



Priority Health
Employer Group & My**Priority**

Medical Drug List

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

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lowercase italics = Generic drugs

UPPERCASE = Brand name drugs

Coverage Level

Notes & Restrictions

HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
* Miscellaneous Medical Drugs				
<i>* Miscellaneous Medical Drugs</i>				
Q5153	N/A	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	Not Covered	Site of Service
Antidote Therapeutics				
<i>Antidote Therapeutics</i>				
J0600	<i>edetate calcium disodium</i>	Injection, edetate calcium disodium, up to 1000 mg	Non-Specialty	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, 56.891A - T56.894S, T56.91xA - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0716	ANASCORP	Injection, centruioides immune f(ab)2, up to 120 milligrams (Code Price is per 1 vial) (For billing prior to 1/1/13 use C9288 or J3590)	Preferred Specialty	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	Non-Specialty	CC (Rattlesnake Antivenom)

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0895	<i>deferoxamine</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0 - D56.9, D57.00 - D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, 56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0x4S, T80.92x1A - T80.92xS.
J0895	DESFERAL	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0 - D56.9, D57.00 - D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, 56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0x4S, T80.92x1A - T80.92xS.
J1610	GLUCAGON EMERGENCY KIT (HUMAN)	Injection, glucagon hydrochloride, per 1 mg	Non-Specialty	
J1611	GLUCAGON (HCL) EMERGENCY KIT	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1612	GVOKE HYPOPEN 1-PK 1 MG/0.2 ML	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
Chemotherapy Antidotes/Protectants				
C9310	VYKOURA	Injection, leucovorin calcium (avyxa), 1 mg	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0207	ETHYOL	Injection, amifostine, 500mg	Preferred Specialty	
J0640	<i>leucovorin calcium injection</i>	Injection, leucovorin calcium, per 50 mg	Non-Specialty	
J0641	<i>levoleucovorin calcium</i>	Injection, levoleucovorin, not otherwise specified, 0.5 mg	Preferred Specialty	
J0642	KHAPZORY	Injection, levoleucovorin (khapzory), 0.5 mg	Preferred Specialty	
J1190	<i>dexrazoxane hcl</i>	Injection, dexrazoxane hydrochloride, per 250 mg	Non-Specialty	
J1448	COSELA	Injection, trilaciclib, 1mg	Preferred Specialty	PA
J9209	<i>mesna intravenous</i>	Injection, mesna, 200 mg	Non-Specialty	
J9209	MESNEX INTRAVENOUS	Injection, mesna, 200 mg	Non-Specialty	
Antihistamine Drugs				
Ethanolamine Derivatives				
J1200	<i>diphenhydramine hcl injection</i>	Injection, diphenhydramine HCl, up to 50 mg	Non-Specialty	
First Generation Antihistamines				
J1200	<i>diphenhydramine hcl injection</i>	Injection, diphenhydramine HCl, up to 50 mg	Non-Specialty	
Other Antihistamines				
J1308	<i>famotidine (pf)-nacl (iso-os)</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial 25's, sdv, p/f, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial inner, p/f, suv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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

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J1308	<i>famotidine 40 mg/4 ml vial inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial muv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial muv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
Phenothiazine Derivatives				
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
Second Generation Antihistamines				
J1201	QUZYTIR	Injection, cetirizine hydrochloride, 0.5 mg	Not Covered	Site of Service
Anti-Infective Agents				
1st Generation Cephalosporin Antibiotics				
J0687	<i>cefazolin</i>	Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg	Non-Specialty	
J0688	<i>cefazolin</i>	Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0689	<i>cefazolin in dextrose (iso-os)</i>	Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg	Non-Specialty	
J0690	<i>cefazolin</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J0690	<i>cefazolin in dextrose (iso-os)</i>	Injection, cefazolin sodium, 500 mg	Non-Specialty	
J3490	<i>cefazolin</i>	Unclassified drugs	Non-Specialty	
J7999	<i>cefazolin in dextrose 5 %</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Non-Specialty	
2Nd Generation Cephalosporin Antibiotics				
J0525	CEFOTAN	Injection, cefotetan disodium, 10 mg	Non-Specialty	
J0525	<i>cefotetan</i>	Injection, cefotetan disodium, 10 mg	Non-Specialty	
3Rd Generation Cephalosporin Antibiotics				
J0696	<i>ceftriaxone 1 gm add-vant vial suv, p/f, outer</i>	Injection, ceftriaxone sodium, per 250 mg	Non-Specialty	
J0714	AVYCAZ	Injection, ceftazidime and avibactam, 0.5 g/0.125 g (For billing prior to 1/1/16 use C9399 or J3490)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.); Site of Service
5Th Generation Cephalosporin Antibiotics				
J0681	ZEVTERA	Injection, ceftobiprole medocaril sodium, 3 mg	Not Covered	Site of Service

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J0695	ZERBAXA	Injection, ceftolozane 50 mg and tazobactam 25 mg (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9452 or J3490)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.); Site of Service
J0712	<i>ceftaroline fosamil</i>	Injection, ceftaroline fosamil, 10 mg (For billing prior to 1/1/12 use J3490 or C9282)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.); Site of Service
J0712	TEFLARO	Injection, ceftaroline fosamil, 10 mg (For billing prior to 1/1/12 use J3490 or C9282)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.); Site of Service
Amebicides				
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
Aminoglycoside Antibiotics				
J0291	ZEMDRI	Injection, plazomicin, 5 mg	Not Covered	Site of Service
J3535	TOBI PODHALER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
Aminomethylcyclines				
J0121	NUZYRA INTRAVENOUS	Injection, omadacycline, 1 mg	Not Covered	Site of Service
Antimalarials				
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
Antiprotozoals, P Jirovecii Pneumonia				
J2545	NEBUPENT	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg	Non-Specialty	
J2545	<i>pentamidine inhalation</i>	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg	Non-Specialty	
Antituberculosis Agents				
J1834	<i>isoniazid injection</i>	Injection, isoniazid, 1 mg	Not Covered	Site of Service
Azole Antifungals				
J1833	CRESEMBA INTRAVENOUS	Injection, isavuconazonium sulfate, 1 mg (For billing prior to 1/1/16 use C9456 or J3490)	Preferred Specialty	PA
J3465	VFEND IV	Injection, voriconazole, 10 mg	Preferred Specialty	
J3465	<i>voriconazole intravenous</i>	Injection, voriconazole, 10 mg	Preferred Specialty	
J3465	<i>voriconazole-hpbccl</i>	Injection, voriconazole, 10 mg	Preferred Specialty	
Carbapenem Antibiotics				
J0742	RECARBRIO	Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1335	<i>ertapenem</i>	Injection, ertapenem sodium, 500 mg	Non-Specialty	
J2183	<i>meropenem</i>	Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg	Preferred Specialty	
J2184	<i>meropenem-0.9% sodium chloride</i>	Injection, meropenem (b. braun), not therapeutically equivalent to j2185, 100 mg	Preferred Specialty	
J2185	<i>meropenem</i>	Injection, meropenem, 100 mg	Preferred Specialty	
J2186	VABOMERE	Injection, meropenem and vaborbactam, 10mg/10mg, (20mg)	Not Covered	CA (Covered Alternative(s): cefazolin, ceftriaxone, cefepime, vancomycin, imipenem-cilastatin, meropenem, piperacillin-tazobactam.); Site of Service
Cepharmycin Antibiotics				
J0525	CEFOTAN	Injection, cefotetan disodium, 10 mg	Non-Specialty	
J0525	<i>cefotetan</i>	Injection, cefotetan disodium, 10 mg	Non-Specialty	
Cmv Antivirals				
J3490	PREVYMIS INTRAVENOUS	Unclassified drugs	Preferred Specialty	PA
Cyclic Lipopeptide Antibiotics				
J0872	<i>daptomycin</i>	Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg	Non-Specialty	
J0873	<i>daptomycin</i>	Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0874	<i>daptomycin in 0.9 % sod chlor</i>	Injection, daptomycin (baxter), not therapeutically equivalent to j0878, 1 mg	Non-Specialty	
J0877	<i>daptomycin</i>	Injection, daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	Non-Specialty	
J0878	<i>daptomycin</i>	Injection, daptomycin, 1 mg	Non-Specialty	
Echinocandin Antifungals				
J0349	REZZAYO	Injection, rezafungin, 1 mg	Not Covered	Site of Service
J0637	<i>caspofungin</i>	Injection, caspofungin acetate, 5 mg	Non-Specialty	
J2246	<i>micafungin in 0.9 % sodium chl</i>	Injection, micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1 mg	Non-Specialty	
J2247	<i>micafungin</i>	Injection, micafungin sodium (par pharm) not thereapeutically equivalent to j2248, 1 mg	Preferred Specialty	
J2248	<i>micafungin</i>	Injection, micafungin sodium, 1 mg	Preferred Specialty	
Entry Inhibitors				
C9399	HEPCLUDEX	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)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Extended-Spectrum Penicillins				
C9399	<i>piperacillin-tazobactam</i>	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
J2543	<i>piperacillin-tazobactam</i>	Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	Non-Specialty	
J2543	ZOSYN IN DEXTROSE (ISO-OSM)	Injection, piperacillin sodium/tazobactam sodium, 1 g/0.125 g (1.125 g)	Non-Specialty	
Fluorocyclines				
J0122	XERAVA	Injection, eravacycline, 1 mg	Not Covered	Site of Service
Glycopeptide Antibiotics				
J0875	<i>dalbavancin</i>	Injection, dalbavancin, 5 mg (For billing prior to 1/1/16 use C9443 or J3490)	Non-Preferred	PA; Site of Service
J0875	DALVANCE	Injection, dalbavancin, 5 mg (For billing prior to 1/1/16 use C9443 or J3490)	Not Covered	CA (Covered Alternative(s): J0875 - dalbavancin (geq) Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2406	KIMYRSA	Injection, oritavancin (kimyrsa), 10 mg	Non-Preferred	PA
J2407	ORBACTIV	Injection, oritavancin (orbactiv), 10 mg (For billing prior to 1/1/16 use C9444 or J3490)	Non-Preferred	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3095	VIBATIV	Injection, telavancin, 10 mg (For billing prior to 1/1/11 use J3490 or C9258)	Non-Preferred	PA
J3374	vancomycin hcl 1.25 gram vial inner, suv, p/f	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	vancomycin hcl 1.25 gram vial outer, suv, p/f	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	vancomycin hcl 1.25 gram vial suv, p/f	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	vancomycin hcl 1.5 gram vial inner, suv, p/f	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	vancomycin hcl 1.5 gram vial outer, suv, p/f	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3374	vancomycin hcl 1.5 gram vial suv, p/f	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
J3375	TYZAVAN	Injection, vancomycin hydrochloride (tyzavan), not therapeutically equivalent to j3373, 10 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3375	vancomycin-diluent combo no.1	Injection, vancomycin hydrochloride (tyzavan), not therapeutically equivalent to j3373, 10 mg	Non-Specialty	
Hiv Capsid Inhibitors				
J0738	YEZTUGO SUBCUTANEOUS	Injection, lenacapavir, 1 mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, reference your plan documents and the Priority Health preventive health care guidelines.; Quantity Limit (2 injections per 1 year)
J0752	YEZTUGO ORAL	Oral, lenacapavir, 300 mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, reference your plan documents and the Priority Health preventive health care guidelines.; Quantity Limit (4 tablets per 1 year)
J1961	SUNLENCA	Injection, lenacapavir (only for use as hiv treatment), 1 mg	Preferred Specialty	
J8499	SUNLENCA	Prescription drug, oral, non-chemotherapeutic, Not Otherwise Specified	Preferred Specialty	
Hiv Entry And Fusion Inhibitors				
J1746	TROGARZO	Injection, ibalizumab-uiyk, 10 mg	Preferred Specialty	PA
Hiv Integrase Inhibitor Antiretrovirals				
J0739	APRETUDE	Injection, cabotegravir, 1 mg	Covered	No PA required if billed with ICD-10 Z29.81; May be covered as preventive at 100%, reference your plan documents and the Priority Health preventive health care guidelines.
J0741	CABENUVA	Injection, cabotegravir and rilpivirine, 2mg/3mg	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Hiv Nucleoside, Nucleotide Rt Inhibitors				
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Refer to Approved Drug List (ADL)	
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab inner</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Refer to Approved Drug List (ADL)	
J0750	<i>emtricitabine-tenofovir disoproxil fumarate 200-300 mg tab outer</i>	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Refer to Approved Drug List (ADL)	
J0750	TRUVADA 200 MG-300 MG TABLET	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Refer to Approved Drug List (ADL)	
J0750	TRUVADA 200 MG-300 MG TABLET F/C	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0751	DESCOVY 200-25 MG TABLET	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	Refer to Approved Drug List (ADL)	
Interferon Antivirals				
J9215	ALFERON N	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	Non-Specialty	
Lincomycin Antibiotics				
J0736	CLEOCIN INJECTION	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin in 5 % dextrose</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin phosphate injection</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0737	<i>clindamycin in 0.9 % sod chlor</i>	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg	Non-Specialty	
Monobactam Antibiotics				
J0457	AZACTAM 1 GM VIAL SUV	Injection, aztreonam, 100 mg	Non-Specialty	
J0457	AZACTAM 2 GM VIAL SUV	Injection, aztreonam, 100 mg	Non-Specialty	
J0457	<i>aztreonam</i>	Injection, aztreonam, 100 mg	Non-Specialty	
J0458	EMBLAVEO	Injection, aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg)	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Monoclonal Antibodies (08:18)				
90378	SYNAGIS 100 MG/ML VIAL	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each (All NDCs Inactive as 12/31/2025)	Not Covered	PA; Site of Service
90378	SYNAGIS 50 MG/0.5 ML VIAL	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each (All NDCs Inactive as 12/31/2025)	Not Covered	PA; Site of Service
90380	BEYFORTUS	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use	Preventive	PA
90381	BEYFORTUS	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use	Preventive	PA
90382	ENFLONISIA	Respiratory syncytial virus, monoclonal antibody, seasonal dose, 0.7 mL, for intramuscular use	Preventive	PA
J0638	ILARIS (PF)	Injection, canakinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9399)	Non-Preferred	PA; Site of Service

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Priority Health Employer group & MyPriority Plans

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

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Other Misc. Antibacterial Agents				
J0911	DEFENCATH	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	Not Separately Payable	
Oxazolidinone Antibiotics				
J2020	linezolid in dextrose 5%	Injection, linezolid, 200 mg	Preferred Specialty	
J2020	ZYVOX INTRAVENOUS	Injection, linezolid, 200 mg	Not Covered	CA (Covered Alternative(s): J2020 - linezolid (geq), J2021 - linezolid (hospira). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2021	linezolid-0.9% sodium chloride	Injection, linezolid (hospira), not therapeutically equivalent to j2020, 200 mg	Preferred Specialty	
J3090	SIVEXTRO INTRAVENOUS	Injection, tedizolid phosphate, 1 mg (For billing prior to 1/1/16 use C9446 or J3490)	Preferred Specialty	PA
Penicillinase-Resistant Penicillins				
J2291	naftillin in dextrose iso-osm	Injection, naftillin sodium (baxter), 20 mg	Non-Specialty	
Polyene Antifungals				
J0285	amphotericin b	Injection, amphotericin B, 50mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Quinolone Antibiotics				
J2280	<i>moxifloxacin-sod.chloride(iso)</i>	Injection, moxifloxacin, 100 mg	Non-Specialty	
Siderophore Cephalosporins				
J0699	FETROJA	Injection, cefiderocol, 10 mg	Not Covered	Site of Service
Tetracycline Antibiotics				
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
Urinary Anti-Infectives				
J0528	CONTEPO	Injection, fosfomycin disodium, 20 mg	Not Covered	Site of Service
Antineoplastic Agents				
Antineoplastic Agents				
A9513	LUTATHERA	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	Preferred Specialty	PA
A9543	ZEVALIN (Y-90)	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries (Code Price is per dose)	Preferred Specialty	PA
A9607	PLUVICTO	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	Preferred Specialty	PA; Site of Service
A9699	BEXLUTRY	Radiopharmaceutical, therapeutic, not otherwise classified	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9312	EVDI	Injection, trabectedin (apotex), not therapeutically equivalent to j9362, 0.01 mg	Not Covered	Site of Service
C9399	AMTAGVI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
C9399	BEXLUTRY	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
C9399	MIMRYLO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
C9399	SARCLISA ESCENA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
C9399	TUDRIQEV	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Cellular/Gene Therapy

