.5 mg	ELITEK	Non-Specialty	
J0180	Injection, agalsidase beta, 1 mg	FABRAZYME	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2840	Injection, sebelipase alfa, 1 mg (For billing prior to 1/1/17 use J3590 or C9478 for OPPS billing)	KANUMA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0217	Injection, velmanase alfa-tycv, 1 mg	LAMZEDE	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg (For billing prior to 1/1/12 use J3590 or C9277)	LUMIZYME	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3397	Injection, vestronidase alfa-vjbk, 1 mg	MEPSEVII	Not Covered	
J1458	Injection, galsulfase, 1 mg	NAGLAZYME	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	NEXVIAZYME	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	POMBILITI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7639	Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram	PULMOZYME	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	REVCOVI	Preferred Specialty	PA
J3590	Unclassified biologics	REVCOVI	Preferred Specialty	PA
J9021	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	RYLAZE	Preferred Specialty	PA
J1322	Injection, elosulfase alfa, 1 mg (For billing prior to 1/1/15 use C9022 or J3590)	VIMIZIM	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3385	Injection, velaglucerase alfa, 100 units (For billing prior to 1/1/11 use J3490 or C9271)	VPRIV	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0218	Injection, olipudase alfa-rpcp, 1 mg	XENPOZYME	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg (For billing prior to 1/1/11 use J3590 or C9266)	XIAFLEX	Preferred Specialty	PA
J1271	Injection, doxycycline hyclate, 1 mg	DOXY-100	Non-Specialty	
J1271	Injection, doxycycline hyclate, 1 mg	*doxycycline hyclate intravenous*	Non-Specialty	
J2281	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg	*moxifloxacin-sod.ace,sul-water*	Non-Specialty	
J2280	Injection, moxifloxacin, 100 mg	*moxifloxacin-sod.chloride(iso)*	Non-Specialty	
J7315	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)	MITOSOL	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7516	Injection, cyclosporine, 250 mg	*cyclosporine intravenous*	Non-Specialty	
J7516	Injection, cyclosporine, 250 mg	SANDIMMUNE INTRAVENOUS	Non-Specialty	
J3241	Injection, teprotumumab-trbw, 10 mg	TEPEZZA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1574	Injection, ganciclovir sodium (exela), not therapeutically equivalent to j1570, 500 mg (All NDCs inactive as of 6/18/2025)	*ganciclovir 500 mg/250 ml bag outer, p/f, sdv*	Non-Specialty	
J1574	Injection, ganciclovir sodium (exela), not therapeutically equivalent to j1570, 500 mg (All NDCs inactive as of 6/18/2025)	*ganciclovir 500 mg/250 ml bag sdv, inner, p/f*	Non-Specialty	
J1570	Injection, ganciclovir sodium, 500 mg	*ganciclovir sodium*	Non-Specialty	
J1095	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)	DEXYCU (PF)	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	ILUVIEN	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.

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)	OZURDEX	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.
J7311	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	RETISERT	Not Covered	
J7402	Mometasone furoate sinus implant, (sinuva), 10 micrograms	SINUVA	Not Covered	
J3299	Injection, triamcinolone acetonide (xipere), 1 mg	XIPERE (PF)	Not Covered	
J7314	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	YUTIQ	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.
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	BYOOVIZ	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	PHOTREXA 0.146% EYE DROPS	Preferred Specialty	
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	PHOTREXA CROSS-LINKING KIT	Preferred Specialty	
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	PHOTREXA VISCOUS 0.146% DROPS	Preferred Specialty	
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	SUSVIMO (INITIAL FILL)	Not Covered	
J1097	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	OMIDRIA	Non-Specialty	
J2403	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	IHEEZO (PF)	Not Covered	
J2782	Injection, avacincapted pegol, 0.1 mg	IZERVAY (PF)	Not Covered	
J2781	Injection, pegcetacoplan, intravitreal, 1 mg	SYFOVRE (PF)	Preferred Specialty	PA
J3396	Injection, verteporfin, 0.1 mg	VISUDYNE	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.
J1097	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	OMIDRIA	Non-Specialty	
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	*phenylephrine hcl injection*	Non-Specialty	
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	VAZCULEP	Non-Specialty	
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	DURYSTA	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7355	Injection, travoprost, intracameral implant, 1 microgram	IDOSE TR	Not Covered	
J0179	Injection, brolucizumab-dbll, 1 mg	BEOVU	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.
Q5128	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	CIMERLI	Preferred Specialty	PA
J0178	Injection, aflibercept, 1 mg	EYLEA	Preferred Specialty	PA
J0177	Injection, aflibercept hd, 1 mg	EYLEA HD	Preferred Specialty	PA
J2778	Injection, ranibizumab, 0.1 mg	LUCENTIS 0.3 MG/0.05 ML VIAL P/F, SUV, SAMPLE	Non-Preferred	PA
J2778	Injection, ranibizumab, 0.1 mg	LUCENTIS INTRAVITREAL SYRINGE	Non-Preferred	PA
Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	PAVBLU	Preferred Specialty	PA
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	SUSVIMO	Not Covered	
J2777	Injection, faricimab-svoa, 0.1 mg	VABYSMO	Preferred Specialty	PA
J1097	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	OMIDRIA	Non-Specialty	
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	*phenylephrine hcl injection*	Non-Specialty	
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	VAZCULEP	Non-Specialty	
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	AKYNZEO (FOSNETUPITANT)	Non-Specialty	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1626	Injection, granisetron hydrochloride, 100 mcg	*granisetron hcl 1 mg/ml vial sdv, p/f*	Non-Specialty	
J1626	Injection, granisetron hydrochloride, 100 mcg	*granisetron hcl 1 mg/ml vial suv, p/f*	Non-Specialty	
J1626	Injection, granisetron hydrochloride, 100 mcg	*granisetron hcl intravenous*	Non-Specialty	
J2405	Injection, ondansetron hydrochloride, per 1 mg	*ondansetron hcl (pf)*	Non-Specialty	
J2405	Injection, ondansetron hydrochloride, per 1 mg	*ondansetron hcl intravenous*	Non-Specialty	
J2469	Injection, palonosetron HCl, 25 mcg	*palonosetron*	Preferred Specialty	
J2468	Injection, palonosetron hydrochloride (posfrea), 25 micrograms	POSFREA	Preferred Specialty	