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0614	GRAFAPEX 1 GRAM VIAL INNER, SUV	Injection, treosulfan, 50 mg	Preferred Specialty	PA
J0614	GRAFAPEX 1 GRAM VIAL OUTER, SUV	Injection, treosulfan, 50 mg	Preferred Specialty	PA; No PA required if billed with ICD-10 C92.00, C92.02, C92.A0, C92.A2, D46.Z, D46.9
J0614	GRAFAPEX 5 GRAM VIAL INNER, SUV	Injection, treosulfan, 50 mg	Preferred Specialty	PA; No PA required if billed with ICD-10 C92.00, C92.02, C92.A0, C92.A2, D46.Z, D46.9
J0614	GRAFAPEX 5 GRAM VIAL OUTER, SUV	Injection, treosulfan, 50 mg	Preferred Specialty	PA; No PA required if billed with ICD-10 C92.00, C92.02, C92.A0, C92.A2, D46.Z, D46.9
J0870	RYTELO	Injection, imetelstat, 1 mg	Preferred Specialty	PA; Site of Service
J0893	<i>decitabine</i>	Injection, decitabine (sun pharma), not therapeutically equivalent to j0894, 1 mg	Preferred Specialty	
J0894	<i>decitabine</i>	Injection, decitabine, 1 mg	Preferred Specialty	
J1323	ELREXFIO	Injection, elranatamab-bcmm, 1 mg	Not Covered	Site of Service
J1326	VYLOY	Injection, zolbetuximab-clzb, 2 mg	Non-Preferred	PA; Site of Service
J1950	LUPRON DEPOT 11.25 MG 3MO KIT 3 MONTH, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service
J1950	LUPRON DEPOT 3.75 MG KIT P/F, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service
J1950	LUPRON DEPOT-PED	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1950	LUPRON DEPOT-PED (3 MONTH)	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1951	FENSOLVI	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	Preferred Specialty	Site of Service
J1952	CAMCEVI (6 MONTH)	Leuprolide injectable, camcevi, 1 mg	Preferred Specialty	Site of Service
J2860	SYLVANT	Injection, siltuximab, 10 mg (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9455 or J3590)	Preferred Specialty	PA
J3055	TALVEY	Injection, talquetamab-tgvs, 0.25 mg	Non-Preferred	PA; Site of Service
J3263	LOQTORZI	Injection, toripalimab-tpzi, 1 mg	Preferred Specialty	PA
J3315	TRELSTAR	Injection, triptorelin pamoate, 3.75 mg	Non-Specialty	
J3316	TRIPTODUR	Injection, triptorelin, extended-release, 3.75 mg	Non-Preferred	
J3490	CLIGAVYX	Unclassified drugs	Not Covered	Site of Service
J3490	MIMRYLO	Unclassified drugs	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7999	<i>bevacizumab</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Preferred Specialty	No PA required for ICD-10 codes B39.4, B39.5, B39.9, E08.311, E08.3211 - E08.3213, E08.3311 - E08.3313, E08.3411 - E08.3413, E08.3511 - E08.3513, E08.3591 - E08.3593, E09.311, E09.3211 - E09.3213, E09.3311 - E09.3313, E09.3411 - E09.3413, E09.3511 - E09.3513, E09.3591 - E09.3593, E10.311, E10.3211 - E10.3213, E10.3311 - E10.3313, E10.3411 - E10.3413, E10.3511 - E10.3513, E10.3591-E10.3593, E11.3100-E11.3199, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411 - E11.3413, E11.3511-E11.3513, E11.3591-E11.3593, E13.311, E13.3211 - E13.3213, E13.3311 - E13.3313, E13.3411-E13.3413, E13.3511, E13.3513, E13.3591 - E13.3593, H21.1x1-H21.1x3, H32, H34.8110-H34.8132, H34.8310-H34.8332, H35.051-H35.059, H35.3210 - H35.3233, H35.351 -H35.353, H35.81, H40.89, H44.2a1-H44.2E3.
J8610	<i>methotrexate sodium oral</i>	Methotrexate, oral, 2.5 mg	Non-Specialty	
J8610	TREXALL	Methotrexate, oral, 2.5 mg	Non-Specialty	
J9000	ADRIAMYCIN	Injection, doxorubicin hydrochloride, 10 mg	Non-Specialty	
J9000	<i>doxorubicin</i>	Injection, doxorubicin hydrochloride, 10 mg	Non-Specialty	
J9011	DATROWAY	Injection, datopotamab deruxtecan-dlnk, 1 mg	Non-Preferred	PA; Site of Service
J9015	PROLEUKIN	Injection, aldesleukin, per single-use vial	Non-Specialty	
J9021	RYLAZE	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	Preferred Specialty	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9022	TECENTRIQ	Injection, atezolizumab, 10 mg (For billing prior to 1/1/18 use J9999 or C9483 for OPSP billing)	Preferred Specialty	PA; Site of Service
J9023	BAVENCIO	Injection, avelumab, 10 mg (For billing prior to 1/1/18 use J9999 or C9491 for OPSP billing)	Preferred Specialty	PA; Site of Service
J9024	TECENTRIQ HYBREZA	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	Preferred Specialty	PA; Site of Service
J9025	<i>azacitidine</i>	Injection, azacitidine, 1 mg	Non-Specialty	
J9025	VIDAZA	Injection, azacitidine, 1 mg	Non-Specialty	
J9026	IMDELLTRA	Injection, tarlatamab-dlle, 1 mg	Preferred Specialty	PA; Site of Service
J9028	ANKTIVA	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	Preferred Specialty	PA; Site of Service
J9029	ADSTILADRIN	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J9030	TICE BCG	BCG live intravesical instillation, 1 mg	Non-Specialty	
J9032	BELEODAQ	Injection, belinostat, 10 mg (For billing prior to 1/1/16 use C9442 or J9999)	Preferred Specialty	PA
J9033	<i>bendamustine</i>	Injection, bendamustine hydrochloride, 1 mg	Non-Specialty	
J9033	TREANDA	Injection, bendamustine hydrochloride, 1 mg	Non-Specialty	
J9034	BENDEKA	Injection, bendamustine HCl (Bendeka), 1 mg	Non-Specialty	

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9045	<i>carboplatin</i>	Injection, carboplatin, 50 mg	Non-Specialty	
J9045	PARAPLATIN 1,000 MG/100 ML VL MUV, P/F	Injection, carboplatin, 50 mg	Non-Specialty	
J9045	PARAPLATIN 50 MG/5 ML VIAL MUV, P/F	Injection, carboplatin, 50 mg	Non-Specialty	
J9047	KYPROLIS	Injection, carfilzomib, 1 mg (For billing prior to 1/1/14 use C9295 or J9999)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32.
J9048	<i>bortezomib 3.5 mg iv vial sdv</i>	Injection, bortezomib (fresenius kabi), not therapeutically equivalent to j9041, 0.1 mg (All NDCs inactive as of 4/3/2024)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9049	<i>bortezomib injection</i>	Injection, bortezomib (hospira), not therapeutically equivalent to j9041, 0.1 mg	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32, C83.10-C83.19 and E85.81.
J9050	<i>carmustine</i>	Injection, carmustine, 100 mg	Non-Specialty	
J9052	<i>carmustine</i>	Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg (All NDCs inactive as of 5/6/2026)	Non-Specialty	
J9053	BLENREP	Injection, belantamab mafodotin-blmf, 0.1 mg	Non-Preferred	PA; Site of Service
J9054	BORUZU	Injection, bortezomib (boruzu), 0.1 mg	Not Covered	CA (Covered Alternatives: J9049 - bortezomib (Hospira), J9046 - bortezomib (Dr. Reddy's), J9048 - bortezomib (fresenius kabi), J9041 - Velcade (bortezomib). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9055	ERBITUX	Injection, cetuximab, 10 mg	Preferred Specialty	PA
J9056	VIVIMUSTA	Injection, bendamustine hydrochloride (vivimusta), 1 mg	Not Covered	CA (Covered Alternatives: J9033 - Treanda (bendamustine hydrochloride), J9034 - Bendeka (bendamustine HCl), J9036 - Belrapzo (bendamustine hydrochloride). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9057	ALIQOPA 60 MG VIAL	Injection, copanlisib, 1 mg (All NDCs inactive as of 10/16/2024)	Preferred Specialty	PA
J9060	<i>cisplatin</i>	Injection, cisplatin, powder or solution, per 10 mg	Non-Specialty	
J9061	RYBREVANT	Injection, amivantamab-vmjw, 2 mg	Preferred Specialty	PA; Site of Service
J9062	RYBREVANT FASPRO	Injection, amivantamab 5 mg and hyaluronidase-lpuj	Not Covered	Site of Service
J9063	ELAHERE	Injection, mirvetuximab soravtansine-gynx, 1 mg	Preferred Specialty	PA; Site of Service
J9065	<i>cladribine</i>	Injection, cladribine, per 1 mg	Non-Specialty	
J9071	<i>cyclophosphamide 1 gm/5 ml vl muv, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 1 gm/5 ml vl suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 2 gm/10 ml vl muv, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml muv, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9071	<i>cyclophosphamide 500 mg/2.5 ml sub</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9072	<i>cyclophosphamide 1 gm/2 ml vial</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9072	<i>cyclophosphamide 2 gm/4 ml vial</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9072	<i>cyclophosphamide 500 mg/ml vial</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9074	<i>cyclophosphamide 1 gm/10 ml vial outer, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vial inner, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vial outer, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vial inner, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vial outer, muv, p/f</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9075	<i>cyclophosphamide intravenous recon soln</i>	Injection, cyclophosphamide, not otherwise specified, 5mg	Non-Specialty	
J9076	<i>cyclophosphamide 1 gm/5 ml vial muv, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
J9076	<i>cyclophosphamide 500 mg/2.5 ml muv, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
J9118	ASPARLAS	Injection, calaspargase pegol-mknl, 10 units	Non-Preferred	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
J9119	LIBTAYO	Injection, cemiplimab-rwlc, 1 mg	Preferred Specialty	PA; Site of Service
J9120	COSMEGEN 500 MCG VIAL	Injection, dactinomycin, 0.5 mg	Non-Specialty	
J9120	<i>dactinomycin</i>	Injection, dactinomycin, 0.5 mg	Non-Specialty	
J9130	<i>dacarbazine</i>	Dacarbazine, 100 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9144	DARZALEX FASPRO	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32 and E85.81.
J9145	DARZALEX	Injection, daratumumab, 10 mg (For billing prior to 1/1/17 use J9999 or C9476 for OPSS billing)	Preferred Specialty	PA; No PA required for ICD-10 codes C90.00-C90.32 and E85.81.
J9153	VYXEOS	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	Preferred Specialty	PA
J9155	FIRMAGON	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9155	FIRMAGON KIT W DILUENT SYRINGE	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9161	LYMPHIR	Injection, denileukin diftiox-cxdl, 1 mcg	Preferred Specialty	PA; Site of Service
J9171	<i>docetaxel</i>	Injection, docetaxel, 1 mg	Preferred Specialty	
J9172	DOCIVYX	Injection, docetaxel (docivyx), 1 mg	Not Covered	CA (Covered Alternative(s): J9171 - docetaxel. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9173	IMFINZI	Injection, durvalumab, 10 mg	Preferred Specialty	PA; Site of Service
J9174	BEIZRAY	Injection, docetaxel (beizray), 1 mg	Not Covered	Site of Service
J9174	BEIZRAY-ALBUMIN	Injection, docetaxel (beizray), 1 mg	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9176	EMPLICITI	Injection, elotuzumab, 1 mg (For billing prior to 1/1/17 use J9999 or C9477 for OPPS billing)	Preferred Specialty	Site of Service
J9177	PADCEV	Injection, enfortumab vedotin-ejfv, 0.25 mg	Preferred Specialty	PA
J9178	ELLENC	Injection, epirubicin HCl, 2 mg	Preferred Specialty	
J9178	<i>epirubicin 200 mg/100 ml vial sub, p/f</i>	Injection, epirubicin HCl, 2 mg	Preferred Specialty	
J9179	<i>eribulin</i>	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)	Non-Preferred	
J9179	HALAVEN	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)	Non-Preferred	
J9181	ETOPOPHOS	Injection, etoposide, 10 mg	Non-Specialty	
J9181	<i>etoposide intravenous</i>	Injection, etoposide, 10 mg	Non-Specialty	
J9183	INLEXZO	Gemcitabine intravesical system, 225 mg	Non-Preferred	PA; Quantity Limit (10 doses per 1 year - Maximum 18 months treatment)
J9184	AVGEMSI	Injection, gemcitabine hydrochloride (avyxa), 200 mg	Not Covered	Site of Service
J9190	ADRUCIL	Injection, fluorouracil, 500 mg	Non-Specialty	
J9190	<i>fluorouracil intravenous</i>	Injection, fluorouracil, 500 mg	Non-Specialty	
J9191	FAVLYXA 2,500 MG/100 ML VIAL	Injection, fluorouracil (avyxa), 10 mg	Not Covered	Site of Service
J9196	<i>gemcitabine</i>	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9200	<i>floxuridine</i>	Injection, floxuridine, 500 mg	Non-Specialty	
J9201	<i>gemcitabine</i>	Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg	Preferred Specialty	
J9202	ZOLADEX	Goserelin acetate implant, per 3.6 mg	Preferred Specialty	
J9203	MYLOTARG	Injection, gemtuzumab ozogamicin, 0.1 mg (For billing prior to 1/1/18 use J9999 or C9399 for OPPS billing)	Non-Preferred	PA
J9204	POTELIGEO	Injection, mogamulizumab-kpkc, 1 mg	Non-Preferred	PA
J9205	ONIVYDE	Injection, irinotecan liposome, 1 mg (For billing prior to 1/1/17 use J9999 or C9474 for OPPS billing)	Preferred Specialty	PA
J9206	CAMPTOSAR	Injection, irinotecan, 20 mg	Preferred Specialty	
J9206	<i>irinotecan</i>	Injection, irinotecan, 20 mg	Preferred Specialty	
J9207	IXEMPRA	Injection, ixabepilone, 1 mg	Non-Specialty	
J9208	IFEX	Injection, ifosfamide, 1 gram	Non-Specialty	
J9208	<i>ifosfamide</i>	Injection, ifosfamide, 1 gram	Non-Specialty	
J9211	IDAMYCIN PFS	Injection, idarubicin hydrochloride, 5 mg	Non-Specialty	
J9211	<i>idarubicin</i>	Injection, idarubicin hydrochloride, 5 mg	Non-Specialty	
J9215	ALFERON N	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	ELIGARD	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	ELIGARD (3 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	ELIGARD (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	ELIGARD (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	LUPRON DEPOT (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	LUPRON DEPOT (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	LUPRON DEPOT 22.5 MG 3MO KIT SUV, P/F	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	LUPRON DEPOT 7.5 MG 1 MONTH KT SINGLE DOSE	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	VABRINTY (1 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Not Covered	Site of Service
J9217	VABRINTY (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Not Covered	Site of Service
J9218	<i>leuprolide</i>	Leuprolide acetate, per 1 mg	Non-Specialty	Site of Service
J9223	ZEPZELCA	Injection, lurbinectedin, 0.1 mg	Non-Specialty	PA
J9226	SUPPRELIN LA	Histrelin implant (Supprelin LA), 50 mg	Non-Preferred	PA
J9227	SARCLISA	Injection, isatuximab-irfc, 10 mg	Preferred Specialty	PA; Site of Service
J9228	YERVOY	Injection, ipilimumab, 1 mg (For billing prior to 1/1/12 use J9999 or C9284)	Preferred Specialty	PA; Site of Service
J9229	BESPONSA	Injection, inotuzumab ozogamicin, 0.1 mg	Preferred Specialty	PA; Site of Service
J9232	<i>docetaxel</i>	Injection, docetaxel (hospira), not therapeutically equivalent to j9171, 1 mg	Preferred Specialty	
J9245	<i>melphalan hcl</i>	Injection, melphalan hydrochloride, not otherwise specified, 50 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9246	EVOMELA	Injection, melphalan (evomela), 1 mg	Preferred Specialty	PA
J9248	HEPZATO	Injection, melphalan (hepzato), 1 mg	Preferred Specialty	PA
J9248	HEPZATO (50 MM CATHETER)	Injection, melphalan (hepzato), 1 mg	Preferred Specialty	PA
J9248	HEPZATO (62 MM CATHETER)	Injection, melphalan (hepzato), 1 mg	Preferred Specialty	PA
J9249	IVRA	Injection, melphalan (apotex), 1 mg	Not Covered	CA (Covered Alternative(s): J9245 - Alkeran (melphalan hydrochloride), J9246 - Evomela (melphalan), J9248 - Hepzato (melphalan). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9263	oxaliplatin	Injection, oxaliplatin, 0.5 mg	Preferred Specialty	
J9264	ABRAXANE	Injection, paclitaxel protein-bound particles, 1 mg	Preferred Specialty	
J9264	paclitaxel protein-bound	Injection, paclitaxel protein-bound particles, 1 mg	Preferred Specialty	
J9266	ONCASPAR	Injection, pegaspargase, per single dose vial	Preferred Specialty	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
J9267	paclitaxel	Injection, paclitaxel, 1 mg	Non-Specialty	
J9268	NIPENT	Injection, pentostatin, per 10 mg	Preferred Specialty	
J9269	ELZONRIS	Injection, tagraxofusp-erzs, 10 micrograms	Preferred Specialty	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9271	KEYTRUDA	Injection, pembrolizumab, 1 mg (For billing prior to 1/1/16 use C9027 or J9999)	Preferred Specialty	PA; Site of Service
J9272	JEMPERLI	Injection, dostarlimab-gxly, 10 mg	Preferred Specialty	PA; Site of Service
J9273	TIVDAK	Injection, tisotumab vedotin-tftv, 1 mg	Preferred Specialty	PA
J9274	KIMMTRAK	Injection, tebentafusp-tebn, 1 microgram	Preferred Specialty	PA
J9275	UNLOXCYT	Injection, cosibelimab-ipdl, 2 mg	Preferred Specialty	PA; Site of Service
J9276	ZIIHERA	Injection, zanidatamab-hrii, 2 mg	Non-Preferred	PA; Site of Service
J9277	KEYTRUDA QLEX	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph	Preferred Specialty	PA; Site of Service
J9278	KYXATA	Injection, carboplatin (avyxa), 1 mg	Not Covered	CA (Covered Alternative(s): J9045 - carboplatin (geq), J9045 - Paraplatin. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9280	<i>mitomycin intravenous</i>	Injection, mitomycin, 5 mg	Non-Specialty	
J9280	MUTAMYCIN	Injection, mitomycin, 5 mg	Non-Specialty	
J9281	JELMYTO	Mitomycin pyelocalyceal instillation, 1 mg	Non-Preferred	Quantity Limit (17 doses per 1 lifetime); Site of Service
J9282	ZUSDURI	Mitomycin, intravesical instillation, 1 mg	Non-Preferred	Quantity Limit (6 doses per 1 lifetime); Site of Service
J9286	COLUMVI	Injection, glofitamab-gxbm, 2.5 mg	Preferred Specialty	PA; Site of Service
J9289	OPDIVO QVANTIG	Injection, nivolumab, 2 mg and hyaluronidase-nvhy	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9292	AXTLE	Injection, pemetrexed dipotassium, 10 mg	Not Covered	CA (Covered Alternative(s): J9294 - pemetrexed (hospira), J9296 - pemetrexed (accord), J9297 - pemetrexed (sandoz), J9305 - Alimta (pemetrexed), J9314 - pemetrexed (teva), J9322 - pemetrexed (bluepoint), J9323 - pemetrexed ditromethamine. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9293	<i>mitoxantrone</i>	Injection, mitoxantrone hydrochloride, per 5 mg	Non-Specialty	
J9294	<i>pemetrexed disodium</i>	Injection, pemetrexed (hospira), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9296	<i>pemetrexed disodium</i>	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg (All NDCs inactive as of 5/5/2026)	Non-Specialty	
J9297	<i>pemetrexed disodium</i>	Injection, pemetrexed (sandoz), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9298	OPDUALAG	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	Preferred Specialty	PA; Site of Service
J9299	OPDIVO	Injection, nivolumab, 1 mg (For billing prior to 1/1/16 use C9453 or J9999)	Preferred Specialty	PA; Site of Service
J9301	GAZYVA	Injection, obinutuzumab, 10 mg (For billing prior to 1/1/15 use C9021 or J9999)	Preferred Specialty	PA
J9302	ARZERRA	Injection, ofatumumab, 10 mg (All NDCs inactive as of 4/8/2026)	Non-Preferred	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9303	VECTIBIX	Injection, panitumumab, 10 mg	Preferred Specialty	PA
J9304	PEMFEXY	Injection, pemetrexed (pemfexy), 10 mg	Non-Specialty	
J9305	ALIMTA 100 MG VIAL	Injection, pemetrexed, not otherwise specified, 10 mg	Non-Specialty	
J9305	ALIMTA 500 MG VIAL	Injection, pemetrexed, not otherwise specified, 10 mg	Non-Specialty	
J9305	<i>pemetrexed disodium</i>	Injection, pemetrexed, not otherwise specified, 10 mg	Non-Specialty	
J9306	PERJETA	Injection, pertuzumab, 1 mg (For billing prior to 1/1/14 use C9292 or J9999)	Preferred Specialty	PA; No PA required for ICD-10 code C50.
J9307	FOLOTYN	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)	Preferred Specialty	PA
J9307	<i>pralatrexate</i>	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)	Preferred Specialty	PA
J9308	CYRAMZA	Injection, ramucirumab, 5 mg (For billing prior to 1/1/16 use C9025 or J9999)	Preferred Specialty	PA; Site of Service
J9309	POLIVY	Injection, polatuzumab vedotin-piiq, 1 mg	Non-Preferred	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9311	RITUXAN HYCELA	Injection, rituximab 10 mg and hyaluronidase	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9312	RITUXAN	Injection, rituximab, 10 mg	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9314	<i>pemetrexed</i>	Injection, pemetrexed (teva), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9316	PHESGO	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	Preferred Specialty	PA; No PA required if billed with ICD-10 C50
J9317	TRODELVY	Injection, sacituzumab govitecan-hziy, 2.5 mg	Preferred Specialty	PA
J9318	<i>romidepsin</i>	Injection, romidepsin, non-lyophilized, 0.1 mg	Preferred Specialty	PA
J9319	ISTODAX	Injection, romidepsin, lyophilized, 0.1 mg	Preferred Specialty	PA
J9319	<i>romidepsin</i>	Injection, romidepsin, lyophilized, 0.1 mg	Preferred Specialty	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9320	ZANOSAR 1 GM POWDER VIAL SDV	Injection, streptozocin, 1 gram	Non-Specialty	
J9321	EPKINLY	Injection, epcoritamab-bysp, 0.16 mg	Preferred Specialty	PA; Site of Service
J9322	<i>pemetrexed disodium</i>	Injection, pemetrexed (bluepoint), not therapeutically equivalent to j9305, 10 mg	Non-Specialty	
J9324	PEMRYDI RTU	Injection, pemetrexed (pemrydi rtu), 10 mg	Not Covered	CA (Covered Alternative(s): J9294 - pemetrexed (hospira), J9296 - pemetrexed (accord), J9297 - pemetrexed (sandoz), J9305 - Alimta (pemetrexed), J9314 - pemetrexed (teva), J9322 - pemetrexed (bluepoint), J9323 - pemetrexed ditromethamine. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9325	IMLYGIC	Injection, talimogene laherparepvec, per 1 million plaque forming units (For billing prior to 1/1/17 use J9999 or C9472 for OPPS billing)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J9326	EMRELIS	Injection, telisotuzumab vedotin-tllv, 1 mg	Preferred Specialty	Site of Service
J9329	TEVIMBRA	Injection, tislelizumab-jsgr, 1mg	Preferred Specialty	PA; Site of Service
J9331	FYARRO	Injection, sirolimus protein-bound particles, 1 mg	Preferred Specialty	PA
J9341	TEPYLUTE	Injection, thiotepa (tepylute), 1 mg	Non-Specialty	
J9345	ZYNYZ	Injection, retifanlimab-dlwr, 1 mg	Preferred Specialty	PA; Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9347	IMJUDO	Injection, tremelimumab-actl, 1 mg	Preferred Specialty	PA; Site of Service
J9348	DANYELZA	Injection, naxitamab-gqgk, 1 mg	Preferred Specialty	PA; Site of Service
J9349	MONJUVI	Injection, tafasitamab-cxix, 2 mg	Preferred Specialty	PA
J9350	LUNSUMIO	Injection, mosunetuzumab-axgb, 1 mg (Code reused effective 7/1/2023)	Preferred Specialty	PA; Site of Service
J9350	LUNSUMIO VELO	Injection, mosunetuzumab-axgb, 1 mg (Code reused effective 7/1/2023)	Preferred Specialty	PA; Site of Service
J9351	<i>topotecan</i>	Injection, topotecan, 0.1 mg	Preferred Specialty	
J9352	YONDELIS	Injection, trabectedin, 0.1 mg (For billing prior to 1/1/17 use J9999 or C9480 for OPPS billing)	Preferred Specialty	PA
J9353	MARGENZA	Injection, margetuximab-cmkb, 5 mg	Preferred Specialty	PA; Site of Service
J9354	KADCYLA	Injection, ado-trastuzumab emtansine, 1 mg (For billing prior to 1/1/14 use C9131 or J9999)	Preferred Specialty	PA
J9355	HERCEPTIN	Injection, trastuzumab, excludes biosimilar, 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9356	HERCEPTIN HYLECTA	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk	Not Covered	CA (Covered Biosimilars: Ogivri or Trazimera); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9358	ENHERTU	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Preferred Specialty	PA; Site of Service
J9359	ZYNLONTA	Injection, loncastuximab tesirine-lpyl, 0.075 mg	Preferred Specialty	PA
J9360	<i>vinblastine</i>	Injection, vinblastine sulfate, 1 mg	Non-Specialty	
J9370	<i>vincristine</i>	Vincristine sulfate, 1 mg	Non-Specialty	
J9380	TECVAYLI	Injection, teclistamab-cqyv, 0.5 mg (Code reused effective 7/1/2023)	Non-Preferred	PA; Site of Service
J9382	BIZENGRI	Injection, zenocutuzumab-zbco, 1 mg	Preferred Specialty	Site of Service
J9390	<i>vinorelbine</i>	Injection, vinorelbine tartrate, per 10 mg	Non-Specialty	
J9395	FASLODEX	Injection, fulvestrant, 25 mg	Preferred Specialty	
J9395	<i>fulvestrant</i>	Injection, fulvestrant, 25 mg	Preferred Specialty	
J9400	ZALTRAP	Injection, ziv-aflibercept, 1 mg (For billing prior to 1/1/14 use C9296 or J9999)	Non-Preferred	
J9600	PHOTOFRIN	Injection, porfimer sodium, 75 mg	Preferred Specialty	
J9601	LYNOZYFIC	Injection, linvoseltamab-gcpt, 1 mg	Non-Preferred	Site of Service
J9999	AMTAGVI	Not otherwise classified, antineoplastic drugs	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J9999	SARCLISA ESCENA	Not otherwise classified, antineoplastic drugs	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9999	UNITUXIN	Not otherwise classified, antineoplastic drugs	Preferred Specialty	PA; Site of Service
Q2041	YESCARTA	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (For billing prior to 4/1/18 use J9999 or C9399 for OPSP billing) (Code Price is for drug ONLY) (Code re-used by CMS)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2042	KYMRIAH	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code was reused by CMS 1/1/2019) (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Code Price is per 250 mL)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q2053	TECARTUS	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2054	BREYANZI	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2054	BREYANZI CD4 COMPONENT (2OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2054	BREYANZI CD8 COMPONENT (1OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q2055	ABECMA	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2056	CARVYKTI	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2058	AUCATZYL	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion (Split dose infusion; complete therapy=2 separate infusions 10 days apart)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q5107	MVASI	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	Preferred Specialty	
Q5112	ONTRUZANT	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5113	HERZUMA	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5114	OGIVRI	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	Preferred Specialty	
Q5115	TRUXIMA	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	Preferred Specialty	Site of Service
Q5116	TRAZIMERA	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5117	KANJINTI	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5118	ZIRABEV	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg	Preferred Specialty	
Q5119	RUXIENCE	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	Preferred Specialty	Site of Service
Q5123	RIABNI	Injection, rituximab-arrr, biosimilar, (riabni), 10 mg	Preferred Specialty	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5126	ALYMSYS	Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg	Not Covered	CA (Covered Alternatives: Q5107 - Mvasi (bevacizumab-awwb), Q5118 - Zirabev (bevacizumab-bvzr) for non-ophthalmic coverage. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5129	VEGZELMA	Injection, bevacizumab-adcd (vegzelma), biosimilar, 10 mg	Not Covered	CA (Covered Biosimilars: Mvasi or Zirabev); Site of Service
Q5146	HERCESSI	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	Not Covered	CA (Covered Alternative(s): Q5114 - Ogivri (Trastuzumab-dkst), Q5112 - Ontruzant (trastuzumab-dttb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5160	JOBEVNE	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	Not Covered	Site of Service
Antitoxins,Immune Glob,Toxoids,Vaccines				
Allergenic Extracts (Therapeutic)				
J3590	PALFORZIA (LEVEL 1)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 2)	Unclassified biologics	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3590	PALFORZIA (LEVEL 3)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 4)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 5)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 6)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 7)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 8)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 9)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA (LEVEL 10)	Unclassified biologics	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3590	PALFORZIA (LEVEL 11 UP-DOSE)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA 1 MG (LEVEL 0)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	PALFORZIA INITIAL (1-3 YRS)	Unclassified biologics	Preferred Specialty	PA
J3590	PALFORZIA INITIAL (4-17 YRS)	Unclassified biologics	Preferred Specialty	PA
J3590	PALFORZIA LEVEL 11 MAINTENANCE	Unclassified biologics	Refer to Approved Drug List (ADL)	
Antitoxins And Immune Globulins				
J0565	ZINPLAVA	Injection, bezlotoxumab, 10 mg (For billing prior to 1/1/18 use J3590 or C9490 for OPPS billing)	Not Covered	Site of Service
J0716	ANASCORP	Injection, centruioides immune f(ab)2, up to 120 milligrams (Code Price is per 1 vial) (For billing prior to 1/1/13 use C9288 or J3590)	Preferred Specialty	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	Non-Specialty	CC (Rattlesnake Antivenom)
J1459	PRIVIGEN	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g liquid), 500 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1551	CUTAQUIG	Injection, immune globulin (cutaquig), 100 mg	Preferred Specialty	PA; Site of Service
J1552	ALYGLO	Injection, immune globulin (alyglo), 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1553	YIMMUGO	Injection, immune globulin (yimmugo), 100 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1554	ASCENIV	Injection, immune globulin (asceniv), 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1555	CUVITRU	Injection, immune globulin (Cuvitru), 100 mg (For billing prior to 1/1/18 use J3590 or C9399 for OPSS billing)	Preferred Specialty	PA; Site of Service
J1556	BIVIGAM	Injection, immune globulin (Bivigam), 500 mg (For billing prior to 1/1/14 see C9130 or J1599)	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammagard (IVIG), J1561 - Gamunex-C/Gammagard (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1557	GAMMAPLEX	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)	Preferred Specialty	PA; Site of Service
J1557	GAMMAPLEX (WITH SORBITOL)	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)	Preferred Specialty	PA; Site of Service
J1558	XEMBIFY	Injection, immune globulin (xembify), 100 mg	Preferred Specialty	PA; Site of Service
J1559	HIZENTRA	Injection, immune globulin (Hizentra), 100 mg (For billing prior to 1/1/11 use J3590 or C9399) (see also 90284 for CPT billing requirements)	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1561	GAMMAKED	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1561	GAMUNEX-C	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1566	GAMMAGARD S-D (IGA < 1 MCG/ML)	Injection, immune globulin, intravenous, lyophilized (e.g powder), not otherwise specified, 500 mg (Only Carimune NF, Panglobulin NF and Gammagard S/D should be billed using this code)	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammaplex (IVIG), J1561 - Gamunex-C/Gammaked (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1568	OCTAGAM	Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1569	GAMMAGARD LIQUID	Injection, immune globulin, (gammagard liquid/gammagard liquid etc), 500 mg	Preferred Specialty	PA; Site of Service
J1569	GAMMAGARD LIQUID ERC	Injection, immune globulin, (gammagard liquid/gammagard liquid etc), 500 mg	Preferred Specialty	PA; Site of Service
J1572	FLEBOGAMMA DIF 5% VIAL 10 GM, INNER, P/F, SUV	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1572	FLEBOGAMMA DIF 5% VIAL 10 GM, OUTER, P/F, SUV	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1572	FLEBOGAMMA DIF 5% VIAL 20 GM,INNER,P/F;SUV	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1572	FLEBOGAMMA DIF 5% VIAL 20 GM,OUTER,P/F;SUV	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1572	FLEBOGAMMA DIF 5% VIAL 5 GM,INNER,P/F;SUV	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1572	FLEBOGAMMA DIF 5% VIAL 5 GM,OUTER,P/F;SUV	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg	Preferred Specialty	PA; Site of Service
J1573	HEPAGAM B	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5 mL (see J1571 for IM use)	Non-Specialty	
J1575	HYQVIA	Injection, immune globulin/hyaluronidase, (Hyqvia), 100 mg immune globulin (For billing prior to 1/1/16 use C9399 or J3590)	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1576	PANZYGA	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammagard (IVIG), J1561 - Gamunex-C/Gammagard (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1577	QIVIGY	Injection, immune globulin (qivigy), 100 mg	Not Covered	CA (Covered Alternative(s): J1459 - Privigen (IVIG), J1557 - Gammagard (IVIG), J1561 - Gamunex-C/Gammagard (IVIG), J1568 - Octagam (IVIG), J1569 - Gammagard liquid (IVIG), J1572 - Flebogamma/Flebogamma DIF (IVIG). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2790	HYPERRHO 1,500 UNIT SYRINGE P/F,INNER,SDV	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	Non-Specialty	
J2790	HYPERRHO 1,500 UNIT SYRINGE P/F,OUTER,SDV	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2790	RHOGAM ULTRA-FILTERED PLUS	Injection, Rho d immune globulin, human, full dose, 300 micrograms (1500 I.U.) (see also 90384 for CPT billing requirements)	Non-Specialty	
J2791	RHOPHYLAC	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU (see also 90384 and 90386 for CPT billing requirements)	Non-Specialty	
Vaccines				
91304	NUVAXOVID 2025-26 0.5 ML SYRINGE SUV, P/F, INNER	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use (All NDCs inactive effective 7/2026)	Preventive	
91304	NUVAXOVID 2025-26 0.5 ML SYRINGE SUV, P/F, OUTER	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use (All NDCs inactive effective 7/2026)	Preventive	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
91304	NUVAXOVID 2026-2027 (PF)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use (All NDCs inactive effective 7/2026)	Preventive	
91319	COMIRNATY 2025-2026(5-11Y)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use (All NDCs inactive effective 9/2026)	Preventive	
91319	COMIRNATY 2026-2027(5-11Y)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use (All NDCs inactive effective 9/2026)	Preventive	