J1627	Injection, granisetron, extended-release, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9486 for OPPS billing)	SUSTOL	Not Covered	
J2359	Injection, olanzapine, 0.5 mg	*olanzapine intramuscular*	Preferred Specialty	
J2359	Injection, olanzapine, 0.5 mg	ZYPREXA 10 MG VIAL	Preferred Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 210 MG VIAL INNER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 210 MG VL KIT OUTER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 210 MG VL KIT SDV, OUTER	Preferred Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 300 MG VIAL INNER, SUV	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 300 MG VL KIT OUTER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 300 MG VL KIT SDV, OUTER	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 405 MG VIAL INNER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 405 MG VL KIT OUTER, SUV	Non-Specialty	
J2358	Injection, olanzapine, long-acting, 1 mg	ZYPREXA RELPREVV 405 MG VL KIT SUV, OUTER	Non-Specialty	
J1836	Injection, metronidazole, 10 mg	METRO I.V.	Non-Specialty	
J1836	Injection, metronidazole, 10 mg	*metronidazole in nacl (iso-os)*	Non-Specialty	
C9399	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)	GATTEX 30-VIAL	Pharmacy Only	
J3490	Unclassified drugs	GATTEX 30-VIAL	Pharmacy Only	
C9399	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)	GATTEX ONE-VIAL	Pharmacy Only	
J3490	Unclassified drugs	GATTEX ONE-VIAL	Pharmacy Only	
J0184	Injection, amisulpride, 1 mg	BARHEMSYS	Not Covered	
J2550	Injection, promethazine HCl, up to 50 mg	PHENERGAN	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2550	Injection, promethazine HCl, up to 50 mg	*promethazine injection*	Non-Specialty	
J1440	Fecal microbiota, live - jslm, 1 ml (Code reused effective 7/1/2023)	REBYOTA	Not Covered	
J1308	Injection, famotidine, 0.25 mg	*famotidine (pf)*	Non-Specialty	
J1308	Injection, famotidine, 0.25 mg	*famotidine (pf)-nacl (iso-os)*	Non-Specialty	
J1308	Injection, famotidine, 0.25 mg	*famotidine intravenous*	Non-Specialty	
J2267	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	OMVOH INTRAVENOUS	Non-Preferred	PA
C9168	Injection, mirikizumab-mrkz, 1 mg (Code deleted effective 6/30/2024)	OMVOH PEN	Pharmacy Only	
J2267	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	OMVOH PEN	Pharmacy Only	
J2267	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	OMVOH SUBCUTANEOUS	Pharmacy Only	
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	AKYNZEO (FOSNETUPITANT)	Non-Specialty	
C9145	Injection, aprepitant, (aponvie), 1 mg	APONVIE	Preferred Specialty	
J3490	Unclassified drugs	APONVIE	Preferred Specialty	
J0185	Injection, aprepitant, 1 mg	CINVANTI	Non-Specialty	
J1453	Injection, fosaprepitant, 1 mg	EMEND (FOSAPREPITANT)	Non-Specialty	
J1434	Injection, fosaprepitant (focinvez), 1 mg	FOCINVEZ	Not Covered	
J1453	Injection, fosaprepitant, 1 mg	*fosaprepitant*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1456	Injection, fosaprepitant (teva), not therapeutically equivalent to j1453, 1 mg	*fosaprepitant*	Non-Specialty	
J2212	Injection, methylnaltrexone, 0.1 mg (For billing prior to 1/1/13 use J3490 or C9399)	RELISTOR SUBCUTANEOUS	Not Covered	
J2472	Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg	*pantoprazole in 0.9% sod chlor*	Non-Specialty	
J2470	Injection, pantoprazole sodium, 40 mg	*pantoprazole intravenous*	Non-Specialty	
J2471	Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg	*pantoprazole intravenous*	Non-Specialty	
J2470	Injection, pantoprazole sodium, 40 mg	PROTONIX INTRAVENOUS	Non-Specialty	
J0895	Injection, deferoxamine mesylate, 500 mg	*deferoxamine*	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.

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0895	Injection, deferoxamine mesylate, 500 mg	DESFERAL	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.
J1010	Injection, methylprednisolone acetate, 1 mg	DEPO-MEDROL	Non-Specialty	
J1010	Injection, methylprednisolone acetate, 1 mg	*methylprednisolone acetate*	Non-Specialty	
J2919	Injection, methylprednisolone sodium succinate, 5 mg	*methylprednisolone sodium succ*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)	OZURDEX	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	Mometasone furoate sinus implant, (sinuva), 10 micrograms	SINUVA	Not Covered	
J2919	Injection, methylprednisolone sodium succinate, 5 mg	SOLU-MEDROL	Non-Specialty	
J2919	Injection, methylprednisolone sodium succinate, 5 mg	SOLU-MEDROL (PF)	Non-Specialty	
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	ZILRETTA	Not Covered	
J3145	Injection, testosterone undecanoate, 1 mg (For billing prior to 1/1/15 use C9023 or J3490)	AVEED	Non-Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1072	Injection, testosterone cypionate (azmiro), 1 mg	AZMIRO	Not Covered	
J3490	Unclassified drugs	TESTOPEL	Non-Specialty	PA
S0189	Testosterone pellet, 75 mg	TESTOPEL	Non-Specialty	PA
J9381	Injection, teplizumab-mzwv, 5 mcg	TZIELD	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3145	Injection, testosterone undecanoate, 1 mg (For billing prior to 1/1/15 use C9023 or J3490)	AVEED	Non-Specialty	PA
J1072	Injection, testosterone cypionate (azmiro), 1 mg	AZMIRO	Not Covered	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	ELURYNG	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	ENILLORING	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	*etonogestrel-ethinyl estradiol*	Pharmacy Only	
J9155	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	FIRMAGON	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9155	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	FIRMAGON KIT W DILUENT SYRINGE	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	HALOETTE	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	KYLEENA	Refer to Contraceptive Coverage	
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	NEXPLANON	Refer to Contraceptive Coverage	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	NUVARING	Pharmacy Only	
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	SKYLA	Refer to Contraceptive Coverage	
J3490	Unclassified drugs	TESTOPEL	Non-Specialty	PA
S0189	Testosterone pellet, 75 mg	TESTOPEL	Non-Specialty	PA
J0606	Injection, etelcalcetide, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9399 for OPPS billing)	PARSABIV	Non-Preferred	PA
J7294	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each	ANNOVERA	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	ELURYNG	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	ENILLORING	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	*etonogestrel-ethinyl estradiol*	Pharmacy Only	

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

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	NUVARING	Pharmacy Only	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN 1 MG HYPOKIT	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN DIAGNOSTIC 1 MG VIAL INNER, SUV	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN DIAGNOSTIC 1 MG VIAL OUTER, SUV	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGEN DIAGNOSTIC 1 MG VIAL SUV	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	GLUCAGON (HCL) EMERGENCY KIT	Non-Specialty	
J1610	Injection, glucagon hydrochloride, per 1 mg	GLUCAGON EMERGENCY KIT (HUMAN)	Non-Specialty	
J1611	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	*glucagon hcl*	Non-Specialty	
J1952	Leuprolide injectable, camcevi, 1 mg	CAMCEVI (6 MONTH)	Preferred Specialty	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD	Preferred Specialty	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD (3 MONTH)	Preferred Specialty	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD (4 MONTH)	Preferred Specialty	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	ELIGARD (6 MONTH)	Preferred Specialty	
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	FENSOLVI	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9218	Leuprolide acetate, per 1 mg	*leuprolide*	Non-Specialty	
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg	*leuprolide depot 22.5 mg vial inner, suv*	Not Covered	
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg	*leuprolide depot 22.5 mg vial outer, suv*	Not Covered	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT (4 MONTH)	Preferred Specialty	
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT (6 MONTH)	Preferred Specialty	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT 11.25 MG 3MO KIT 3 MONTH, SUV	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT 22.5 MG 3MO KIT SUV, P/F	Preferred Specialty	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT 3.75 MG KIT P/F, SUV	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT 3.75 MG KIT SUV, P/F, SAMPLE	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	LUPRON DEPOT 7.5 MG KIT SINGLE DOSE	Preferred Specialty	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT-PED	Preferred Specialty	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	LUPRON DEPOT-PED (3 MONTH)	Preferred Specialty	
J9226	Histrelin implant (Supprelin LA), 50 mg	SUPPRELIN LA	Non-Preferred	PA
J3315	Injection, triptorelin pamoate, 3.75 mg	TRELSTAR	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3316	Injection, triptorelin, extended-release, 3.75 mg	TRIPTODUR	Non-Preferred	
J9202	Goserelin acetate implant, per 3.6 mg	ZOLADEX	Preferred Specialty	
C9399	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)	ZEPBOUND 10 MG/0.5 ML VIAL	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 10 MG/0.5 ML VIAL	Pharmacy Only	
C9399	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)	ZEPBOUND 12.5 MG/0.5 ML VIAL	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 12.5 MG/0.5 ML VIAL	Pharmacy Only	
C9399	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)	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, INNER	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, INNER	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, OUTER	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, OUTER	Pharmacy Only	
C9399	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)	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, INNER	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, INNER	Pharmacy Only	
C9399	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)	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, OUTER	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, OUTER	Pharmacy Only	
C9399	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)	ZEPBOUND 7.5 MG/0.5 ML VIAL	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND 7.5 MG/0.5 ML VIAL	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	ZEPBOUND SUBCUTANEOUS PEN INJECTOR	Pharmacy Only	
J3490	Unclassified drugs	ZEPBOUND SUBCUTANEOUS PEN INJECTOR	Pharmacy Only	
J7352	Afamelanotide implant, 1 mg	SCENESSE	Preferred Specialty	PA
J3110	Injection, teriparatide, 10 mcg	FORTEO	Pharmacy Only	
J3110	Injection, teriparatide, 10 mcg	*teriparatide*	Pharmacy Only	
C9399	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)	YORVIPATH	Pharmacy Only	
J3490	Unclassified drugs	YORVIPATH	Pharmacy Only	
J0801	Injection, corticotropin (acthar gel), up to 40 units	ACTHAR	Pharmacy Only	
J0801	Injection, corticotropin (acthar gel), up to 40 units	ACTHAR SELFJECT	Pharmacy Only	
J0802	Injection, corticotropin (ani), up to 40 units	CORTROPHIN GEL	Pharmacy Only	
J2597	Injection, desmopressin acetate, per 1 mcg	DDAVP INJECTION	Non-Specialty	
J2597	Injection, desmopressin acetate, per 1 mcg	*desmopressin injection*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2941	Injection, somatropin, 1 mg	GENOTROPIN	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	GENOTROPIN MINIQUICK	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	HUMATROPE INJECTION CARTRIDGE	Pharmacy Only	
C9399	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)	NGENLA	Pharmacy Only	
J3590	Unclassified biologics	NGENLA	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	NORDITROPIN FLEXPRO	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	NUTROPIN AQ NUSPIN	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	OMNITROPE	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	SAIZEN 5 MG VIAL	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	SAIZEN 8.8 MG VIAL	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	SAIZEN SAIZENPREP	Pharmacy Only	
J2941	Injection, somatropin, 1 mg	SEROSTIM	Pharmacy Only	
J2598	Injection, vasopressin, 1 unit	*vasopressin*	Non-Specialty	
J2599	Injection, vasopressin (american regent), not therapeutically equivalent to j2598, 1 unit	*vasopressin*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2601	Injection, vasopressin (baxter), 1 unit	*vasopressin in 0.9 % sod chlor intravenous solution*	Non-Specialty	
J2598	Injection, vasopressin, 1 unit	VASOSTRICT	Non-Specialty	
J2941	Injection, somatropin, 1 mg	ZOMACTON	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	ELURYNG	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	ENILLORING	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	*etonogestrel-ethinyl estradiol*	Pharmacy Only	
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	HALOETTE	Pharmacy Only	
J1729	Injection, hydroxyprogesterone caproate, Not Otherwise Specified, 10 mg (For billing prior to 1/1/18 use J3490 or Q9985) (All NDCs inactive as of 11/29/2023)	*hydroxyprogesterone 1.25 g/5 ml*	Preferred Specialty	PA; No PA required for ICD-10 codes C54-C54.9, C55, E23.0, E28.31-E28.319, E28.39, E28.9, N91-N91.5, N92.1, N92.5, N92.6, N93.8, N93.9, N95.1, N97.0, and Z85.42.