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
91320	COMIRNATY 2025-26 (12Y UP)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use (All NDCs inactive effective 9/2026)	Preventive	
91320	COMIRNATY 2026-27 (12Y UP)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use (All NDCs inactive effective 9/2026)	Preventive	
91321	SPIKEVAX 2025-2026 (6MO-11YR) 0.25 ML SYRINGE SUV, P/F, INNER	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, 25 mcg/0.25 mL dosage, for intramuscular use	Preventive	
91321	SPIKEVAX 2025-2026 (6MO-11YR) 0.25 ML SYRINGE SUV, P/F, OUTER	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, 25 mcg/0.25 mL dosage, for intramuscular use	Preventive	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
91321	SPIKEVAX 2026-27 (6M-11Y) (PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, 25 mcg/0.25 mL dosage, for intramuscular use	Preventive	
91322	SPIKEVAX 2025-2026 (12YR UP) 0.5 ML SYRINGE SUV, P/F, INNER	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, 50 mcg/0.5 mL dosage, for intramuscular use	Preventive	
91322	SPIKEVAX 2025-2026 (12YR UP) 0.5 ML SYRINGE SUV, P/F, OUTER	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, 50 mcg/0.5 mL dosage, for intramuscular use	Preventive	
91322	SPIKEVAX 2026-2027(12Y UP)(PF)	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA LNP, 50 mcg/0.5 mL dosage, for intramuscular use	Preventive	
91323	MNEXSPIKE 2025-2026 (12YR UP) 0.2 ML SYRINGE SUV, P/F, INNER	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 10 mcg/0.2 mL dosage, for intramuscular use	Preventive	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
91323	MNEXSPIKE 2025-2026 (12YR UP) 0.2 ML SYRINGE SUV, P/F, OUTER	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 10 mcg/0.2 mL dosage, for intramuscular use	Preventive	
91323	MNEXSPIKE 2026-2027 (PF)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 10 mcg/0.2 mL dosage, for intramuscular use	Preventive	
Autonomic Drugs				
Alpha- And Beta-Adrenergic Agonists				
J0163	ADRENALIN IN 0.9 % SOD CHLOR	Injection, epinephrine in sodium chloride (endo), 0.1 mg	Non-Specialty	
J0164	<i>epineph bitart in 0.9% sod chl intravenous solution</i>	Injection, epinephrine in sodium chloride (baxter), 0.1 mg	Non-Specialty	
J3490	REZIPRES	Unclassified drugs	Non-Specialty	
Alpha-Adrenergic Agonists (12:12)				
J2371	<i>phenylephrine hcl injection</i>	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2371	VAZCULEP	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2372	BIORPHEN	Injection, phenylephrine hydrochloride (biorphen), 20 micrograms	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2373	IMMPHENTIV	Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms	Non-Specialty	
Antimuscarinics/Antispasmodics				
J0462	<i>atropine injection solution</i>	Injection, atropine sulfate, not therapeutically equivalent to j0461, 0.01 mg	Non-Specialty	
J0462	<i>atropine intravenous solution</i>	Injection, atropine sulfate, not therapeutically equivalent to j0461, 0.01 mg	Non-Specialty	
J0463	<i>atropine injection solution</i>	Injection, atropine sulfate (fresenius and therapeutically equivalent), 0.01 mg	Non-Specialty	
J7677	YUPELRI	Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram	Not Covered	Site of Service
Antiparkinsonian Agents				
J0515	<i>benztropine injection</i>	Injection, benztropine mesylate, per 1mg	Non-Specialty	
Botulinum Toxins				
J0585	BOTOX	Injection, onabotulinumtoxinA, 1 unit	Preferred Specialty	PA
J0585	BOTOX COSMETIC	Injection, onabotulinumtoxinA, 1 unit	Not Covered	Site of Service
J0586	DYSPORT	Injection, abobotulinumtoxinA, 5 units (For billing prior to 1/1/10 use J3590 or C9399)	Preferred Specialty	PA
J0587	MYOBLOC	Injection, rimabotulinumtoxinB, 100 units	Preferred Specialty	PA

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J0588	XEOMIN	Injection, incobotulinumtoxinA, 1 unit	Preferred Specialty	PA
J0589	DAXXIFY	Injection, daxibotulinumtoxina-lanm, 1 unit	Preferred Specialty	PA
J3590	JEUVEAU	Unclassified biologics	Not Covered	Site of Service
Gaba-Derivative Skeletal Muscle Relaxant				
J0475	<i>baclofen intrathecal kit</i>	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	<i>baclofen intrathecal solution</i>	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN 10,000 MCG/20 ML SYRG P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN 20,000 MCG/20 ML SYRG P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN 40,000 MCG/20 ML SYRG P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	GABLOFEN INTRATHECAL SOLUTION	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/20 ML AMPULE INNER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/20 ML KIT OUTER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/20 ML KIT SUV, P/F	Injection, baclofen, 10 mg	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0475	LIORESAL IT 10 MG/5 ML AMPULE INNER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML AMPULE SUV, P/F, INNER	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML KIT OUTER, P/F, SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 10 MG/5 ML KIT SUV, P/F, OUTER	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML AMPULE INNER, SUV, P/F	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML AMPULE INNER,SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML KIT OUTER, SUV, P/F	Injection, baclofen, 10 mg	Preferred Specialty	
J0475	LIORESAL IT 40 MG/20 ML KIT OUTER,SUV	Injection, baclofen, 10 mg	Preferred Specialty	
J0476	<i>baclofen intrathecal syringe</i>	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	GABLOFEN 50 MCG/ML SYRINGE P/F, SUV	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	LIORESAL IT 0.05 MG/ML AMPULE INNER, SUV, P/F	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0476	LIORESAL IT 0.05 MG/ML AMPULE OUTER, SUV, P/F	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
J0476	LIORESAL IT 0.05 MG/ML AMPULE SUV, P/F	Injection, baclofen, 50 mcg, for intrathecal trial	Non-Specialty	
Neuromuscular Blocking Agents				
J0330	<i>succinylcholine 100 mg/5 ml syringe sub, p/f, inner</i>	Injection, succinylcholine chloride, up to 20mg	Non-Specialty	
J0330	<i>succinylcholine 100 mg/5 ml syringe sub, p/f, outer</i>	Injection, succinylcholine chloride, up to 20mg	Non-Specialty	
J0330	<i>succinylcholine chloride injection</i>	Injection, succinylcholine chloride, up to 20mg	Non-Specialty	
Non-Sel. Beta-Adrenergic Blocking Agents				
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syring sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syring sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syring inner, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, suv, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
Parasympathomimetic (Cholinergic Agents)				
J2710	BLOXIVERZ	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe inner, suv</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe outer, suv</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine methylsulfate intravenous solution</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2711	PREVDUO	Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg	Non-Specialty	
Selective Alpha-1-Adrenergic Block.Agent				
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng suv, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, suv, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, suv, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
Selective Beta-2-Adrenergic Agonists				
J3105	<i>terbutaline subcutaneous</i>	Injection, terbutaline sulfate, up to 1 mg	Non-Specialty	
J7611	<i>albuterol 2.5 mg/0.5 ml sol</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol 0.083% inhal soln 25's, u-d</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 0.63 mg/3 ml sol 30's,p/f,stri</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol inner</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol outer</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol u-d, 25's</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 1.25 mg/3 ml sol inner</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol outer</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol p/f,pedia,25's,u-d</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol p/f,pedia,30's,u-d</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol u-d, 25's</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 2.5 mg/3 ml soln</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 25's, u-d, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 30's, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 30's, u-d, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 60's, u-d, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 2.5 mg/3 ml soln inner</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln outer</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln p/f, inner</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln p/f, outer</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
Selective Beta-Adrenergic Blocking Agent				
J1805	BREVIBLOC	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	BREVIBLOC IN NACL (ISO-OSM)	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol in nacl (iso-osm)</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1805	<i>esmolol intravenous solution</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1806	<i>esmolol in sterile water</i>	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	Non-Specialty	
J3490	RAPIBLYK	Unclassified drugs	Not Covered	Site of Service
Smoking Cessation Agents				
J2315	VIVITROL	Injection, naltrexone, depot form, 1 mg	Preferred Specialty	
Blood Derivatives				
Blood Derivatives				
J0256	ARALAST NP	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	Preferred Specialty	PA; Site of Service
J0256	PROLASTIN-C	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	Preferred Specialty	PA; Site of Service
J0256	ZEMAIRA	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified	Preferred Specialty	PA; Site of Service
J0257	GLASSIA	Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg (For billing prior to 1/1/12 use J3590 or C9399)	Preferred Specialty	PA; Site of Service
J2998	RYPLAZIM	Injection, plasminogen, human-tvmh, 1 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Blood Formation, Coagulation, Thrombosis				
Antianemia Drugs				
J0882	ARANESP (IN POLYSORBATE)	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	Preferred Specialty	
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Preferred Specialty	
J0896	REBLOZYL	Injection, luspatercept-aamt, 0.25 mg	Preferred Specialty	PA
J0901	VAFSEO	Vadadustat, oral, 1 mg (for esrd on dialysis)	Not Covered	Site of Service
Anticoagulants, Miscellaneous				
J0911	DEFENCATH	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)	Not Separately Payable	
Blood Form.,Coag,Thrombosis Agents Misc.				
J0791	ADAKVEO	Injection, crizanlizumab-tmca, 5 mg	Non-Preferred	PA; Site of Service
Direct Thrombin Inhibitors				
J0582	<i>bivalirudin intravenous solution</i>	Injection, bivalirudin (endo), not therapeutically equivalent to j0583, 1 mg	Non-Specialty	
Hematopoietic Agents				
J0882	ARANESP (IN POLYSORBATE)	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Preferred Specialty	
J0896	REBLOZYL	Injection, luspatercept-aamt, 0.25 mg	Preferred Specialty	PA
J0901	VAFSEO	Vadadustat, oral, 1 mg (for esrd on dialysis)	Not Covered	Site of Service
J1449	ROLVEDON	Injection, eflapegrastim-xnst, 0.1 mg	Not Covered	Site of Service
J2277	APHEXDA	Injection, motixafortide, 0.25 mg	Non-Preferred	
J2506	NEULASTA	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Preferred Specialty	
J2506	NEULASTA ONPRO	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Preferred Specialty	
J2562	MOZOBIL	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)	Non-Preferred	
J2562	<i>plerixafor</i>	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)	Non-Preferred	
J2802	NPLATE	Injection, romiplostim, 1 microgram	Preferred Specialty	PA
J2820	LEUKINE	Injection, sargramostim (GM-CSF), 50 mcg	Preferred Specialty	
J9361	RYZNEUTA	Injection, efbemalenograstim alfa-vuxw, 0.5 mg	Not Covered	Site of Service
Q5101	ZARXIO	Injection, filgrastim-sndz, biosimilar, (Zarxio), 1 microgram	Preferred Specialty	

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5108	FULPHILA	Injection, pegfilgrastim-jmdb (fulphila), biosimilar, 0.5 mg	Preferred Specialty	
Q5110	NIVESTYM	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram	Preferred Specialty	
Q5111	UDENYCA	Injection, pegfilgrastim-cbqv (udenyc), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5111	UDENYCA AUTOINJECTOR	Injection, pegfilgrastim-cbqv (udenyc), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5111	UDENYCA ONBODY	Injection, pegfilgrastim-cbqv (udenyc), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5120	ZIEXTENZO	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5122	NYVEPRIA	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	Preferred Specialty	Site of Service
Q5125	RELEUKO	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	Preferred Specialty	
Q5127	STIMUFEND	Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5130	FYLNETRA	Injection, pegfilgrastim-pbbk (flyneta), biosimilar, 0.5 mg	Not Covered	CA (Covered Alternative(s): J2506 - Neulasta/Neulasta Onpro (pegfilgrastim), Q5108 - Fulphila (pegfilgrastim-jmdb). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5148	NYPOZI	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	Not Covered	CA (Covered Alternative(s): J1442 - Neupogen (filgrastim), Q5110 - Nivestym (filgrastim-aafi), Q5125 - Releuko (filgrastim-ayow), Q5101 - Zarxio (filgrastim-sndz). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Hemostatics				
J1411	HEMGENIX	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1412	ROCTAVIAN	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10 ¹³ vector genomes (All NDCs inactive as of 6/10/2026)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J2597	DDAVP INJECTION	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	
J2597	<i>desmopressin injection</i>	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	
J3290	CYKLOKAPRON	Injection, tranexamic acid, 5 mg	Not Covered	Site of Service
J3290	<i>tranexamic acid intravenous</i>	Injection, tranexamic acid, 5 mg	Not Covered	Site of Service
J7165	BALFAXAR	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	Non-Specialty	
J7170	HEMLIBRA	Injection, emicizumab-kxwh, 0.5 mg	Refer to Approved Drug List (ADL)	
J7173	ALHEMO PEN	Injection, concizumab-mtci, 0.5 mg	Refer to Approved Drug List (ADL)	
J7174	QFITLIA	Injection, fitusiran, 0.04 mg	Preferred Specialty	PA; Site of Service
J7174	QFITLIA PEN	Injection, fitusiran, 0.04 mg	Not Covered	PA; Site of Service
J7175	COAGADEX	Injection, factor X, (human), 1 IU (For billing prior to 1/1/17 use J3590 or C9399 for OPPS billing)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7176	FESILTY	Injection, human fibrinogen - chmt (fesilty), 1 mg	Not Covered	Site of Service
J7177	FIBRYGA	Injection, human fibrinogen concentrate (fibryga), 1 mg (Price is per 1mg. Product contains approximately 1 gram (900-1300mg))	Not Separately Payable	
J7179	VONVENDI	Injection, Von Willebrand factor (recombinant), (Vonvendi), 1 IU VWF:RCo (For billing prior to 1/1/17 use J7199 or C9399 for OPSS billing)	Refer to Approved Drug List (ADL)	
J7180	CORIFACT	Injection, factor XIII (antihemophilic factor, human), 1 IU (Code Price is per 1 IU - Corifact contains 1000-1600 Units) (For billing prior to 1/1/12 use J3590 or C9399)	Refer to Approved Drug List (ADL)	
J7181	TRETTEN	Injection, factor XIII A-subunit, (recombinant), per IU For billing prior to 1/1/15 use C9134 or J3590)	Refer to Approved Drug List (ADL)	
J7182	NOVOEIGHT	Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU	Refer to Approved Drug List (ADL)	
J7183	WILATE	Injection, Von Willebrand factor complex (human), Wilate, 1 IU VWF:RCO	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7185	XYNTHA	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU	Refer to Approved Drug List (ADL)	
J7185	XYNTHA SOLOFUSE	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU	Refer to Approved Drug List (ADL)	
J7186	ALPHANATE	Injection, antihemophilic factor VIII/Von Willebrand factor complex (human), per factor VIII I.U.	Refer to Approved Drug List (ADL)	
J7187	HUMATE-P	Injection, Von Willebrand factor complex (Humate-P), per IU, VWF:RCO	Refer to Approved Drug List (ADL)	
J7188	OBIZUR	Injection, factor VIII (antihemophilic factor, recombinant), (Obizur), per IU (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9399 or J7199)	Refer to Approved Drug List (ADL)	
J7189	NOVOSEVEN RT	Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram	Refer to Approved Drug List (ADL)	
J7190	HEMOFIL M HIGH	Factor VIII (antihemophilic factor [human]) per IU	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7190	HEMOFIL M LOW	Factor VIII (antihemophilic factor [human]) per IU	Refer to Approved Drug List (ADL)	
J7190	HEMOFIL M MID	Factor VIII (antihemophilic factor [human]) per IU	Refer to Approved Drug List (ADL)	
J7190	HEMOFIL M SUPER HIGH	Factor VIII (antihemophilic factor [human]) per IU	Refer to Approved Drug List (ADL)	
J7190	KOATE	Factor VIII (antihemophilic factor [human]) per IU	Refer to Approved Drug List (ADL)	
J7192	ADVATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 1,000 UNIT VIAL INNER, SUV	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 1,000 UNIT VIAL PRICE\UNIT,SUV OUTER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	

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HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7192	KOGENATE FS 2,000 UNIT VIAL PRICE/UNIT,SUV,INNER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 2,000 UNIT VIAL PRICE/UNIT,SUV,OUTER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 250 UNIT VIAL PRICE/UNIT,SUV,INNER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 250 UNIT VIAL PRICE/UNIT,SUV,OUTER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 3,000 UNIT VIAL PRICE/UNIT,SUV,OUTER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	KOGENATE FS 3,000 UNIT VIAL SUV, INNER	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7192	KOGENATE FS 500 UNIT VIAL PRICE/UNIT, SUV	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7192	RECOMBINATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified (Effective 9/1/18 Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J7193	ALPHANINE SD	Factor IX (antihemophilic factor, purified, non-recombinant) per IU	Refer to Approved Drug List (ADL)	
J7194	PROFILNINE	Factor IX, complex, per IU	Refer to Approved Drug List (ADL)	
J7195	BENEFIX	Injection factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified	Refer to Approved Drug List (ADL)	
J7198	FEIBA NF	Anti-inhibitor, per IU	Refer to Approved Drug List (ADL)	
J7200	RIXUBIS	Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU (For billing prior to 1/1/15 use C9133 or J7195)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7201	ALPROLIX	Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1 IU	Refer to Approved Drug List (ADL)	
J7202	IDELVION	Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, 1 IU (For billing prior to 1/1/17 use J7199 or C9139 for OPPS billing)	Refer to Approved Drug List (ADL)	
J7203	REBINYN	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	Refer to Approved Drug List (ADL)	
J7204	ESPEROCT	Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu	Refer to Approved Drug List (ADL)	
J7205	ELOCTATE	Injection, factor VIII, Fc fusion protein (recombinant), per IU	Refer to Approved Drug List (ADL)	
J7207	ADYNOVATE	Injection, factor VIII, (antihemophilic factor, recombinant), pegylated, 1 IU (For billing prior to 1/1/17 use J7199 or C9137 for OPPS billing)	Refer to Approved Drug List (ADL)	
J7208	JIVI	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7209	NUWIQ	Injection, factor VIII, (antihemophilic factor, recombinant), (Nuwiq), 1 IU (For billing prior to 1/1/17 use J7199 or C9138 for OPBS billing)	Refer to Approved Drug List (ADL)	
J7210	AFSTYLA	Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU (For billing prior to 1/1/18 use J7199 or C9140 for OPBS billing)	Refer to Approved Drug List (ADL)	
J7211	KOVALTRY	Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU (For billing prior to 1/1/18 use J7192)	Refer to Approved Drug List (ADL)	
J7212	SEVENFACT	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	Refer to Approved Drug List (ADL)	
J7213	IXINITY	Injection, coagulation factor ix (recombinant), ixinity, 1 i.u.	Refer to Approved Drug List (ADL)	
J7214	ALTUVIIIIO	Injection, factor viii/von willebrand factor complex, recombinant (altuviio), per factor viii i.u.	Refer to Approved Drug List (ADL)	
Iron Preparations				
J1437	MONOFERRIC	Injection, ferric derisomaltose, 10 mg	Non-Preferred	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1439	<i>ferric carboxymaltose</i>	Injection, ferric carboxymaltose, 1 mg	Non-Preferred	
J1439	INJECTAFER	Injection, ferric carboxymaltose, 1 mg	Non-Preferred	
J1750	INFED	Injection, iron dextran, 50 mg (Code reinstated effective 1/1/09)	Non-Specialty	
J1756	<i>iron sucrose 100 mg/5 ml vial sub, plf</i>	Injection, iron sucrose, 1 mg	Non-Specialty	
J1756	VENOFER	Injection, iron sucrose, 1 mg	Non-Specialty	
J2916	FERRLECIT	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	Non-Specialty	
J2916	<i>sodium ferric gluconate-sucrose</i>	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	Non-Specialty	
Q0138	FERAHEME	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) (For billing prior to 1/1/10 use J3490 or C9399)	Non-Specialty	
Q0138	<i>ferumoxytol</i>	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) (For billing prior to 1/1/10 use J3490 or C9399)	Non-Specialty	
Thrombolytic Agents				
J3101	TNKASE	Injection, tenecteplase, 1 mg	Non-Specialty	
Von Willebrand Factor-Related Antithromb				
J3590	CABLIVI INJECTION KIT	Unclassified biologics	Preferred Specialty	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Cardiovascular Drugs				
Alpha-Adrenergic Blocking Agents (24:16)				
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
Angptl3 Inhibitors (24:06)				
J1305	EVKEEZA	Injection, evinacumab-dgnb, 5mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antilipemic Agents, Miscellaneous				
C9399	REDEMPLO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	TRYNGOLZA 80 MG/0.8 ML AUTOINJ	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
J1306	LEQVIO	Injection, inclisiran, 1 mg	Non-Preferred	PA; Site of Service
Beta-Adrenergic Blocking Agents (24:20)				
J1805	BREVIBLOC	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	BREVIBLOC IN NACL (ISO-OSM)	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol in nacl (iso-osm)</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol intravenous solution</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1806	<i>esmolol in sterile water</i>	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt suv, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syring sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syring sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syring inner, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syring outer, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J3490	RAPIBLYK	Unclassified drugs	Not Covered	Site of Service
Bradykinin Receptors Antagonists				
J1744	FIRAZYR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Refer to Approved Drug List (ADL)	
J1744	<i>icatibant</i>	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1744	SAJAZIR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Refer to Approved Drug List (ADL)	
Calcium-Channel Blocking Agents				
J1164	<i>diltiazem 100 mg/100 ml-nacl bag inner, suv, p/f</i>	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	Non-Specialty	
J1164	<i>diltiazem 100 mg/100 ml-nacl bag outer, suv, p/f</i>	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	Non-Specialty	
Cardiotonic Agents				
J1160	<i>digoxin injection</i>	Injection, digoxin, up to 0.5 mg	Non-Specialty	
J1160	LANOXIN INJECTION	Injection, digoxin, up to 0.5 mg	Non-Specialty	
J1160	LANOXIN PEDIATRIC	Injection, digoxin, up to 0.5 mg	Non-Specialty	
Class II Antiarrhythmics				
J1805	BREVIBLOC	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	BREVIBLOC IN NACL (ISO-OSM)	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol in nacl (iso-osm)</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1805	<i>esmolol intravenous solution</i>	Injection, esmolol hydrochloride, 10 mg	Non-Specialty	
J1806	<i>esmolol in sterile water</i>	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg	Non-Specialty	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml crpjt sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, inner</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol hcl 20 mg/4 ml syrng sub, outer</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1920	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng inner, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol hcl 10 mg/2 ml syrng outer, sub, p/f</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J1921	<i>labetalol intravenous solution</i>	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg	Non-Specialty	
J3490	RAPIBLYK	Unclassified drugs	Not Covered	Site of Service
Class Iv Antiarrhythmics				
J1164	<i>diltiazem 100 mg/100 ml-nacl bag inner, sub, p/f</i>	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	Non-Specialty	
J1164	<i>diltiazem 100 mg/100 ml-nacl bag outer, sub, p/f</i>	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	Non-Specialty	
Dihydropyridines				
J0759	CLEVIPREX	Injection, clevidipine butyrate, 1 mg	Not Covered	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Kallikrein Inhibitors (24:48:08)				
J0593	TAKHZYRO	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	
J0593	TAKHZYRO 300 MG/2 ML VIAL	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	
J1290	KALBITOR	Injection, ecallantide, 1 mg (For billing prior to 1/1/11 use J3590 or C9263)	Refer to Approved Drug List (ADL)	
Loop Diuretics (24:36)				
J1807	<i>ethacrynate sodium</i>	Injection, ethacrynate sodium, 1 mg	Not Covered	Site of Service
J1938	<i>furosemide injection</i>	Injection, furosemide, 1 mg	Non-Specialty	
J1941	FUROCIX	Injection, furosemide (furoscix), 20 mg	Not Covered	Site of Service
J1941	FUROCIX READYFLOW	Injection, furosemide (furoscix), 20 mg	Not Covered	Site of Service
Nitrates And Nitrites				
J2305	<i>nitroglycerin in 5 % dextrose</i>	Injection, nitroglycerin, 5 mg	Non-Specialty	
J2305	<i>nitroglycerin intravenous</i>	Injection, nitroglycerin, 5 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Osmotic Diuretics (24:36)				
J2151	mannitol 20 %	Injection, mannitol, 250 mg	Non-Specialty	
J2151	mannitol 25 %	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 10% (50 GM/500 ML) VIAFLEX, SINGLE USE	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 20 %	Injection, mannitol, 250 mg	Non-Specialty	
Vasodilating Agents, Miscellaneous				
J1325	epoprostenol	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1325	FLOLAN 0.5 MG VIAL	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1325	FLOLAN 1.5 MG VIAL	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1325	VELETRI	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1749	AURLUMYN	Injection, iloprost, 0.1 mcg	Not Covered	Site of Service; CC (No PA Required - Inpatient Use Only)
J3285	REMOTULIN 100 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	REMOTULIN 20 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	REMOTULIN 200 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	REMOTULIN 50 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3285	<i>treprostinil sodium</i>	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3535	TYVASO DPI 16 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 16 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 16 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 16-32-48 MCG TITRAT	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 32 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 32 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 32 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3535	TYVASO DPI 32-64 MCG MAINT KIT	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 48 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 48 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 48 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 64 MCG CARTRIDGE	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 64 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 64 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J3535	TYVASO DPI 80 MCG CARTRIDGE INNER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3535	TYVASO DPI 80 MCG CARTRIDGE OUTER	Drug administered through a metered dose inhaler	Refer to Approved Drug List (ADL)	
J7686	TYVASO	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service
J7686	TYVASO INSTITUTIONAL START KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service
J7686	TYVASO REFILL KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service
J7686	TYVASO STARTER KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Cellular And Gene Therapy				
Cellular Therapy				
C9399	AMTAGVI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3402	RYONCIL	Injection, remestemcel-l-rknd, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3590	LANTIDRA	Unclassified biologics	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3590	RETHYMIC	Unclassified biologics	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J9999	AMTAGVI	Not otherwise classified, antineoplastic drugs	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Code Price is per 250 mL)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Gene Therapy				
C9399	GENGLYCOS	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Cellular/Gene Therapy; Site of Service