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	KYLEENA	Refer to Contraceptive Coverage	
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	NEXPLANON	Refer to Contraceptive Coverage	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	NUVARING	Pharmacy Only	
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	SKYLA	Refer to Contraceptive Coverage	
J1930	Injection, lanreotide, 1 mg (Code re-used by CMS effective 1/1/2009)	*lanreotide*	Non-Specialty	
J1932	Injection, lanreotide, (cipla), 1 mg	*lanreotide*	Non-Specialty	
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	*octreotide,microspheres*	Preferred Specialty	
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	SANDOSTATIN LAR DEPOT	Preferred Specialty	
J2502	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)	SIGNIFOR LAR	Non-Preferred	PA
J1930	Injection, lanreotide, 1 mg (Code re-used by CMS effective 1/1/2009)	SOMATULINE DEPOT	Non-Specialty	
C9399	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)	EGRIFTA SV	Pharmacy Only	
J3590	Unclassified biologics	EGRIFTA SV	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	EGRIFTA WR	Pharmacy Only	
J3590	Unclassified biologics	EGRIFTA WR	Pharmacy Only	
J2170	Injection, mecasermin, 1 mg	INCRELEX	Pharmacy Only	
J0650	Injection, levothyroxine sodium, not otherwise specified, 10 mcg	*levothyroxine intravenous*	Non-Specialty	
J0651	Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to j0650, 10 mcg	*levothyroxine intravenous*	Non-Specialty	
J0652	Injection, levothyroxine sodium (hikma), not therapeutically equivalent to j0650, 10 mcg	*levothyroxine intravenous*	Non-Specialty	
J9065	Injection, cladribine, per 1 mg	*cladribine*	Non-Specialty	
C9399	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)	BOMYNTRA	Not Covered	
J3590	Unclassified biologics	BOMYNTRA	Not Covered	
C9399	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)	CONEXXENCE	Not Covered	
J3590	Unclassified biologics	CONEXXENCE	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3111	Injection, romosozumab-aqqg, 1 mg	EVENITY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	JUBBONTI	Not Covered	
J0897	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	PROLIA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	WYOST	Not Covered	
J0897	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	XGEVA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7516	Injection, cyclosporine, 250 mg	*cyclosporine intravenous*	Non-Specialty	
J7525	Tacrolimus, parenteral, 5 mg	PROGRAF INTRAVENOUS	Non-Specialty	
J7516	Injection, cyclosporine, 250 mg	SANDIMMUNE INTRAVENOUS	Non-Specialty	
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	BKEMV	Not Covered	
J3490	Unclassified drugs	EMPAVELI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1302	Injection, sutimlimab-jome, 10 mg	ENJAYMO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2782	Injection, avacincapted pegol, 0.1 mg	IZERVAY (PF)	Not Covered	
J1307	Injection, crovalimab-akkz, 10 mg	PIASKY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1299	Injection, eculizumab, 2 mg	SOLIRIS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2781	Injection, pegcetacoplan, intravitreal, 1 mg	SYFOVRE (PF)	Preferred Specialty	PA
J1303	Injection, ravulizumab-cwvz, 10 mg	ULTOMIRIS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	ZILBRYSQ	Pharmacy Only	
J3490	Unclassified drugs	ZILBRYSQ	Pharmacy Only	
J3380	Injection, vedolizumab, intravenous, 1 mg	ENTYVIO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	ENTYVIO PEN	Pharmacy Only	
J3590	Unclassified biologics	ENTYVIO PEN	Pharmacy Only	
J0129	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)	ORENCIA (WITH MALTOSE)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0129	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)	ORENCIA CLICKJECT	Pharmacy Only	
J8610	Methotrexate, oral, 2.5 mg	*methotrexate sodium oral*	Non-Specialty	
Q5123	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg	RIABNI	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ruxience or Truxima)
J9312	Injection, rituximab, 10 mg	RITUXAN	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ruxience or Truxima)
J9311	Injection, rituximab 10 mg and hyaluronidase	RITUXAN HYCELA	Not Covered	Preferred (Covered) Alternative (Covered Biosimilars: Ruxience or Truxima)
Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	RUXIENCE	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA INTRAVENOUS	Preferred Specialty	PA
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA PEN	Pharmacy Only	
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA PEN INDUCTION PK-CROHN	Pharmacy Only	
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA SUBCUTANEOUS	Pharmacy Only	
J8610	Methotrexate, oral, 2.5 mg	TREXALL	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	TRUXIMA	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0490	Injection, belimumab, 10 mg	BENLYSTA INTRAVENOUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	BENLYSTA SUBCUTANEOUS	Pharmacy Only	
J3590	Unclassified biologics	BENLYSTA SUBCUTANEOUS	Pharmacy Only	
J0491	Injection, anifrolumab-fnia, 1 mg	SAPHNELO	Not Covered	
J9071	Injection, cyclophosphamide, (auromedics), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9072	Injection, cyclophosphamide (avyxa), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9073	Injection, cyclophosphamide (dr. reddy's), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9074	Injection, cyclophosphamide (sandoz), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9075	Injection, cyclophosphamide, not otherwise specified, 5mg	*cyclophosphamide intravenous*	Non-Specialty	
J9076	Injection, cyclophosphamide (baxter), 5 mg	*cyclophosphamide intravenous*	Non-Specialty	
J9072	Injection, cyclophosphamide (avyxa), 5 mg	FRINDOVYX	Non-Specialty	
J9210	Injection, emapalumab-lzsg, 1 mg	GAMIFANT	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J9215	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	ALFERON N	Non-Specialty	
J1830	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)	BETASERON SUBCUTANEOUS KIT	Pharmacy Only	
J1830	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)	EXTAVIA 0.3 MG KIT P/F, OUTER,SUV	Pharmacy Only	
J1830	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)	EXTAVIA 0.3 MG KIT P/F,INNER,SUV	Pharmacy Only	
J1830	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)	EXTAVIA 0.3 MG VIAL	Pharmacy Only	
J0480	Injection, basiliximab, 20 mg	SIMULECT	Preferred Specialty	
J2357	Injection, omalizumab, 5 mg	XOLAIR SUBCUTANEOUS AUTO-INJECTOR	Pharmacy Only	
J2357	Injection, omalizumab, 5 mg	XOLAIR SUBCUTANEOUS RECON SOLN	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2357	Injection, omalizumab, 5 mg	XOLAIR SUBCUTANEOUS SYRINGE	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) 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	ACTEMRA 200 MG/10 ML VIAL	Not Covered	