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	KEBILIDI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Cellular/Gene Therapy; Site of Service
C9399	KRESLADI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Cellular/Gene Therapy; Site of Service
C9399	TREGZI	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Cellular/Gene Therapy	PA; Site of Service
C9399	TREGZI HSPC AND TREG COMPONENT	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
J1411	HEMGENIX	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J1412	ROCTAVIAN	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2×10^{13} vector genomes (All NDCs inactive as of 6/10/2026)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1413	ELEVIDYS	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Not Covered	Cellular/Gene Therapy; Site of Service
J3386	WASKYRA	Injection, etuvetidigene autotemcel, per treatment	Not Covered	Cellular/Gene Therapy; Site of Service
J3387	SKYSONA	Injection, elivaldogene autotemcel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3391	LENMELDY	Injection, atidarsagene autotemcel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3392	CASGEVY	Injection, exagamglogene autotemcel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3393	ZYNTEGLO	Injection, betibeglogene autotemcel, per treatment	Not Covered	Site of Service
J3394	LYFGENIA	Injection, lovotibeglogene autotemcel, per treatment	Not Covered	Site of Service
J3398	LUXTURNA	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3399	ZOLGENSMA	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10 ¹⁵ vector genomes	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3401	VYJUVEK	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 ⁹ pfu/ml vector genomes, per 0.1 ml	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3403	ENCELTO	Revakinagene taroretcel-lwey, per implant	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3404	PAPZIMEOS	Injection, zopapogene imadenovect-drba suspension, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3405	ITVISMA	Injection, onasemnogene abeparvovec-brve, per treatment	Not Covered	Cellular/Gene Therapy; Site of Service
J3590	TREGZI	Unclassified biologics	Cellular/Gene Therapy	PA; Site of Service
J9029	ADSTILADRIN	Intravesical instillation, nadofaragene firadenovect-vncg, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J9325	IMLYGIC	Injection, talimogene laherparepvec, per 1 million plaque forming units (For billing prior to 1/1/17 use J9999 or C9472 for OPSP billing)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2041	YESCARTA	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (For billing prior to 4/1/18 use J9999 or C9399 for OPSP billing) (Code Price is for drug ONLY) (Code re-used by CMS)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2042	KYMRIA	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code was reused by CMS 1/1/2019) (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q2053	TECARTUS	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2054	BREYANZI	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2054	BREYANZI CD4 COMPONENT (2OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2054	BREYANZI CD8 COMPONENT (1OF 2)	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q2055	ABECMA	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2056	CARVYKTI	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Code Price is for drug only)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2057	TECELRA	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Q2058	AUCATZYL	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion (Split dose infusion; complete therapy=2 separate infusions 10 days apart)	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
Central Nervous System Agents				
<i>Amyotrophic Lateral Sclerosis(Als) Agent</i>				
J1301	edaravone	Injection, edaravone, 1 mg	Non-Preferred	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1301	RADICAVA	Injection, edaravone, 1 mg	Non-Preferred	PA; Site of Service
J1304	QALSODY	Injection, tofersen, 1 mg	Not Covered	Site of Service
Analgesics And Antipyretics, Misc.				
J8499	JOURNAVX	Prescription drug, oral, non-chemotherapeutic, Not Otherwise Specified	Refer to Approved Drug List (ADL)	
Anorexigenic Agents, Miscellaneous				
C9399	ZEPBOUND 10 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	ZEPBOUND 12.5 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
J3490	ZEPBOUND 7.5 MG/0.5 ML VIAL	Unclassified drugs	Refer to Approved Drug List (ADL)	
Anticholinergic Agents (Cns)				
J0515	<i>benztropine injection</i>	Injection, benztropine mesylate, per 1mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antidepressants, Miscellaneous				
J3490	KETALAR	Unclassified drugs	Not Covered	Site of Service; CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
J3490	<i>ketamine injection</i>	Unclassified drugs	Not Covered	Site of Service; CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
J7999	<i>ketamine 50 mg/5 ml-0.9% nacl syringe (compd-rx) sub</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	
J7999	<i>ketamine 50 mg/5 ml-nacl syringe (compd-rx)</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	
J7999	<i>ketamine 50 mg/ml-0.9% nacl syringe (compd-rx)</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	
J7999	<i>ketamine 50 mg/ml-water syringe (compd-rx)</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	
J7999	<i>ketamine hcl 50 mg/ml syringe (compd-rx) sub</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	
J7999	<i>ketamine hcl 50 mg/ml syringe (of-repack) sub</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	
J7999	<i>ketamine in nacl, iso-osmotic intravenous syringe</i>	Compounded drug, not otherwise classified (NDCs listed are for final compounded products only)	Not Covered	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antimanic Agents				
J0401	ABILIFY MAINTENA	Injection, aripiprazole (abilify maintena), 1 mg	Non-Preferred	
J0402	ABILIFY ASIMTUFII	Injection, aripiprazole (abilify asimtufii), 1 mg	Preferred Specialty	
J1943	ARISTADA INITIO	Injection, aripiprazole lauroxil, (aristada initio), 1 mg	Non-Preferred	
J1944	ARISTADA	Injection, aripiprazole lauroxil, (aristada), 1 mg	Non-Preferred	
J2358	ZYPREXA RELPREVV	Injection, olanzapine, long-acting, 1 mg	Non-Specialty	
J2359	<i>olanzapine intramuscular</i>	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2359	ZYPREXA INTRAMUSCULAR	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2794	RISPERDAL CONSTA	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2794	<i>risperidone microspheres</i>	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2798	PERSERIS	Injection, risperidone, (perseris), 0.5 mg	Non-Preferred	
J2799	UZEDY	Injection, risperidone (uzedy), 1 mg	Preferred Specialty	
J3486	GEODON INTRAMUSCULAR	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	
J3486	<i>ziprasidone mesylate</i>	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antimigraine Agents, Miscellaneous				
J0131	<i>acetaminophen 1,000 mg/100 ml bag inner, suv, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml bag outer, suv, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml bag p/f, single use</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml bag single-use, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner, suv, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl inner,suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer, suv, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml vl outer,suv</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0134	<i>acetaminophen 1,000 mg/100 ml bag plf, sub, inner</i>	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0134	<i>acetaminophen 1,000 mg/100 ml bag plf, sub, outer</i>	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0136	<i>acetaminophen 1,000 mg/100 ml bag plf, sub</i>	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0136	<i>acetaminophen 500 mg/50 ml bag single use, plf</i>	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0137	<i>acetaminophen 1,000 mg/100 ml bag inner, single use</i>	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0137	<i>acetaminophen 1,000 mg/100 ml bag outer, single use</i>	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg	Non-Specialty	
J0138	COMBOGESIC IV	Injection, acetaminophen 10 mg and ibuprofen 3 mg	Not Covered	Site of Service
Anxiolytics, Sedatives, And Hypnotics, Misc				
C9399	PRECEDEX 1,000 MCG/250 ML BAG SUB, P/F, INNER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	PRECEDEX 1,000 MCG/250 ML BAG SUV, P/F, OUTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 1,000 MCG/250 ML BTL SINGLE USE, P/F	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, INNER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BAG SUV, P/F, OUTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BOTTLE INNER, SUV, P/F	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	PRECEDEX 200 MCG/50 ML BOTTLE OUTER, SUV, P/F	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, INNER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
C9399	PRECEDEX 200 MCG/50 ML BOTTLE P/F, SUV, OUTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Specialty	
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J3490	PRECEDEX 1,000 MCG/250 ML BTL SINGLE-USE, P/F	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, INNER	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BAG SUV, P/F, OUTER	Unclassified drugs	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3490	PRECEDEX 400 MCG/100 ML BOTTLE INNER, SUV, P/F	Unclassified drugs	Non-Specialty	
J3490	PRECEDEX 400 MCG/100 ML BOTTLE OUTER, SUV, P/F	Unclassified drugs	Non-Specialty	
Atypical Antipsychotics				
J0401	ABILIFY MAINTENA	Injection, aripiprazole (abilify maintena), 1 mg	Non-Preferred	
J0402	ABILIFY ASIMTUFII	Injection, aripiprazole (abilify asimtufii), 1 mg	Preferred Specialty	
J1943	ARISTADA INITIO	Injection, aripiprazole lauroxil, (aristada initio), 1 mg	Non-Preferred	
J1944	ARISTADA	Injection, aripiprazole lauroxil, (aristada), 1 mg	Non-Preferred	
J2358	ZYPREXA RELPREVV	Injection, olanzapine, long-acting, 1 mg	Non-Specialty	
J2359	<i>olanzapine intramuscular</i>	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2359	ZYPREXA INTRAMUSCULAR	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2426	INVEGA SUSTENNA	Injection, paliperidone palmitate extended release (invega sustenna), 1 mg	Preferred Specialty	
J2427	INVEGA HAFYERA	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg	Preferred Specialty	
J2427	INVEGA TRINZA	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg	Preferred Specialty	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2428	ERZOFRI 117 MG/0.75 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera & Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2428	ERZOFRI 156 MG/ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2428	ERZOFRI 234 MG/1.5 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2428	ERZOFRI 351 MG/2.25 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2428	ERZOFRI 39 MG/0.25 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2428	ERZOFRI 78 MG/0.5 ML SYRINGE	Injection, paliperidone palmitate extended release (erzofri), 1 mg	Not Covered	CA (Covered Alternative(s): J2427 - Invega Hafyera ; Invega Trinza (paliperidone palmitate extended release), J2426 - Invega Sustenna (paliperidone palmitate extended release). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2794	RISPERDAL CONSTA	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2794	<i>risperidone microspheres</i>	Injection, risperidone (risperdal consta), 0.5 mg	Preferred Specialty	
J2798	PERSERIS	Injection, risperidone, (perseris), 0.5 mg	Non-Preferred	
J2799	UZEDY	Injection, risperidone (uzedy), 1 mg	Preferred Specialty	
J3486	GEODON INTRAMUSCULAR	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	
J3486	<i>ziprasidone mesylate</i>	Injection, ziprasidone mesylate, 10 mg	Non-Specialty	
Barbiturates (Anticonvulsants)				
J2560	<i>phenobarbital sodium</i>	Injection, phenobarbital sodium, up to 120 mg	Non-Specialty	
J2561	SEZABY	Injection, phenobarbital sodium (sezaby), 1 mg	Not Covered	CA (Covered Alternative(s): J2560 - phenobarbital sodium. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Barbiturates (Anxiolytic, Sedative/Hyp)				
J2560	<i>phenobarbital sodium</i>	Injection, phenobarbital sodium, up to 120 mg	Non-Specialty	
J2561	SEZABY	Injection, phenobarbital sodium (sezaby), 1 mg	Not Covered	CA (Covered Alternative(s): J2560 - phenobarbital sodium. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Benzodiazepines (Anticonvulsants)				
J2060	ATIVAN INJECTION	Injection, lorazepam, 2 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2060	<i>lorazepam injection</i>	Injection, lorazepam, 2 mg	Non-Specialty	
J3360	<i>diazepam injection</i>	Injection, diazepam, up to 5 mg	Non-Specialty	
J3490	<i>midazolam intramuscular</i>	Unclassified drugs	Refer to Approved Drug List (ADL)	
Benzodiazepines (Anxiolytic, Sedative/Hyp)				
J2060	ATIVAN INJECTION	Injection, lorazepam, 2 mg	Non-Specialty	
J2060	<i>lorazepam injection</i>	Injection, lorazepam, 2 mg	Non-Specialty	
J2252	<i>midazolam in nacl, iso-osmo(pf) intravenous solution</i>	Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to j2250, 1 mg	Non-Specialty	
J3360	<i>diazepam injection</i>	Injection, diazepam, up to 5 mg	Non-Specialty	
Butyrophenones				
J1630	<i>haloperidol lac 5 mg/ml syring plf, sub, inner</i>	Injection, haloperidol, up to 5 mg	Non-Specialty	
J1630	<i>haloperidol lac 5 mg/ml syring plf, sub, outer</i>	Injection, haloperidol, up to 5 mg	Non-Specialty	
J1630	<i>haloperidol lactate injection</i>	Injection, haloperidol, up to 5 mg	Non-Specialty	
J1631	<i>haloperidol decanoate</i>	Injection, haloperidol decanoate, per 50 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Calcitonin Gene-Related Peptide Antag.				
J3031	AJOVY AUTOINJECTOR	Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	
J3031	AJOVY SYRINGE	Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	
J3032	VYEPTI	Injection, eptinezumab-jjmr, 1 mg	Non-Preferred	PA
Central Nervous System Agents, Misc.				
J3490	VYLEESI	Unclassified drugs	Refer to Approved Drug List (ADL)	
Dibenzoxapines				
J2062	ADASUVE	Loxapine for inhalation, 1 mg	Not Covered	Site of Service; CC (No PA Required - Inpatient Use Only)
Dopamine Precursors				
J7340	DUOPA	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 mL	Non-Preferred	PA
J7356	VYALEV	Injection, foscarnidopa 0.25 mg/foslevodopa 5 mg	Not Covered	Site of Service
Nmda Antagonists				
J0013	SPRAVATO	Esketamine, nasal spray, 1 mg	Non-Preferred	PA

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Non-Barbiturates				
J3490	KETALAR	Unclassified drugs	Not Covered	Site of Service; CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
J3490	<i>ketamine injection</i>	Unclassified drugs	Not Covered	Site of Service; CC (Anesthetic agent - covered only when billed in conjunction with an anesthesia service for a covered procedure. Ketamine is not covered as a stand-alone injection for ANY reason for ANY plan.)
Nonergot-Deriv.Dopamine Receptor Agonist				
C9399	ONAPGO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Non-Preferred	PA; Site of Service
J0364	APOKYN	Injection, apomorphine hydrochloride, 1 mg	Refer to Approved Drug List (ADL)	
J0364	<i>apomorphine</i>	Injection, apomorphine hydrochloride, 1 mg	Refer to Approved Drug List (ADL)	
Non-Opioid Analgesics				
J0131	<i>acetaminophen 1,000 mg/100 ml bag inner, suv, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	
J0131	<i>acetaminophen 1,000 mg/100 ml bag outer, suv, p/f</i>	Injection, acetaminophen, not otherwise specified, 10 mg	Non-Specialty	

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

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

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1171	DILAUDID 1 MG/ML SYRINGE SUV, P/F, OUTER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 2 MG/ML SYRINGE SUV, P/F, INNER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	DILAUDID 2 MG/ML SYRINGE SUV, P/F, OUTER	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	<i>hydromorphone (pf)</i>	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J1171	<i>hydromorphone injection</i>	Injection, hydromorphone, 0.1 mg	Non-Specialty	
J2175	DEMEROL	Injection, meperidine hydrochloride, per 100 mg	Non-Specialty	
J2175	DEMEROL (PF)	Injection, meperidine hydrochloride, per 100 mg	Non-Specialty	
J2175	<i>meperidine (pf)</i>	Injection, meperidine hydrochloride, per 100 mg	Non-Specialty	
Opioid Antagonists (28:10)				
J2315	VIVITROL	Injection, naltrexone, depot form, 1 mg	Preferred Specialty	
Opioid Partial Agonists				
J0577	BRIXADI	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	Preferred Specialty	
J0578	BRIXADI	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	Preferred Specialty	
J0592	<i>buprenorphine hcl injection</i>	Injection, buprenorphine hydrochloride, 0.1 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q9991	SUBLOCADE	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg (For billing prior to 7/1/18 use J3490 or C9399 for Hospital OPPS use) (Code Price is per 100 mg)	Preferred Specialty	
Q9992	SUBLOCADE	Injection, buprenorphine extended-release (Sublocade), greater than 100 mg (For billing prior to 7/1/18 use J3490 or C9399 for Hospital OPPS use) (Code Price is per 300 mg)	Preferred Specialty	
Phenothiazines				
J2679	<i>fluphenazine hcl injection</i>	Injection, fluphenazine hcl, 1.25 mg	Non-Specialty	
J2680	<i>fluphenazine decanoate</i>	Injection, fluphenazine decanoate, up to 25 mg	Non-Specialty	
J3230	<i>chlorpromazine injection</i>	Injection, chlorpromazine HCl, up to 50 mg	Non-Specialty	
Reversible Cox-1/Cox-2 Inhibitors				
J0138	COMBOGESIC IV	Injection, acetaminophen 10 mg and ibuprofen 3 mg	Not Covered	Site of Service
J0668	ZYNRELEF	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	Not Covered	Site of Service
J1737	XIFYRM	Injection, meloxicam (azurity), 1 mg	Not Covered	Site of Service