J3262	Injection, tocilizumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9264)	ACTEMRA 200 MG/10 ML VIAL	Not Covered	Preferred (Covered) Alternative (Covered Biosimilar: Tyenne)
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) 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	ACTEMRA 400 MG/20 ML VIAL	Not Covered	
J3262	Injection, tocilizumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9264)	ACTEMRA 400 MG/20 ML VIAL	Not Covered	Preferred (Covered) Alternative (Covered Biosimilar: Tyenne)
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) 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	ACTEMRA 80 MG/4 ML VIAL	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3262	Injection, tocilizumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9264)	ACTEMRA 80 MG/4 ML VIAL	Not Covered	Preferred (Covered) Alternative (Covered Biosimilar: Tyenne)
C9399	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)	ACTEMRA ACTPEN	Pharmacy Only	
J3590	Unclassified biologics	ACTEMRA ACTPEN	Pharmacy Only	
J3590	Unclassified biologics	ACTEMRA SUBCUTANEOUS	Pharmacy Only	
C9399	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)	COSENTYX (2 SYRINGES)	Pharmacy Only	
J3590	Unclassified biologics	COSENTYX (2 SYRINGES)	Pharmacy Only	
J3247	Injection, secukinumab, intravenous, 1 mg	COSENTYX INTRAVENOUS	Not Covered	
C9399	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)	COSENTYX PEN	Pharmacy Only	
J3590	Unclassified biologics	COSENTYX PEN	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	COSENTYX PEN (2 PENS)	Pharmacy Only	
J3590	Unclassified biologics	COSENTYX PEN (2 PENS)	Pharmacy Only	
C9399	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)	COSENTYX SUBCUTANEOUS	Pharmacy Only	
J3590	Unclassified biologics	COSENTYX SUBCUTANEOUS	Pharmacy Only	
C9399	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)	COSENTYX UNOREADY PEN	Pharmacy Only	
J3590	Unclassified biologics	COSENTYX UNOREADY PEN	Pharmacy Only	
C9399	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)	KEVZARA	Pharmacy Only	
J3590	Unclassified biologics	KEVZARA	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3590	Unclassified biologics	KINERET	Pharmacy Only	
Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	OTULFI INTRAVENOUS	Not Covered	
Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	OTULFI SUBCUTANEOUS	Pharmacy Only	
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	PYZCHIVA INTRAVENOUS	Not Covered	
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	PYZCHIVA SUBCUTANEOUS SYRINGE	Pharmacy Only	
Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	SELARSDI INTRAVENOUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	SELARSDI SUBCUTANEOUS	Pharmacy Only	
C9487	Ustekinumab, for intravenous injection, 1 mg (For Hospital OPPS billing prior to 4/1/17 use C9399) - see also J3590 (Code deleted effective 6/30/17) - see Q9989 or J3358 based on DOS	STELARA INTRAVENOUS	Not Covered	
J3358	Ustekinumab, for intravenous injection, 1 mg (For billing prior to 1/1/18 use Q9989)	STELARA INTRAVENOUS	Not Covered	
Q9989	Ustekinumab, for intravenous injection, 1 mg (Code deleted effective 12/31/17) - see J3358	STELARA INTRAVENOUS	Not Covered	
C9261	Injection, ustekinumab, 1 mg (Code deleted effective 12/31/10 - see J3357)	STELARA SUBCUTANEOUS	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3357	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	STELARA SUBCUTANEOUS	Pharmacy Only	
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	STEQEYMA	Pharmacy Only	
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	STEQEYMA I.V.	Not Covered	
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	TOFIDENCE	Not Covered	
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	TYENNE AUTOINJECTOR	Pharmacy Only	
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	TYENNE INTRAVENOUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	TYENNE SUBCUTANEOUS	Pharmacy Only	
J3358	Ustekinumab, for intravenous injection, 1 mg (For billing prior to 1/1/18 use Q9989)	*ustekinumab intravenous*	Not Covered	
J3357	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	*ustekinumab subcutaneous*	Pharmacy Only	
Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	*ustekinumab-aekn*	Pharmacy Only	
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	*ustekinumab-ttwe intravenous*	Not Covered	
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	*ustekinumab-ttwe subcutaneous*	Pharmacy Only	
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg	WEZLANA	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	WEZLANA I.V.	Not Covered	
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	YESINTEK INTRAVENOUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	YESINTEK SUBCUTANEOUS	Pharmacy Only	
J2329	Injection, ublituximab-xiiy, 1mg	BRIUMVI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	KESIMPTA PEN	Pharmacy Only	
J3590	Unclassified biologics	KESIMPTA PEN	Pharmacy Only	
J0202	Injection, alemtuzumab, 1 mg	LEMTRADA	Not Covered	
J2350	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)	OCREVUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2323	Injection, natalizumab, 1 mg	TYSABRI	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0172	Injection, aducanumab-avwa, 2 mg (All NDCs inactive as of 1/9/2025)	ADUHELM 170 MG/1.7 ML VIAL	Not Covered	
J0172	Injection, aducanumab-avwa, 2 mg (All NDCs inactive as of 1/9/2025)	ADUHELM 300 MG/3 ML VIAL	Not Covered	
J0175	Injection, donanemab-azbt, 2 mg	KISUNLA	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0174	Injection, lecanemab-irmb, 1 mg	LEQEMBI	Not Covered	
J1823	Injection, inebilizumab-cdon, 1 mg	UPLIZNA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	IMAAVY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	Unclassified biologics	IMAAVY	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9333	Injection, rozanolixizumab-noli, 1 mg	RYSTIGGO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9332	Injection, efgartigimod alfa-fcab, 2mg	VYVGART	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	VYVGART HYTRULO SUBCUTANEOUS SOLUTION	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	VYVGART HYTRULO SUBCUTANEOUS SYRINGE	Pharmacy Only	
J7504	Lymphocyte immune globulin, anti-thymocyte globulin, equine, parenteral, 250 mg	ATGAM	Non-Specialty	
J0485	Injection, belatacept, 1 mg (For billing prior to 1/1/13 use C9286 or J3590)	NULOJIX	Non-Preferred	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5145	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Recommend NDC Level Pricing)	ABRILADA(CF)	Pharmacy Only	

PA-Prior Authorization; **Gene/Cellular Therapy**-Gene/Cellular Therapy; **SOS**-Site of Service

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5145	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Recommend NDC Level Pricing)	ABRILADA(CF) PEN	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	*adalimumab-aacf*	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	ADALIMUMAB-AACF(CF) PEN CROHNS	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	ADALIMUMAB-AACF(CF) PEN PS-UV	Pharmacy Only	
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	*adalimumab-aaty*	Pharmacy Only	
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	*adalimumab-adbm*	Pharmacy Only	
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	ADALIMUMAB-ADBM(CF) PEN CROHNS	Pharmacy Only	
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	ADALIMUMAB-ADBM(CF) PEN PS-UV	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	*adalimumab-fkjp*	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	*adalimumab-fkjp(cf) 20 mg/0.4 ml syringe*	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	*adalimumab-fkjp(cf) 40 mg/0.8 ml syringe*	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	*adalimumab-fkjp(cf) pen 40 mg/0.8 ml*	Pharmacy Only	
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg	*adalimumab-ryvk*	Pharmacy Only	
Q5121	Injection, infliximab-axxq, biosimilar, (avsola), 10 mg	AVSOLA	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: Q5103 - Inflectra (infliximab-dyyb) and Q5104 - Renflexis (infliximab-abda))
J0717	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)	CIMZIA 2X200 MG/ML SYRINGE KIT	Pharmacy Only	
J0717	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)	CIMZIA POWDER FOR RECONST	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0717	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)	CIMZIA STARTER KIT	Pharmacy Only	
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	CYLTEZO(CF)	Pharmacy Only	
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	CYLTEZO(CF) PEN	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	CYLTEZO(CF) PEN CROHN'S-UC-HS	Pharmacy Only	
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	CYLTEZO(CF) PEN PSORIASIS-UV	Pharmacy Only	
J1438	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)	ENBREL	Pharmacy Only	
J1438	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)	ENBREL 25 MG KIT INNER, MDV	Pharmacy Only	
J1438	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)	ENBREL 25 MG KIT OUTER, MDV	Pharmacy Only	
J1438	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)	ENBREL MINI	Pharmacy Only	
J1438	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)	ENBREL SURECLICK	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	HULIO(CF)	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	HULIO(CF) 20 MG/0.4 ML SYRINGE	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	HULIO(CF) 40 MG/0.8 ML SYRINGE	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	HULIO(CF) PEN	Pharmacy Only	
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	HULIO(CF) PEN 40 MG/0.8 ML	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA PEN	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA PEN PSORIASIS-UVEITIS-ADOL HS STARTER 40 MG/0.8 ML	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF)	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF) PEDIATRIC CROHN'S START 80 MG/0.8 ML-40 MG/0.4 ML	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SYRINGE	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF) PEN	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF) PEN CROHNS-UC-HS	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF) PEN PEDIATRIC ULCER COLITIS STARTER 80 MG/0.8 ML	Pharmacy Only	
J0139	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	HUMIRA(CF) PEN PSOR-UV-ADOL HS	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	IDACIO(CF) 40 MG/0.8 ML SYRINGE (2 PACK)	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	IDACIO(CF) PEN 40 MG/0.8 ML	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	IDACIO(CF) PEN 40 MG/0.8 ML (2 PACK)	Pharmacy Only	
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	IDACIO(CF) PEN CROHN'S-UC START 40 MG/0.8 ML (6 PACK)	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	IDACIO(CF) PEN PLAQUE PSORIASIS STARTER 40 MG/0.8 ML (4PK)	Pharmacy Only	
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg	INFLECTRA	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1745	Injection, infliximab, excludes biosimilar, 10 mg (Code is to be used for Remicade or Infliximab)	*infliximab*	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: Q5103 - Inflectra (infliximab-dyyb) and Q5104 - Renflexis (infliximab-abda))
J1745	Injection, infliximab, excludes biosimilar, 10 mg (Code is to be used for Remicade or Infliximab)	REMICADE	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: Q5103 - Inflectra (infliximab-dyyb) and Q5104 - Renflexis (infliximab-abda))
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg	RENFLEXIS	Preferred Specialty	Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg	SIMLANDI(CF)	Pharmacy Only	
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg	SIMLANDI(CF) AUTOINJECTOR	Pharmacy Only	
C9399	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)	SIMPONI	Pharmacy Only	
J3590	Unclassified biologics	SIMPONI	Pharmacy Only	
J1602	Injection, golimumab, 1 mg, for intravenous use (For billing prior to 1/1/14 use C9399 or J3590)	SIMPONI ARIA	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	YUFLYMA(CF)	Pharmacy Only	
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	YUFLYMA(CF) AI CROHN'S-UC-HS	Pharmacy Only	
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	YUFLYMA(CF) AUTOINJECTOR	Pharmacy Only	
J1748	Injection, infliximab-dyyb (zymfentra), 10 mg	ZYMFENTRA	Not Covered	Preferred (Covered) Alternative (Covered Alternatives: Q5103 - Inflectra (infliximab-dyyb) and Q5104 - Renflexis (infliximab-abda))
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	*bupivacaine (pf)*	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	*bupivacaine hcl*	Non-Specialty	
J0666	Injection, bupivacaine liposome, 1 mg	*bupivacaine liposome (pf)*	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	*bupivacaine-dextrose-water(pf)*	Non-Specialty	
J0666	Injection, bupivacaine liposome, 1 mg	EXPAREL (PF)	Non-Specialty	
J2403	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	IHEEZO (PF)	Not Covered	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	MARCAINE	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	MARCAINE (PF)	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	MARCAINE SPINAL (PF)	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9144	Injection, bupivacaine (posimir), 1 mg	POSIMIR	Non-Specialty	
J3490	Unclassified drugs	POSIMIR	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	SENSORCAINE	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	SENSORCAINE-MPF	Non-Specialty	
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg	SENSORCAINE-MPF SPINAL	Non-Specialty	
C9089	Bupivacaine, collagen-matrix implant, 1 mg	XARACOLL	Not Covered	
J3490	Unclassified drugs	XARACOLL	Not Covered	