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HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Devices				
Devices				
J7318	DUROLANE	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	Not Covered	Site of Service
J7320	GENVISC 850	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg (Code re-used by CMS effective 1/1/17) (GenVisc 850 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	Site of Service
J7321	HYALGAN	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL, Supartz and Visco-3 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	Site of Service
J7321	SUPARTZ FX	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL, Supartz and Visco-3 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7321	VISCO-3	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL, Supartz and Visco-3 dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)	Not Covered	Site of Service
J7322	HYMOVIS	Hyaluronan or derivative, hymovis or hymovis one, for intra-articular injection, 1 mg	Not Covered	Site of Service
J7322	HYMOVIS ONE	Hyaluronan or derivative, hymovis or hymovis one, for intra-articular injection, 1 mg	Not Covered	Site of Service
J7323	EUFLEXXA	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose (20 mg/2 mL) (Note: Total dose regimen = 3 injections)	Not Covered	Site of Service
J7324	ORTHOVISC	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL) (Note: Total dose regimen = 3 - 4 injections)	Not Covered	Site of Service
J7325	SYNIVISC	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg (For billing prior to 1/1/10 see J7322 for Synvisc and J3490 for Synvisc-One)	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7325	SYNVISC-ONE	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg (For billing prior to 1/1/10 see J7322 for Synvisc and J3490 for Synvisc-One)	Not Covered	Site of Service
J7326	GEL-ONE	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	Not Covered	Site of Service
J7327	MONOVISC	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose (For billing prior to 1/1/15 use C9399 or J3490) (Dose 88 mg/4 mL) (Note: Total dose regimen = 1 dose)	Not Covered	Site of Service
J7328	GELSYN-3	Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg	Not Covered	Site of Service
J7329	TRIVISC	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	Not Covered	Site of Service
J7331	SYNOJOYNT 1% 20 MG/2 ML SYRING	Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg	Not Covered	Site of Service
J7332	TRILURON	Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg	Not Covered	Site of Service
Diagnostic Agents				
Adrenocortical Insufficiency				
J0801	ACTHAR	Injection, corticotropin (acthar gel), up to 40 units	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0801	ACTHAR SELFJECT	Injection, corticotropin (acthar gel), up to 40 units	Refer to Approved Drug List (ADL)	
J0802	CORTROPHIN GEL	Injection, corticotropin (ani), up to 40 units	Refer to Approved Drug List (ADL)	
Diagnostic Agents				
A9596	ILLUCCIX	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie (NDC Unit Pricing is based on 7 mCi dose)	Non-Specialty	
J1611	<i>glucagon 1 mg vial inner, suv</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial outer, suv</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial suv, inner</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial suv, outer</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1611	<i>glucagon 1 mg vial sub,inner</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon 1 mg vial sub,outer</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1612	GVOKE VIALDX 1 MG/0.2 ML VIAL INNER, SUV	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
J1612	GVOKE VIALDX 1 MG/0.2 ML VIAL OUTER, SUV	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
Gallbladder Function				
J2805	KINEVAC	Injection, sincalide, 5 micrograms	Non-Specialty	
J2805	<i>sincalide</i>	Injection, sincalide, 5 micrograms	Non-Specialty	
Kidney Function				
J2151	<i>mannitol 20 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 10% (50 GM/500 ML) VIAFLEX, SINGLE USE	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 20 %	Injection, mannitol, 250 mg	Non-Specialty	
Myasthenia Gravis				
J2710	BLOXIVERZ	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine 3 mg/3 ml syringe inner, sub</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2710	<i>neostigmine 3 mg/3 ml syringe outer, sub</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
J2710	<i>neostigmine methylsulfate intravenous solution</i>	Injection, neostigmine methylsulfate, up to 0.5 mg	Non-Specialty	
Roentgenography And Other Imaging Agents				
A9585	PIXXOSCAN	Injection, gadobutrol, 0.1 mL (For billing prior to 1/1/12 use J3490 or C9399)	Not Covered	Site of Service
Thyroid Function				
J3240	THYROGEN	Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial (Code Price is per 1 vial)	Preferred Specialty	
Electrolytic, Caloric, And Water Balance				
Electrolytic, Caloric, Water Balance Misc,				
J0584	CRYSVITA	Injection, burosumab-twza 1 mg	Preferred Specialty	PA; Site of Service
Irrigating Solutions				
J2151	<i>mannitol 20 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 10% (50 GM/500 ML) VIAFLEX, SINGLE USE	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 20 %	Injection, mannitol, 250 mg	Non-Specialty	
Loop Diuretics (40:28)				
J1807	<i>ethacrynate sodium</i>	Injection, ethacrynate sodium, 1 mg	Not Covered	Site of Service
J1938	<i>furosemide injection</i>	Injection, furosemide, 1 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1941	FUROSCIX	Injection, furosemide (furoscix), 20 mg	Not Covered	Site of Service
J1941	FUROSCIX READYFLOW	Injection, furosemide (furoscix), 20 mg	Not Covered	Site of Service
Osmotic Diuretics (40:28)				
J2151	mannitol 20 %	Injection, mannitol, 250 mg	Non-Specialty	
J2151	mannitol 25 %	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 10% (50 GM/500 ML) VIAFLEX, SINGLE USE	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 20 %	Injection, mannitol, 250 mg	Non-Specialty	
Phosphate-Removing Agents				
J0607	FOSRENOL	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)	Refer to Approved Drug List (ADL)	
J0607	lanthanum	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)	Refer to Approved Drug List (ADL)	
J0608	FOSRENOL	Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to j0607 (for esrd on dialysis)	Refer to Approved Drug List (ADL)	
J0609	AURYXIA	Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0615	<i>calcium acetate</i>	Calcium acetate, oral, 23 mg (for esrd on dialysis)	Refer to Approved Drug List (ADL)	
J0615	<i>calcium acetate(phosphat bind)</i>	Calcium acetate, oral, 23 mg (for esrd on dialysis)	Refer to Approved Drug List (ADL)	
Replacement Preparations				
C9399	ZYCUBO	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)	Refer to Approved Drug List (ADL)	
J3490	<i>potassium phos in 0.9 % nacl intravenous piggyback</i>	Unclassified drugs	Non-Specialty	
Enzymes				
Enzyme Inhibitors				
J1202	OPFOLDA	Miglustat, oral, 65 mg	Preferred Specialty	PA; Site of Service
Enzymes				
C9399	REVCovi	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	PA
J0180	FABRAZYME	Injection, agalsidase beta, 1 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0217	LAMZEDE	Injection, velmanase alfa-tycv, 1 mg	Preferred Specialty	PA; Site of Service
J0218	XENPOZYME	Injection, olipudase alfa-rpcp, 1 mg	Preferred Specialty	PA; Site of Service
J0219	NEXVIAZYME	Injection, avalglucosidase alfa-ngpt, 4 mg	Non-Preferred	PA; Site of Service
J0221	LUMIZYME	Injection, alglucosidase alfa, (Lumizyme), 10 mg (For billing prior to 1/1/12 use J3590 or C9277)	Preferred Specialty	PA; Site of Service
J0567	BRINEURA INTRAVENTRICULAR KIT	Injection, cerliponase alfa, 1 mg	Preferred Specialty	PA
J0775	XIAFLEX	Injection, collagenase, clostridium histolyticum, 0.01 mg (For billing prior to 1/1/11 use J3590 or C9266)	Preferred Specialty	PA
J1203	POMBILITI	Injection, cipaglucosidase alfa-atga, 5 mg	Preferred Specialty	PA; Site of Service
J1322	VIMIZIM	Injection, elosulfase alfa, 1 mg (For billing prior to 1/1/15 use C9022 or J3590)	Preferred Specialty	PA; Site of Service
J1458	NAGLAZYME	Injection, galsulfase, 1 mg	Preferred Specialty	PA; Site of Service
J1743	ELAPRASE	Injection, idursulfase, 1 mg	Preferred Specialty	PA; Site of Service
J1786	CEREZYME	Injection, imiglucerase, 10 units	Preferred Specialty	PA; Site of Service
J1931	ALDURAZYME	Injection, laronidase, 0.1 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2508	ELFABRIO	Injection, pegunigalsidase alfa-iwxj, 1 mg	Preferred Specialty	PA; Site of Service
J2783	ELITEK	Injection, rasburicase, 0.5 mg	Non-Specialty	
J2840	KANUMA	Injection, sebelipase alfa, 1 mg (For billing prior to 1/1/17 use J3590 or C9478 for OPPS billing)	Preferred Specialty	PA; Site of Service
J3060	ELELYSO	Injection, taliglucerase alfa, 10 units	Preferred Specialty	PA; Site of Service
J3385	VPRIV	Injection, velaglucerase alfa, 100 units (For billing prior to 1/1/11 use J3490 or C9271)	Preferred Specialty	PA; Site of Service
J3397	MEPSEVII	Injection, vestronidase alfa-vjbk, 1 mg	Not Covered	Site of Service
J7171	ADZYNMA	Injection, adamts13, recombinant-krhn, 10 iu	Preferred Specialty	PA; Site of Service
J7639	PULMOZYME	Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram	Refer to Approved Drug List (ADL)	
J9021	RYLAZE	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	Preferred Specialty	PA
J9118	ASPARLAS	Injection, calaspargase pegol-mknl, 10 units	Non-Preferred	PA; No PA required for ICD-10 codes C91.00 - C91.02 , C83.50 - C83.59.
Eye, Ear, Nose And Throat (Eent) Preps.				
Antibacterials (52:04)				
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J2280	<i>moxifloxacin-sod.chloride(iso)</i>	Injection, moxifloxacin, 100 mg	Non-Specialty	
J2281	<i>moxifloxacin-sod.ace,sul-water</i>	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg	Non-Specialty	
Antiglaucoma Agents, Miscellaneous				
J7315	MITOSOL	Mitomycin, ophthalmic, 0.2 mg (Code re-used by CMS effective 1/1/13) (For billing prior to 1/1/13 use J3490 or C9399)	Non-Specialty	
Anti-Inflammatory Agents (Eent)				
C9399	LUMVOA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Preferred Specialty	PA; Site of Service
J3241	TEPEZZA	Injection, teprotumumab-trbw, 10 mg	Preferred Specialty	PA; Site of Service
J7516	<i>cyclosporine 250 mg/5 ml ampul p/f, suv, inner</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	<i>cyclosporine 250 mg/5 ml ampul p/f, suv, outer</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	<i>cyclosporine 250 mg/5 ml ampul suv</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	SANDIMMUNE INTRAVENOUS	Injection, cyclosporine, 250 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antivirals (Eent)				
J1570	<i>ganciclovir sodium</i>	Injection, ganciclovir sodium, 500 mg	Non-Specialty	
Corticosteroids (Eent)				
J1095	DEXYCU (PF)	Injection, dexamethasone 9 percent, intraocular, 1 microgram (Code reused by CMS January 1, 2019) (Each single dose vial provides a 0.005 mL dose equivalent to 517 micrograms)	Not Covered	Site of Service
J3299	XIPERE (PF)	Injection, triamcinolone acetonide (xipere), 1 mg	Not Covered	Site of Service
J7311	RETISERT	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	Not Covered	Site of Service
J7312	OZURDEX	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311E10.321 -E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.353, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.353, H30.001-H30.93, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390.

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7313	ILUVIEN	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311, E10.321-E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.3513, H30.001-H30.039, H30.20-H30.23, H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7314	YUTIQ 0.18 MG IMPLANT	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes H30.001-H30.039, H30.20-H30.23, H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7402	SINUVA	Mometasone furoate sinus implant, (sinuva), 10 micrograms	Not Covered	Site of Service
Eent Drugs, Miscellaneous				
J2779	SUSVIMO 10 MG/0.1 ML KIT	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	Not Covered	CA (Covered Alternative(s): J2778 - Lucentis (ranibizumab), Q5124 - Byooviz (ranibizumab-nuna), Q5128 - Cimerli (ranibizumab-eqrn). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J2787	PHOTREXA CROSS-LINKING KIT	Riboflavin 5'-phosphate, ophthalmic solution (photrexa viscous/photrexa), up to 3 ml	Preferred Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5124	BYOOVIZ	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	Preferred Specialty	PA
Eent Nonsteroidal Anti-Inflam. Agents				
J1097	OMIDRIA	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Non-Specialty	
Local Anesthetics (Eent)				
J2403	IHEEZO (PF)	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	Not Covered	Site of Service
Macular Degeneration Agents				
J2781	SYFOVRE (PF)	Injection, pegcetacoplan, intravitreal, 1 mg	Preferred Specialty	PA
J2782	IZERVAY (PF)	Injection, avacincapted pegol, 0.1 mg	Not Covered	Site of Service
J3396	VISUDYNE	Injection, verteporfin, 0.1 mg	Preferred Specialty	PA; No PA required for ICD-10 codes B39.4,B39.5, H32,H35.3210-H35.3233, H35.711 - H35.713, H44.20-H44.2E9.
Mydriatics				
J1097	OMIDRIA	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Non-Specialty	
J2371	<i>phenylephrine hcl injection</i>	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2371	VAZCULEP	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
Osmotic Agents				
J2151	<i>mannitol 20 %</i>	Injection, mannitol, 250 mg	Non-Specialty	
J2151	<i>mannitol 25 %</i>	Injection, mannitol, 250 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2151	OSMITROL 10% (50 GM/500 ML) VIAFLEX, SINGLE USE	Injection, mannitol, 250 mg	Non-Specialty	
J2151	OSMITROL 20 %	Injection, mannitol, 250 mg	Non-Specialty	
Prostaglandin Analogs				
J7351	DURYSTA	Injection, bimatoprost, intracameral implant, 1 microgram	Not Covered	Site of Service
J7355	IDOSE TR	Injection, travoprost, intracameral implant, 1 microgram	Not Covered	Site of Service
Vascular Endothelial Growth Factor Antag				
J0177	EYLEA HD	Injection, aflibercept hd, 1 mg	Preferred Specialty	PA
J0178	EYLEA	Injection, aflibercept, 1 mg	Preferred Specialty	PA
J0179	BEOVU	Injection, brolucizumab-dbl, 1 mg	Non-Preferred	PA; No PA required for ICD-10 codes H35.3210-H35.3213, H35.3220-H35.3223, H35.3230-H35.3233, H35.3290-H35.3293.
J2777	VABYSMO	Injection, faricimab-svoa, 0.1 mg	Preferred Specialty	PA
J2778	LUCENTIS INTRAVITREAL SYRINGE	Injection, ranibizumab, 0.1 mg	Non-Preferred	PA
J2779	SUSVIMO	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	Not Covered	Site of Service
Q5128	CIMERLI	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	Preferred Specialty	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5147	PAVBLU	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	Preferred Specialty	PA
Q5155	YESAFILI	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	Not Covered	Site of Service
Q5168	NUFYMCO	Injection, ranibizumab-leyk (nufymco), biosimilar, 0.1 mg	Not Covered	Site of Service
Vasoconstrictors				
J1097	OMIDRIA	phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Non-Specialty	
J2371	<i>phenylephrine hcl injection</i>	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
J2371	VAZCULEP	Injection, phenylephrine hydrochloride, 20 micrograms	Non-Specialty	
Gastrointestinal Drugs				
5-Ht₃ Receptor Antagonists				
J1454	AKYNZEO (FOSNETUPITANT)	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	Non-Specialty	
J1626	<i>granisetron (pf)</i>	Injection, granisetron hydrochloride, 100 mcg	Non-Specialty	
J1626	<i>granisetron hcl intravenous</i>	Injection, granisetron hydrochloride, 100 mcg	Non-Specialty	
J1627	SUSTOL	Injection, granisetron, extended-release, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9486 for OPPS billing)	Not Covered	Site of Service
J2405	<i>ondansetron hcl (pf)</i>	Injection, ondansetron hydrochloride, per 1 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2405	<i>ondansetron hcl intravenous</i>	Injection, ondansetron hydrochloride, per 1 mg	Non-Specialty	
J2468	POSFREA	Injection, palonosetron hydrochloride (posfrea), 25 micrograms	Preferred Specialty	
J2469	<i>palonosetron</i>	Injection, palonosetron HCl, 25 mcg	Preferred Specialty	
Antiemetics, Miscellaneous				
J2358	ZYPREXA RELPREVV	Injection, olanzapine, long-acting, 1 mg	Non-Specialty	
J2359	<i>olanzapine intramuscular</i>	Injection, olanzapine, 0.5 mg	Preferred Specialty	
J2359	ZYPREXA INTRAMUSCULAR	Injection, olanzapine, 0.5 mg	Preferred Specialty	
Antiulcer Agents And Acid Suppressants				
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
Digestants				
J3490	GATTEX 30-VIAL	Unclassified drugs	Refer to Approved Drug List (ADL)	
J3490	GATTEX ONE-VIAL	Unclassified drugs	Refer to Approved Drug List (ADL)	
Dopamine Receptor Antagonists				
J0184	BARHEMSYS	Injection, amisulpride, 1 mg	Not Covered	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
GI Drugs, Miscellaneous				
J1440	REBYOTA	Fecal microbiota, live - jsml, 1 ml (Code reused effective 7/1/2023)	Not Covered	Site of Service
Histamine H2-Antagonists				
J1308	<i>famotidine (pf)-nacl (iso-os)</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial 25's, sdv, p/f, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial inner, p/f, suv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial inner, suv, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial outer, p/f, suv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial outer, suv, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, inner, sdv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, outer, sdv</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, suv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial p/f, suv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1308	<i>famotidine 20 mg/2 ml vial sdv,p/f,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 20 mg/2 ml vial suv, p/f</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial 10's,mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mdv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial mdv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial muv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 200 mg/20 ml vial muv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial mdv,outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial muv, inner</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial muv, outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	
J1308	<i>famotidine 40 mg/4 ml vial outer</i>	Injection, famotidine, 0.25 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Immunomodulatory Agents (56:44)				
J2267	OMVOH INTRAVENOUS	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	Non-Preferred	PA
J2267	OMVOH PEN	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
J2267	OMVOH SUBCUTANEOUS	Injection, mirikizumab-mrkz, 1 mg (Code Price is based on Median Pricing Methodology)	Refer to Approved Drug List (ADL)	
Neurokinin-1 Receptor Antagonists				
J0185	CINVANTI	Injection, aprepitant, 1 mg	Non-Specialty	
J1434	FOCINVEZ	Injection, fosaprepitant (focinvez), 1 mg	Not Covered	CA (Covered Alternative(s): J1453 - Emend (fosaprepitant), J1456 - fosaprepitant (teva). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1453	EMEND (FOSAPREPITANT)	Injection, fosaprepitant, 1 mg	Non-Specialty	
J1453	<i>fosaprepitant</i>	Injection, fosaprepitant, 1 mg	Non-Specialty	
J1454	AKYNZEO (FOSNETUPITANT)	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	Non-Specialty	
J1456	<i>fosaprepitant</i>	Injection, fosaprepitant (teva), not therapeutically equivalent to j1453, 1 mg	Non-Specialty	
J3490	NAVITRUX	Unclassified drugs	Not Covered	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J8502	APONVIE	Injection, aprepitant (aponvie), 1 mg	Preferred Specialty	
Opioid Antagonists (56:18)				
J2212	RELISTOR SUBCUTANEOUS	Injection, methylnaltrexone, 0.1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Not Covered	Site of Service
Proton-Pump Inhibitors				
J1370	<i>esomeprazole sodium</i>	Injection, esomeprazole sodium, 1 mg	Not Covered	Site of Service
J2470	<i>pantoprazole intravenous</i>	Injection, pantoprazole sodium, 40 mg	Non-Specialty	
J2470	PROTONIX INTRAVENOUS	Injection, pantoprazole sodium, 40 mg	Non-Specialty	
J2471	<i>pantoprazole intravenous</i>	Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg	Non-Specialty	
J2472	<i>pantoprazole in 0.9% sod chlor</i>	Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg	Non-Specialty	
Heavy Metal Antagonists				
Heavy Metal Antagonists				
J0600	<i>edetate calcium disodium</i>	Injection, edetate calcium disodium, up to 1000 mg	Non-Specialty	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, 56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0895	<i>deferoxamine 2 gram vial p/f, sub</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 2 gram vial sub</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 2 gram vial sub, inner</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0 - D56.9, D57.00 - D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 2 gram vial sub, inner</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0895	<i>deferoxamine 2 gram vial sub, outer</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 2 gram vial sub,inner</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 2 gram vial sub,outer</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 500 mg vial inner</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0895	<i>deferoxamine 500 mg vial outer</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 500 mg vial sub</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 500 mg vial sub, inner</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.
J0895	<i>deferoxamine 500 mg vial sub, outer</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94xS, T57.0x1A - T57.0X4S, T80.92xA - T80.92xS.