C9088	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	ZYNRELEF	Not Covered	
J0206	Injection, allopurinol sodium, 1 mg	*allopurinol sodium*	Non-Specialty	
J0206	Injection, allopurinol sodium, 1 mg	ALOPRIM	Non-Specialty	
J2507	Injection, pegloticase, 1 mg (For billing prior to 1/1/12 use J3590 or C9281)	KRYSTEXXA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1426	Injection, casimersen, 10 mg	AMONDYS-45	Not Covered	
J1428	Injection, eteplirsen, 10 mg (For billing prior to 1/1/18 use J3490 or C9484 for OPPS billing)	EXONDYS-51	Not Covered	
J2326	Injection, nusinersen, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9489 for OPPS billing)	SPINRAZA (PF)	Preferred Specialty	PA
J1427	Injection, viltolarsen, 10 mg	VILTEPSO	Not Covered	
J1429	Injection, golodirsen, 10 mg	VYONDYS-53	Not Covered	
J3110	Injection, teriparatide, 10 mcg	FORTEO	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J3110	Injection, teriparatide, 10 mcg	*teriparatide*	Pharmacy Only	
J1000	Injection, depo-estradiol cypionate, up to 5 mg	DEPO-ESTRADIOL	Non-Specialty	
J1740	Injection, ibandronate sodium, 1 mg	*ibandronate intravenous*	Preferred Specialty	
J2430	Injection, pamidronate disodium, per 30 mg	*pamidronate intravenous solution*	Non-Specialty	
J3489	Injection, zoledronic acid, 1 mg	RECLAST	Non-Specialty	
J3489	Injection, zoledronic acid, 1 mg	*zoledronic acid intravenous solution*	Non-Specialty	
J3489	Injection, zoledronic acid, 1 mg	*zoledronic acid-mannitol-water*	Non-Specialty	
J3489	Injection, zoledronic acid, 1 mg	*zoledronic ac-mannitol-0.9nacl*	Non-Specialty	
J1744	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	FIRAZYR	Pharmacy Only	
J1744	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	*icatibant*	Pharmacy Only	
J1744	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	SAJAZIR	Pharmacy Only	
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	EPYSQLI	Not Covered	
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units (For billing prior to 1/1/11 use J3590 or C9269)	BERINERT	Pharmacy Only	
J0598	Injection, C1 esterase inhibitor (human), Cinryze, 10 units	CINRYZE	Not Covered	
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	HAEGARDA	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0596	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units (For billing prior to 1/1/16 use C9445 or J3590)	RUCONEST	Pharmacy Only	
J9376	Injection, pozelimab-bbfg, 1 mg	VEOPOZ	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	OCREVUS ZUNOVO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J9015	Injection, aldesleukin, per single-use vial	PROLEUKIN	Non-Specialty	
J0225	Injection, vutrisiran, 1 mg	AMVUTTRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1955	Injection, levocarnitine, per 1 g	CARNITOR INTRAVENOUS	Non-Specialty	
J0223	Injection, givosiran, 0.5 mg	GIVLAARI	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0591	Injection, deoxycholic acid, 1 mg	KYBELLA	Not Covered	
J1955	Injection, levocarnitine, per 1 g	*levocarnitine intravenous*	Non-Specialty	
J9038	Injection, axatilimab-csfr, 0.1 mg	NIKTIMVO	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	NULIBRY	Preferred Specialty	PA
J3490	Unclassified drugs	NULIBRY	Preferred Specialty	PA

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0222	Injection, Patisiran, 0.1 mg	ONPATTRO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0224	Injection, lumasiran, 0.5 mg	OXLUMO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	RIVFLOZA	Not Covered	
J3490	Unclassified drugs	RIVFLOZA	Not Covered	
J7352	Afamelanotide implant, 1 mg	SCENESSE	Preferred Specialty	PA
J2210	Injection, methylergonovine maleate, up to 0.2 mg	*methylergonovine injection*	Non-Specialty	
A9607	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	PLUVICTO	Preferred Specialty	PA
A9601	Flortaucipir f 18 injection, diagnostic, 1 millicurie	TAUVID	Non-Specialty	
A9606	Radium Ra-223 dichloride, therapeutic, per microcurie (For billing prior to 1/1/15 use C9399 or A9699)	XOFIGO	Non-Preferred	PA
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADRENALIN	Non-Specialty	
J3490	Unclassified drugs	ADRENALIN 4 MG/250 ML-0.9% NACL SUV, INNER	Non-Specialty	
J3490	Unclassified drugs	ADRENALIN 4 MG/250 ML-0.9% NACL SUV, OUTER	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADYPHREN	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADYPHREN AMP	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	ADYPHREN II	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 0.1 mg/ml syringe suv*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 1 mg/10 ml abbojct suv, inner*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 1 mg/10 ml abbojct suv, outer*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine 1 mg/10 ml luerjet suv*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine hcl (pf)*	Non-Specialty	
J0173	Injection, epinephrine (belcher), not therapeutically equivalent to j0171, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine hcl (pf)*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine injection solution*	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J0173	Injection, epinephrine (belcher), not therapeutically equivalent to j0171, 0.1 mg (Code deleted effective 6/30/2025)	*epinephrine injection solution*	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINE PROFESSIONAL	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINE PROFESSIONL EMS KT	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINESNAP	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINESNAP-EMS	Non-Specialty	
J0171	Injection, adrenalin, epinephrine, 0.1 mg (Code deleted effective 6/30/2025)	EPINEPHRINESNAP-V	Non-Specialty	
J3490	Unclassified drugs	REZIPRES	Non-Specialty	
J7677	Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram	YUPELRI	Not Covered	
J7601	Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg	OHTUVAYRE	Pharmacy Only	
J1200	Injection, diphenhydramine HCl, up to 50 mg	*diphenhydramine hcl injection*	Non-Specialty	
J2550	Injection, promethazine HCl, up to 50 mg	PHENERGAN	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J2550	Injection, promethazine HCl, up to 50 mg	*promethazine injection*	Non-Specialty	
J2786	Injection, reslizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9481 for OPPS billing)	CINQAIR	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0517	Injection, benralizumab, 1 mg	FASENRA	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0517	Injection, benralizumab, 1 mg	FASENRA PEN	Pharmacy Only	
J0638	Injection, canakinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9399)	ILARIS (PF)	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2182	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPPS billing)	NUCALA SUBCUTANEOUS AUTO-INJECTOR	Pharmacy Only	
J2182	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPPS billing)	NUCALA SUBCUTANEOUS RECON SOLN	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J2182	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPPS billing)	NUCALA SUBCUTANEOUS SYRINGE	Pharmacy Only	
J2356	Injection, tezepelumab-ekko, 1 mg	TEZSPIRE SUBCUTANEOUS PEN INJECTOR	Pharmacy Only	
J2356	Injection, tezepelumab-ekko, 1 mg	TEZSPIRE SUBCUTANEOUS SYRINGE	Not Covered	
J7639	Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram	PULMOZYME	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
Q4074	Iloprost, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 20 micrograms (Please note: AWP/WAC pricing is the same for the 10 mcg and 20 mcg unit dose vials. Therefore bill/reimburse 1 unit of the code regardless of strength used)	VENTAVIS	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	WINREVAIR	Preferred Specialty	PA
J3590	Unclassified biologics	WINREVAIR	Preferred Specialty	PA
J1201	Injection, cetirizine hydrochloride, 0.5 mg	QUZYTTIR	Not Covered	
J7611	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg (Code reinstated effective 4/1/2008)	*albuterol sulfate inhalation solution for nebulization*	Non-Specialty	
J7613	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	*albuterol sulfate inhalation solution for nebulization*	Non-Specialty	
J3105	Injection, terbutaline sulfate, up to 1 mg	*terbutaline subcutaneous*	Non-Specialty	
J1749	Injection, iloprost, 0.1 mcg	AURLUMYN	Not Covered	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	*epoprostenol*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	*epoprostenol sodium 0.5 mg vl*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	*epoprostenol sodium 1.5 mg vl*	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	FLOLAN	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 100 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 20 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 200 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	REMODULIN 50 MG/20 ML VIAL	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3285	Injection, treprostinil, 1 mg	*treprostinil sodium*	Preferred Specialty	PA
J7686	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)	TYVASO	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7686	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)	TYVASO INSTITUTIONAL START KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	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)	TYVASO REFILL KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7686	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)	TYVASO STARTER KIT	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1325	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	VELETRI	Non-Preferred	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J0736	Injection, clindamycin phosphate, 300 mg	CLEOCIN 300 MG-D5W-GALAXY INNER, SINGLE USE	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	CLEOCIN INJECTION	Non-Specialty	
J0737	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg	*clindamycin in 0.9 % sod chlor*	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	*clindamycin in 5 % dextrose*	Non-Specialty	
J0736	Injection, clindamycin phosphate, 300 mg	*clindamycin phosphate injection*	Non-Specialty	
J1271	Injection, doxycycline hyclate, 1 mg	DOXY-100	Non-Specialty	
J1271	Injection, doxycycline hyclate, 1 mg	*doxycycline hyclate intravenous*	Non-Specialty	
J1836	Injection, metronidazole, 10 mg	METRO I.V.	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1836	Injection, metronidazole, 10 mg	*metronidazole in nacl (iso-os)*	Non-Specialty	
J2281	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg	*moxifloxacin-sod.ace,sul-water*	Non-Specialty	
J2280	Injection, moxifloxacin, 100 mg	*moxifloxacin-sod.chloride(iso)*	Non-Specialty	
J9190	Injection, fluorouracil, 500 mg	ADRUCIL	Non-Specialty	
J9190	Injection, fluorouracil, 500 mg	*fluorouracil intravenous*	Non-Specialty	
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)	LEVULAN	Non-Specialty	
J0879	Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis)	KORSUVA	Preferred Specialty	PA
J7354	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	YCANTH	Non-Specialty	
J2425	Injection, palifermin, 50 micrograms	KEPIVANCE	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	ILUVIEN	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.
J7311	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	RETISERT	Not Covered	
J7402	Mometasone furoate sinus implant, (sinuva), 10 micrograms	SINUVA	Not Covered	
J7314	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	YUTIQ	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.
J3245	Injection, tildrakizumab, 1 mg (Code reused by CMS 1/1/2019)	ILUMYA	Non-Preferred	PA
J7525	Tacrolimus, parenteral, 5 mg	PROGRAF INTRAVENOUS	Non-Specialty	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
C9399	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)	SILIQ	Pharmacy Only	
J3590	Unclassified biologics	SILIQ	Pharmacy Only	
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	SKYRIZI INTRAVENOUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	SKYRIZI SUBCUTANEOUS	Pharmacy Only	
J3590	Unclassified biologics	SKYRIZI SUBCUTANEOUS	Pharmacy Only	
J1747	Injection, spesolimab-sbzo, 1 mg	SPEVIGO 150 MG/ML SYRINGE INNER, SUV, P/F	Not Covered	
J1747	Injection, spesolimab-sbzo, 1 mg	SPEVIGO 150 MG/ML SYRINGE OUTER, SUV, P/F	Not Covered	
J1747	Injection, spesolimab-sbzo, 1 mg	SPEVIGO INTRAVENOUS	Not Covered	
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA INTRAVENOUS	Preferred Specialty	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA PEN	Pharmacy Only	
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA PEN INDUCTION PK-CROHN	Pharmacy Only	

HCPCS/ CPT Code	HCPCS/CPT Code Description	Drug Name	Coverage Level	Notes & Restrictions
J1628	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	TREMFYA SUBCUTANEOUS	Pharmacy Only	
J7336	Capsaicin 8% patch, per square centimeter	QUTENZA	Non-Preferred	PA
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	VYJUVEK	Gene/Cellular Therapy	PA; Gene/Cellular Therapy (**Gene/Cellular Therapy -;**Coverage is dependent on member’s benefit plan documents. This product is defined by the FDA’s Office of Therapeutic Products (OTP) as an approved Cellular and Gene Therapy product. For more information, see the FDA’s website Cellular and Gene Therapy Products); Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
C9399	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)	ZEVASKYN	Gene/Cellular Therapy	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J3590	Unclassified biologics	ZEVASKYN	Gene/Cellular Therapy	PA; Site of Service (Site of Service applies. View Infusion Services and Equipment Policy 91414 for details)
J7352	Afamelanotide implant, 1 mg	SCENESSE	Preferred Specialty	PA
J0636	Injection, calcitriol, 0.1 mcg	*calcitriol intravenous*	Non-Specialty	

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