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0895	<i>deferoxamine 500 mg vial sub,inner</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94x4S, T57.0x1A - T57.0x4S, T80.92x1A - T80.92x4S.
J0895	<i>deferoxamine 500 mg vial sub,outer</i>	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94x4S, T57.0x1A - T57.0x4S, T80.92x1A - T80.92x4S.
J0895	DESFERAL MESYLATE 500 MG VL INNER,SUV	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	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, T56.91x1A - T56.94x4S, T57.0x1A - T57.0x4S, T80.92x1A - T80.92x4S.
J0895	DESFERAL MESYLATE 500 MG VL OUTER,SUV	Injection, deferoxamine mesylate, 500 mg	Non-Preferred	PA; No PA required for ICD-10 codes D56.0-D56.9, D57.00-D57.819, E72.00 - E72.09, E83.00 - E83.09, E83.10 - E83.19, E83.52, K74.3, K74.4, K74.5, T56.0x1A - T56.0x4S, T56.1x1A - T56.1x4S, T56.3x1A - T56.3x4S, T56.4x1A - T56.4x4S, T56.5x1A - T56.5x4S, T56.811A - T56.814S, T56.891A - T56.894S, T56.91x1A - T56.94x4S, T57.0x1A - T57.0x4S, T80.92x1A - T80.92x4S.

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Hormones And Synthetic Substitutes				
Adrenals				
J1010	DEPO-MEDROL	Injection, methylprednisolone acetate, 1 mg	Non-Specialty	
J1010	<i>methylprednisolone acetate</i>	Injection, methylprednisolone acetate, 1 mg	Non-Specialty	
J2919	<i>methylprednisolone sodium succ</i>	Injection, methylprednisolone sodium succinate, 5 mg	Non-Specialty	
J2919	SOLU-MEDROL	Injection, methylprednisolone sodium succinate, 5 mg	Non-Specialty	
J2919	SOLU-MEDROL (PF)	Injection, methylprednisolone sodium succinate, 5 mg	Non-Specialty	
J3304	ZILRETTA	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Not Covered	Site of Service
J7312	OZURDEX	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311-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-H30.93, H34.8110, H34.8120, H34.8130, H34.8310, H34.8320, H34.8330, H34.8390.
J7402	SINUVA	Mometasone furoate sinus implant, (sinuva), 10 micrograms	Not Covered	Site of Service

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Androgens				
J1072	AZMIRO	Injection, testosterone cypionate (azmiro), 1 mg	Not Covered	Site of Service
J1073	TESTOPEL	Testosterone pellet, implant, 75 mg	Non-Specialty	PA
J3145	AVEED	Injection, testosterone undecanoate, 1 mg (For billing prior to 1/1/15 use C9023 or J3490)	Non-Specialty	PA
Antidiabetic Agents, Miscellaneous				
J9381	TZIELD	Injection, teplizumab-mzwv, 5 mcg	Non-Preferred	PA; Site of Service
Antigonadotropins				
J1072	AZMIRO	Injection, testosterone cypionate (azmiro), 1 mg	Not Covered	Site of Service
J1073	TESTOPEL	Testosterone pellet, implant, 75 mg	Non-Specialty	PA
J3145	AVEED	Injection, testosterone undecanoate, 1 mg (For billing prior to 1/1/15 use C9023 or J3490)	Non-Specialty	PA
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7296	KYLEENA	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	Refer to Contraceptive Coverage	
J7301	SKYLA	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	Refer to Contraceptive Coverage	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	Refer to Contraceptive Coverage	
J9155	FIRMAGON	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.
J9155	FIRMAGON KIT W DILUENT SYRINGE	Injection, degarelix, 1 mg (For billing prior to 1/1/10 use J9999 or C9399)	Non-Specialty	PA; No PA required for ICD-10 codes C61, C79.82 and D07.5.

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Priority Health Employer group & MyPriority Plans

HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antiparathyroid Agents				
J0606	PARSABIV	Injection, etelcalcetide, 0.1 mg (For billing prior to 1/1/18 use J3490 or C9399 for OPPS billing)	Non- Preferred	PA
Contraceptives				
J7294	ANNOVERA	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each	Refer to Approved Drug List (ADL)	
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	

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

Priority Health Employer group & MyPriority Plans

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

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
Glycogenolytic Agents				
J1610	GLUCAGON EMERGENCY KIT (HUMAN)	Injection, glucagon hydrochloride, per 1 mg	Non-Specialty	
J1611	GLUCAGON (HCL) EMERGENCY KIT	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1611	<i>glucagon hcl</i>	Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg	Non-Specialty	
J1612	GVOKE HYPOPEN 1-PK 1 MG/0.2 ML	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
J1612	GVOKE VIALDX 1 MG/0.2 ML VIAL INNER, SUV	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
J1612	GVOKE VIALDX 1 MG/0.2 ML VIAL OUTER, SUV	Injection, glucagon (gvoke), 0.01 mg	Non-Specialty	
Gonadotropins				
J1950	LUPRON DEPOT 11.25 MG 3MO KIT 3 MONTH, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service
J1950	LUPRON DEPOT 3.75 MG KIT P/F, SUV	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1950	LUPRON DEPOT-PED	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1950	LUPRON DEPOT-PED (3 MONTH)	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Preferred Specialty	
J1951	FENSOLVI	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	Preferred Specialty	Site of Service
J1952	CAMCEVI (6 MONTH)	Leuprolide injectable, camcevi, 1 mg	Preferred Specialty	Site of Service
J3315	TRELSTAR	Injection, triptorelin pamoate, 3.75 mg	Non-Specialty	
J3316	TRIPTODUR	Injection, triptorelin, extended-release, 3.75 mg	Non-Preferred	
J9202	ZOLADEX	Goserelin acetate implant, per 3.6 mg	Preferred Specialty	
J9217	ELIGARD	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	ELIGARD (3 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

Priority Health Employer group & MyPriority Plans

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

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9217	LUPRON DEPOT (6 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	LUPRON DEPOT 22.5 MG 3MO KIT SUV, P/F	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	LUPRON DEPOT 7.5 MG 1 MONTH KT SINGLE DOSE	Leuprolide acetate (for depot suspension), 7.5 mg	Preferred Specialty	CA (Covered Alternative(s): J9217 - Eligard, J9217 - Lupron Depot. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9217	VABRINTY (1 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Not Covered	Site of Service
J9217	VABRINTY (4 MONTH)	Leuprolide acetate (for depot suspension), 7.5 mg	Not Covered	Site of Service
J9218	<i>leuprolide</i>	Leuprolide acetate, per 1 mg	Non-Specialty	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9226	SUPPRELIN LA	Histrelin implant (Supprelin LA), 50 mg	Non-Preferred	PA
Incretin Mimetics				
C9399	ZEPBOUND 10 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	ZEPBOUND 12.5 MG/0.5 ML VIAL	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	ZEPBOUND SUBCUTANEOUS PEN INJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
J3490	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, INNER	Unclassified drugs	Refer to Approved Drug List (ADL)	
J3490	ZEPBOUND 2.5 MG/0.5 ML VIAL SUV, P/F, OUTER	Unclassified drugs	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3490	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, INNER	Unclassified drugs	Refer to Approved Drug List (ADL)	
J3490	ZEPBOUND 5 MG/0.5 ML VIAL SUV, P/F, OUTER	Unclassified drugs	Refer to Approved Drug List (ADL)	
J3490	ZEPBOUND 7.5 MG/0.5 ML VIAL	Unclassified drugs	Refer to Approved Drug List (ADL)	
J3490	ZEPBOUND SUBCUTANEOUS PEN INJECTOR	Unclassified drugs	Refer to Approved Drug List (ADL)	
Insulins				
J1815	LANGLARA U-100 INSULIN	Injection, insulin, per 5 units	Refer to Approved Drug List (ADL)	
Long-Acting Insulins				
J1815	LANGLARA U-100 INSULIN	Injection, insulin, per 5 units	Refer to Approved Drug List (ADL)	
Melanocortin Receptor Agonists				
J7352	SCENESSE	Afamelanotide implant, 1 mg	Preferred Specialty	PA

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Parathyroid Agents				
J3110	FORTEO	Injection, teriparatide, 10 mcg	Refer to Approved Drug List (ADL)	
J3110	<i>teriparatide</i>	Injection, teriparatide, 10 mcg	Refer to Approved Drug List (ADL)	
J3490	YORVIPATH	Unclassified drugs	Refer to Approved Drug List (ADL)	
Pituitary				
J0801	ACTHAR	Injection, corticotropin (acthar gel), up to 40 units	Refer to Approved Drug List (ADL)	
J0801	ACTHAR SELFJECT	Injection, corticotropin (acthar gel), up to 40 units	Refer to Approved Drug List (ADL)	
J0802	CORTROPHIN GEL	Injection, corticotropin (ani), up to 40 units	Refer to Approved Drug List (ADL)	
J2596	<i>vasopressin in 0.9 % sod chlor intravenous solution</i>	Injection, vasopressin (long grove), not therapeutically equivalent to j2598, 1 unit	Non-Specialty	
J2597	DDAVP INJECTION	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2597	<i>desmopressin injection</i>	Injection, desmopressin acetate, per 1 mcg	Non-Specialty	
J2598	<i>vasopressin</i>	Injection, vasopressin, 1 unit	Non-Specialty	
J2598	VASOSTRICT	Injection, vasopressin, 1 unit	Non-Specialty	
J2599	<i>vasopressin</i>	Injection, vasopressin (american reagent), not therapeutically equivalent to j2598, 1 unit	Non-Specialty	
J2601	<i>vasopressin in 0.9 % sod chlor intravenous solution</i>	Injection, vasopressin (baxter), 1 unit	Non-Specialty	
J2941	GENOTROPIN	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	GENOTROPIN MINIQUEL	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	HUMATROPE	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	NORDITROPIN FLEXP	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	NUTROPIN AQ NUSPIN 10 INJECTOR	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2941	NUTROPIN AQ NUSPIN 20 INJECTOR	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	NUTROPIN AQ NUSPIN 5 INJECTOR	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	OMNITROPE	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	SAIZEN SAIZENPREP	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	SEROSTIM	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J2941	ZOMACTON	Injection, somatropin, 1 mg	Refer to Approved Drug List (ADL)	
J3590	NGENLA	Unclassified biologics	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Progestins				
J7295	ELURYNG	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	ENILLORING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	<i>etonogestrel-ethinyl estradiol</i>	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	HALOETTE	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7295	NUVARING	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	Refer to Approved Drug List (ADL)	
J7296	KYLEENA	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg (For billing prior to 1/1/18 use Q9984)	Refer to Contraceptive Coverage	
J7301	SKYLA	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	Refer to Contraceptive Coverage	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)	Refer to Contraceptive Coverage	
Somatostatin Agonists				
J1930	<i>lanreotide</i>	Injection, lanreotide, 1 mg (Code re-used by CMS effective 1/1/2009)	Non-Specialty	
J1930	SOMATULINE DEPOT	Injection, lanreotide, 1 mg (Code re-used by CMS effective 1/1/2009)	Non-Specialty	
J1932	<i>lanreotide</i>	Injection, lanreotide, (cipl), 1 mg	Non-Specialty	
J2353	<i>octreotide,microspheres</i>	Injection, octreotide, depot form for intramuscular injection, 1 mg	Preferred Specialty	
J2353	SANDOSTATIN LAR DEPOT	Injection, octreotide, depot form for intramuscular injection, 1 mg	Preferred Specialty	
J2354	BYNFEZIA	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	Refer to Approved Drug List (ADL)	
J2502	SIGNIFOR LAR	Injection, pasireotide long acting, 1 mg (Code Price is based on Median pricing methodology due to flat pricing) (For billing prior to 1/1/16 use C9454 or J3490)	Non-Preferred	PA

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Somatotropin Agonists				
C9399	EGRIFTA SV	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	EGRIFTA WR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
J2170	INCRELEX	Injection, mecasermin, 1 mg	Refer to Approved Drug List (ADL)	
Thyroid Agents				
J0650	<i>levothyroxine intravenous</i>	Injection, levothyroxine sodium, not otherwise specified, 10 mcg	Non-Specialty	
J0651	<i>levothyroxine intravenous</i>	Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to j0650, 10 mcg	Non-Specialty	
J0652	<i>levothyroxine intravenous</i>	Injection, levothyroxine sodium (hikma), not therapeutically equivalent to j0650, 10 mcg	Non-Specialty	
Immunomodulatory Agents (90:00)				
Antimetabolites				
J9065	<i>cladribine</i>	Injection, cladribine, per 1 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
April Or Baff Inhibitor Agents				
C9399	TRUTAKNA	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)	Refer to Approved Drug List (ADL)	
C9399	VOYXACT	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
Bone-Modifying Agents				
J0897	PROLIA	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	Not Covered	CA (Covered Alternative(s): C9399, J3590 - Bldyos (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J0897	XGEVA 120 MG/1.7 ML VIAL SUV, P/F	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	Not Covered	CA (Covered Alternative(s): C9399, J3590 - Bldyos (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0897	XGEVA 120 MG/1.7 ML VIAL SUV, STERILE, P/F	Injection, denosumab, 1 mg (Code price uses median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J3111	EVENITY	Injection, romosozumab-aqqg, 1 mg	Preferred Specialty	PA; Site of Service
Q5136	JUBBONTI	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bildyos (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5136	WYOST	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5157	OSENVELT	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5157	STOBOCLO	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bildyos (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5158	BOMYNTRA	Injection, denosumab-bnht (bomyntra/conexence), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bilprevda (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5158	CONEXENCE	Injection, denosumab-bnht (bomyntra/conexence), biosimilar, 1 mg (Code Price is based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): J3590, C9399 - Bildyos (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5159	OSPOMYV	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): C9399, J3590 - Bildyos (denosumab-nxxp). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5161	AUKELSO	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg	Not Covered	Site of Service
Q5161	BOSAYA	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg	Not Covered	Site of Service
Q5162	BILDYOS	Injection, denosumab-nxxp (bilydos/bilprevda), biosimilar, 1 mg	Preferred Specialty	Site of Service
Q5162	BILPREVDA	Injection, denosumab-nxxp (bilydos/bilprevda), biosimilar, 1 mg	Preferred Specialty	Site of Service
Q5166	JUBEREQ	Injection, denosumab-desu (osvyrti/jubereq), biosimilar, 1 mg	Not Covered	Site of Service
Q5166	OSVYRTI	Injection, denosumab-desu (osvyrti/jubereq), biosimilar, 1 mg	Not Covered	Site of Service
Q5167	ENOBY	Injection, denosumab-qbde (enoby/xtrenbo), biosimilar, 1 mg (Code price based on median pricing methodology)	Preferred Specialty	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5167	XTRENBO	Injection, denosumab-qbde (enoby/xtrenbo), biosimilar, 1 mg (Code price based on median pricing methodology)	Preferred Specialty	Site of Service
Calcineurin Inhibitors, Misc (90:28)				
J7516	<i>cyclosporine 250 mg/5 ml ampul p/f, suv, inner</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	<i>cyclosporine 250 mg/5 ml ampul p/f, suv, outer</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	<i>cyclosporine 250 mg/5 ml ampul suv</i>	Injection, cyclosporine, 250 mg	Non-Specialty	
J7516	SANDIMMUNE INTRAVENOUS	Injection, cyclosporine, 250 mg	Non-Specialty	
J7525	PROGRAF INTRAVENOUS	Tacrolimus, parenteral, 5 mg	Non-Specialty	
Complement Inhibitor Agents (90:20)				
J1289	YARTEMLEA	Injection, narsoplimab-wuug, 1 mg	Non-Preferred	PA; Site of Service
J1299	SOLIRIS	Injection, eculizumab, 2 mg	Not Covered	CA (Covered Alternative(s): Q5151 - eculizumab-aagh (epysqli). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1302	ENJAYMO	Injection, sutimlimab-jome, 10 mg	Non-Preferred	PA; Site of Service
J1303	ULTOMIRIS	Injection, ravulizumab-cwvz, 10 mg	Preferred Specialty	PA; Site of Service
J1307	PIASKY	Injection, crovalimab-akkz, 10 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2781	SYFOVRE (PF)	Injection, pegcetacoplan, intravitreal, 1 mg	Preferred Specialty	PA
J2782	IZERVAY (PF)	Injection, avacincapted pegol, 0.1 mg	Not Covered	Site of Service
J3490	EMPAVELI	Unclassified drugs	Preferred Specialty	PA; Site of Service
Q5152	BKEMV	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	Not Covered	CA (Covered Alternative(s): Q5151 - eculizumab-aagh (epysqli). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Complement Inhibitors (90:08)				
J3490	ZILBRYSQ	Unclassified drugs	Refer to Approved Drug List (ADL)	
Disease-Modifying Antirheumat Drugs Misc				
J0129	ORENCIA (WITH MALTOSE)	Injection, abatacept, 10 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug self administered)	Non-Preferred	PA; Site of Service
J0129	ORENCIA CLICKJECT	Injection, abatacept, 10 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug self administered)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3380	ENTYVIO	Injection, vedolizumab, intravenous, 1 mg	Non-Preferred	PA; Site of Service
J3590	ENTYVIO PEN	Unclassified biologics	Refer to Approved Drug List (ADL)	
Disease-Modifying Antirheumatic Drugs				
J1628	TREMFYA INTRAVENOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Not Covered	Site of Service
J1628	TREMFYA ONE-PRESS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J1628	TREMFYA PEN	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J1628	TREMFYA PEN INDUCTION PK(2PEN)	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J1628	TREMFYA SUBCUTANEOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J8610	<i>methotrexate sodium oral</i>	Methotrexate, oral, 2.5 mg	Non-Specialty	
J8610	TREXALL	Methotrexate, oral, 2.5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9311	RITUXAN HYCELA	Injection, rituximab 10 mg and hyaluronidase	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9312	RITUXAN	Injection, rituximab, 10 mg	Not Covered	CA (Covered Alternative(s): Q5123 - Riabni (rituximab-arrx), Q5119 - Ruxience (rituximab-pvvr), Q5115 - Truxima (rituximab-abbs). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5115	TRUXIMA	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	Preferred Specialty	Site of Service
Q5119	RUXIENCE	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	Preferred Specialty	Site of Service
Q5123	RIABNI	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg	Preferred Specialty	Site of Service
Igg1 Monoclonal Antibodies				
C9399	BENLYSTA SUBCUTANEOUS	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
J0490	BENLYSTA INTRAVENOUS	Injection, belimumab, 10 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0491	SAPHNELO INTRAVENOUS	Injection, anifrolumab-fnia, 1 mg	Not Covered	Site of Service
J0491	SAPHNELO PEN	Injection, anifrolumab-fnia, 1 mg	Refer to Approved Drug List (ADL)	
Immunomodulatory Agents (90:00)				
J9071	<i>cyclophosphamide 1 gm/5 ml vl muv, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 1 gm/5 ml vl suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 2 gm/10 ml vl muv, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml muv, p/f</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9071	<i>cyclophosphamide 500 mg/2.5 ml suv</i>	Injection, cyclophosphamide, (auromedics), 5 mg	Non-Specialty	
J9072	<i>cyclophosphamide 1 gm/2 ml vl</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9072	<i>cyclophosphamide 2 gm/4 ml vial</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9072	<i>cyclophosphamide 500 mg/ml vial</i>	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9072	FRINDOVYX	Injection, cyclophosphamide (frindovyx), 5 mg	Not Covered	CA (Covered Alternatives: J9071 - cyclophosphamide (auromedics), J9076 - cyclophosphamide (baxter), J9073 - cyclophosphamide (Dr. Reddy's), J9075 - - cyclophosphamide. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J9073	<i>cyclophosphamide 1 gm/5 ml vial inner, muv, p/f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 1 gm/5 ml vial muv, p/f</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9073	<i>cyclophosphamide 1 gm/5 ml vial outer, multiple, per form</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 2 gm/10 ml vial multiple, per form</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 500 mg/2.5 ml inner, multiple, per form</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 500 mg/2.5 ml multiple, per form</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9073	<i>cyclophosphamide 500 mg/2.5 ml outer, multiple, per form</i>	Injection, cyclophosphamide (dr. reddy's), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 1 gm/10 ml vial inner, multiple, per form</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 1 gm/10 ml vial outer, multiple, per form</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vial inner, multiple, per form</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 2 gm/20 ml vial outer, multiple, per form</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vial inner, multiple, per form</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	
J9074	<i>cyclophosphamide 500 mg/5 ml vial outer, multiple, per form</i>	Injection, cyclophosphamide (sandoz), 5 mg	Non-Specialty	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9075	<i>cyclophosphamide intravenous recon soln</i>	Injection, cyclophosphamide, not otherwise specified, 5mg	Non-Specialty	
J9076	<i>cyclophosphamide 1 gm/5 ml vial, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
J9076	<i>cyclophosphamide 500 mg/2.5 ml vial, p/f</i>	Injection, cyclophosphamide (baxter), 5 mg	Non-Specialty	
Interferon Gamma Inhibitor Agents, Misc				
J9210	GAMIFANT	Injection, emapalumab-lzsg, 1 mg	Preferred Specialty	PA
Interferons				
J1830	BETASERON SUBCUTANEOUS KIT	Injection, interferon beta-1B, 0.25 mg (code may be used for Medicare when drug administered under direct supervision of a physician; not for use if self-administered)	Refer to Approved Drug List (ADL)	
J9215	ALFERON N	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 IU (All NDCs inactive as of 5/8/2024)	Non-Specialty	
Interleukin Inhibitor Agents, Misc				
C9217	XOLAIR SUBCUTANEOUS RECON SOLN	Injection, omalizumab, per 5 mg (Code deleted effective 1/1/05 refer to J2357)	Not Covered	Site of Service
J0480	SIMULECT	Injection, basiliximab, 20 mg	Preferred Specialty	
J2357	XOLAIR SUBCUTANEOUS AUTO-INJECTOR	Injection, omalizumab, 5 mg	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2357	XOLAIR SUBCUTANEOUS RECON SOLN	Injection, omalizumab, 5 mg	Not Covered	Site of Service
J2357	XOLAIR SUBCUTANEOUS SYRINGE	Injection, omalizumab, 5 mg	Not Covered	Site of Service
Q5154	OMLYCLO	Injection, omalizumab-igec (omlyclo), biosimilar, 5 mg	Preferred Specialty	PA; Site of Service
S0107	XOLAIR SUBCUTANEOUS RECON SOLN	Injection, omalizumab, 25 mg (Code deleted effective 04/01/05 - see J2357)	Not Covered	Site of Service
Interleukin-Mediated Agents, Misc				
C9399	ACTEMRA ACTPEN	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
J3247	COSENTYX INTRAVENOUS	Injection, secukinumab, intravenous, 1 mg	Not Covered	Site of Service
J3262	ACTEMRA INTRAVENOUS	Injection, tocilizumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9264)	Not Covered	CA (Covered Alternative(s): Q5135 - Tyenne intravenous solution (tocilizumab-aazg). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3357	STELARA SUBCUTANEOUS SOLUTION	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J3357	STELARA SUBCUTANEOUS SYRINGE	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	Refer to Approved Drug List (ADL)	
J3357	<i>ustekinumab subcutaneous</i>	Ustekinumab, for subcutaneous injection, 1 mg (Code price based on median pricing methodology)	Refer to Approved Drug List (ADL)	
J3358	STELARA INTRAVENOUS	Ustekinumab, for intravenous injection, 1 mg (For billing prior to 1/1/18 use Q9989)	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J3358	<i>ustekinumab intravenous</i>	Ustekinumab, for intravenous injection, 1 mg (For billing prior to 1/1/18 use Q9989)	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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HCP/CS/ CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3590	ACTEMRA SUBCUTANEOUS	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	COSENTYX (2 SYRINGES)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	COSENTYX PEN	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	COSENTYX PEN (2 PENS)	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	COSENTYX SUBCUTANEOUS	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	COSENTYX UNOREADY PEN	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	KEVZARA	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	KINERET	Unclassified biologics	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5098	IMULDOSA 130 MG/26 ML VIAL	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5098	IMULDOSA 130 MG/26 ML VIAL	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5098	IMULDOSA SUBCUTANEOUS	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5099	STEQEYMA INTRAVENOUS	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5099	STEQEYMA SUBCUTANEOUS SOLUTION	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5099	STEQEYMA SUBCUTANEOUS SYRINGE	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5100	YESINTEK INTRAVENOUS	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5100	YESINTEK SUBCUTANEOUS SOLUTION	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5100	YESINTEK SUBCUTANEOUS SYRINGE	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5133	TOFIDENCE	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	Not Covered	Site of Service
Q5135	TYENNE AUTOINJECTOR	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5135	TYENNE INTRAVENOUS	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5135	TYENNE SUBCUTANEOUS	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5137	WEZLANA 45 MG/0.5 ML VIAL	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5137	WEZLANA 45 MG/0.5 ML VIAL	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg	Refer to Approved Drug List (ADL)	
Q5137	WEZLANA SUBCUTANEOUS SYRINGE	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg	Refer to Approved Drug List (ADL)	
Q5138	WEZLANA INTRAVENOUS	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5156	AVTOZMA	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5156	AVTOZMA AUTOINJECTOR	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	

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

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5164	STARJEMZA INTRAVENOUS	Injection, ustekinumab-hmny (starjemza), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5164	STARJEMZA SUBCUTANEOUS SOLUTION	Injection, ustekinumab-hmny (starjemza), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q5164	STARJEMZA SUBCUTANEOUS SYRINGE	Injection, ustekinumab-hmny (starjemza), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q9996	PYZCHIVA SUBCUTANEOUS SOLUTION	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q9996	PYZCHIVA SUBCUTANEOUS SYRINGE	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	Refer to Approved Drug List (ADL)	
Q9996	<i>ustekinumab-ttwe subcutaneous</i>	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	Refer to Approved Drug List (ADL)	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q9997	PYZCHIVA INTRAVENOUS	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q9997	<i>ustekinumab-ttwe intravenous</i>	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q9998	SELARSDI INTRAVENOUS	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q9998	SELARSDI SUBCUTANEOUS SOLUTION	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Preferred Specialty	PA; Site of Service
Q9998	SELARSDI SUBCUTANEOUS SYRINGE	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q9998	<i>ustekinumab-aekn</i>	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	

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

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q9999	OTULFI INTRAVENOUS	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q9999	OTULFI SUBCUTANEOUS SOLUTION	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	Not Covered	CA (Covered Alternative(s): Q9998 - Selarsdi (ustekinumab-aekn), Q5100 - Yesintek (ustekinumab-kfce). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q9999	OTULFI SUBCUTANEOUS SYRINGE	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Monoclonal Antibodies (90:04)				
J0202	LEMTRADA	Injection, alemtuzumab, 1 mg	Not Covered	Site of Service
J2323	TYSABRI	Injection, natalizumab, 1 mg	Not Covered	CA (Covered Alternative(s): Q5134 - Tyruko. Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2329	BRIUMVI	Injection, ublituximab-xiiy, 1mg	Preferred Specialty	PA; Site of Service
J2350	OCREVUS	Injection, ocrelizumab, 1 mg (For billing prior to 1/1/18 use J3590 or C9494 for OPPS billing) (Code re-used by CMS 1/1/18)	Preferred Specialty	PA; Site of Service
J3590	KESIMPTA PEN	Unclassified biologics	Refer to Approved Drug List (ADL)	
Q5134	TYRUKO	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	Non-Preferred	PA; Site of Service
Monoclonal Antibodies (90:10)				
J0174	LEQEMBI	Lecanemab-irmb, for intravenous injection, 1 mg	Not Covered	Site of Service
J0175	KISUNLA	Injection, donanemab-azbt, 2 mg	Not Covered	Site of Service
J3490	LEQEMBI IQLIK 360 MG/1.8 ML AUTOINJECTOR	Unclassified drugs	Refer to Approved Drug List (ADL)	
Monoclonal Antibodies (90:12)				
J1823	UPLIZNA	Injection, inebilizumab-cdon, 1 mg	Preferred Specialty	PA; Site of Service
Neonatal Fc Receptor Blockers				
J9256	IMAAVY	Injection, nipocalimab-aahu, 3 mg	Preferred Specialty	PA; Site of Service
J9332	VYVGART	Injection, efgartigimod alfa-fcab, 2mg	Preferred Specialty	PA; Site of Service
J9333	RYSTIGGO	Injection, rozanolixizumab-noli, 1 mg	Preferred Specialty	PA; Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9334	VYVGART HYTRULO SUBCUTANEOUS SOLUTION	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Preferred Specialty	PA; Site of Service
J9334	VYVGART HYTRULO SUBCUTANEOUS SYRINGE	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Refer to Approved Drug List (ADL)	PA
Polyclonal Antibodies, Miscellaneous				
J7504	ATGAM	Lymphocyte immune globulin, anti-thymocyte globulin, equine, parenteral, 250 mg	Non-Specialty	
T-Cell Costimulatory Blockers, Misc				
J0485	NULOJIX	Injection, belatacept, 1 mg (For billing prior to 1/1/13 use C9286 or J3590)	Non-Preferred	Site of Service
Tumor Necrosis Factor Inhibitors, Misc				
C9399	<i>adalimumab-adaz</i>	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	<i>adalimumab-bwww subcutaneous auto-injector</i>	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	AMJEVITA(CF)	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	AMJEVITA(CF) AUTOINJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	HADLIMA	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	HADLIMA PUSH TOUCH	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)	Refer to Approved Drug List (ADL)	
C9399	HADLIMA(CF)	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	HADLIMA(CF) PUSHTOUCH	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	HYRIMOZ PEN CROHN'S-UC STARTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	HYRIMOZ PEN PSORIASIS STARTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	HYRIMOZ(CF)	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	HYRIMOZ(CF) PEDI CROHN STARTER	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	HYRIMOZ(CF) PEN	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	YUSIMRY(CF) PEN	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
J0139	HUMIRA	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Refer to Approved Drug List (ADL)	
J0139	HUMIRA PEN	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Refer to Approved Drug List (ADL)	
J0139	HUMIRA(CF)	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Refer to Approved Drug List (ADL)	
J0139	HUMIRA(CF) PEN	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Refer to Approved Drug List (ADL)	
J0139	HUMIRA(CF) PEN CROHNS-UC-HS	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0139	HUMIRA(CF) PEN PS-UV-ADOL HS START 80 MG/0.8 ML-40 MG/0.4 ML	Injection, adalimumab, 1 mg (Use NDC level pricing for appropriate reimbursement based on NDC submitted)	Refer to Approved Drug List (ADL)	
J0717	CIMZIA 2X200 MG/ML SYRINGE KIT 2X200MG SYR/BOX, SUV	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)	Refer to Approved Drug List (ADL)	
J0717	CIMZIA POWDER FOR RECONST	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Non-Preferred	PA; Site of Service
J0717	CIMZIA STARTER KIT	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Refer to Approved Drug List (ADL)	
J1438	ENBREL	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1438	ENBREL MINI	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	
J1438	ENBREL SURECLICK	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)	Refer to Approved Drug List (ADL)	
J1602	SIMPONI ARIA	Injection, golimumab, 1 mg, for intravenous use (For billing prior to 1/1/14 use C9399 or J3590)	Non-Preferred	PA; Site of Service
J1745	<i>infliximab</i>	Injection, infliximab, excludes biosimilar, 10 mg (Code is to be used for Remicade or Infliximab)	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J1745	REMICADE	Injection, infliximab, excludes biosimilar, 10 mg (Code is to be used for Remicade or Infliximab)	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1748	ZYMFENTRA	Injection, infliximab-dyyb (zymfentra), 10 mg	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
J3590	SIMPONI	Unclassified biologics	Refer to Approved Drug List (ADL)	
Q5103	INFLECTRA	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg	Not Covered	CA (Covered Alternative(s): Q5121 - Avsola (infliximab-axxq), Q5104 - Renflexis (infliximab-abda). Search our Medical Drug List to understand the clinical requirements for the alternatives. Some drugs may require the provider to request authorization prior to the drug being administered.); Site of Service
Q5104	RENFLEXIS	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg	Preferred Specialty	Site of Service
Q5121	AVSOLA	Injection, infliximab-axxq, biosimilar, (avsola), 10 mg	Preferred Specialty	Site of Service
Q5140	<i>adalimumab-fkjp</i>	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5140	HULIO(CF)	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5140	HULIO(CF) PEN	Injection, adalimumab-fkjp, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5141	<i>adalimumab-aaty</i>	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5141	ADALIMUMAB-AATY(CF) AI CROHNS	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5141	YUFLYMA(CF)	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5141	YUFLYMA(CF) AI CROHN'S-UC-HS	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5141	YUFLYMA(CF) AUTOINJECTOR	Injection, adalimumab-aaty, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5142	<i>adalimumab-ryvk</i>	Injection, adalimumab-ryvk biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5142	SIMLANDI(CF)	Injection, adalimumab-ryvk biosimilar, 1 mg	Refer to Approved Drug List (ADL)	

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

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5142	SIMLANDI(CF) AUTOINJECTOR	Injection, adalimumab-ryvk biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5143	<i>adalimumab-adbm</i>	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5143	CYLTEZO(CF)	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5143	CYLTEZO(CF) PEN	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5143	CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5143	CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.8 ML	Injection, adalimumab-adbm, biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5144	<i>adalimumab-aacf</i>	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5144	ADALIMUMAB-AACF(CF) PEN CROHNS	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q5144	ADALIMUMAB-AACF(CF) PEN PS-UV	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Refer to Approved Drug List (ADL)	
Q5145	ABRILADA(CF)	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	
Q5145	ABRILADA(CF) PEN	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Recommend NDC Level Pricing)	Refer to Approved Drug List (ADL)	

Local Anesthetics

Local Anesthetics

J0665	<i>bupivacaine (pf)</i>	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	<i>bupivacaine hcl</i>	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	<i>bupivacaine-dextrose-water(pf)</i>	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	MARCAINE	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	MARCAINE (PF)	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	MARCAINE SPINAL (PF)	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	SENSORCAINE	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0665	SENSORCAINE-MPF	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0665	SENSORCAINE-MPF SPINAL	Injection, bupivacaine, not otherwise specified, 0.5 mg	Non-Specialty	
J0666	<i>bupivacaine liposome (pf)</i>	Injection, bupivacaine liposome, 1 mg	Non-Specialty	
J0666	EXPAREL (PF)	Injection, bupivacaine liposome, 1 mg	Non-Specialty	
J0668	ZYNRELEF	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	Not Covered	Site of Service
J2403	IHEEZO (PF)	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	Not Covered	Site of Service
J2795	<i>ropivacaine (pf) injection solution</i>	Injection, ropivacaine hydrochloride, 1 mg	Non-Specialty	
J2795	<i>ropivacaine (pf)-nacl,iso-osm injection</i>	Injection, ropivacaine hydrochloride, 1 mg	Non-Specialty	
J3490	POSIMIR	Unclassified drugs	Non-Specialty	
J3490	XARACOLL	Unclassified drugs	Not Covered	Site of Service
Miscellaneous Therapeutic Agents				
Antigout Agents				
J0206	<i>allopurinol sodium</i>	Injection, allopurinol sodium, 1 mg	Non-Specialty	
J0206	ALOPRIM	Injection, allopurinol sodium, 1 mg	Non-Specialty	
J2507	KRYSTEXXA	Injection, pegloticase, 1 mg (For billing prior to 1/1/12 use J3590 or C9281)	Preferred Specialty	PA; Site of Service

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Antisense Oligonucleotides				
C9399	ZANVASTRO	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
J1426	AMONDYS-45	Injection, casimersen, 10 mg	Not Covered	Site of Service
J1427	VILTEPSO	Injection, viltolarsen, 10 mg	Not Covered	Site of Service
J1428	EXONDYS-51	Injection, eteplirsan, 10 mg (For billing prior to 1/1/18 use J3490 or C9484 for OPBS billing)	Not Covered	Site of Service
J1429	VYONDYS-53	Injection, golodirsan, 10 mg	Not Covered	Site of Service
J2326	SPINRAZA (PF)	Injection, nusinersen, 0.1 mg (Effective 5/1/2026: Recommend NDC Level Pricing for appropriate reimbursement based on NDC submitted)	Preferred Specialty	PA
J3490	ZANVASTRO	Unclassified drugs	Not Covered	Site of Service
Bone Anabolic Agents				
J3110	FORTEO	Injection, teriparatide, 10 mcg	Refer to Approved Drug List (ADL)	
J3110	<i>teriparatide</i>	Injection, teriparatide, 10 mcg	Refer to Approved Drug List (ADL)	

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

Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Bone Resorption Inhibitors				
J1000	DEPO-ESTRADIOL	Injection, depo-estradiol cypionate, up to 5 mg	Non-Specialty	
J1740	<i>ibandronate intravenous syringe</i>	Injection, ibandronate sodium, 1 mg	Preferred Specialty	
J2430	<i>pamidronate intravenous solution</i>	Injection, pamidronate disodium, per 30 mg	Non-Specialty	
J3489	RECLAST	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml inner, suv, p/f</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml outer, suv, p/f</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml sdv</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml single use</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml single use bottle</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml single use, p/f</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml single-use</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid 5 mg/100 ml suv, p/f</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
J3489	<i>zoledronic acid intravenous solution</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3489	<i>zoledronic ac-mannitol-0.9nacl</i>	Injection, zoledronic acid, 1 mg	Non-Specialty	
Bradykinin Receptor Antagonists				
J1744	FIRAZYR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Refer to Approved Drug List (ADL)	
J1744	<i>icatibant</i>	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Refer to Approved Drug List (ADL)	
J1744	SAJAZIR	Injection, icatibant, 1 mg (For billing prior to 1/1/13 use J3490 or C9399)	Refer to Approved Drug List (ADL)	
Complement Inhibitors (92:32)				
J0596	RUCONEST	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units (For billing prior to 1/1/16 use C9445 or J3590)	Refer to Approved Drug List (ADL)	
J0597	BERINERT	Injection, C-1 esterase inhibitor (human), Berinert, 10 units (For billing prior to 1/1/11 use J3590 or C9269)	Refer to Approved Drug List (ADL)	
J0598	CINRYZE	Injection, C1 esterase inhibitor (human), Cinryze, 10 units	Not Covered	Site of Service
J0599	HAEGARDA	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	Refer to Approved Drug List (ADL)	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J9376	VEOPOZ	Injection, pozelimab-bbfg, 1 mg	Preferred Specialty	PA; Site of Service
Complement Inhibitors				
Q5151	EPYSQLI	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	Preferred Specialty	PA; Site of Service
Immunomodulatory Agents				
J2351	OCREVUS ZUNOVO	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	Preferred Specialty	PA; Site of Service
J9015	PROLEUKIN	Injection, aldesleukin, per single-use vial	Non-Specialty	
Other Miscellaneous Therapeutic Agents				
C9399	FORZINITY	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	YUVIWEL	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)	Refer to Approved Drug List (ADL)	
J0222	ONPATTRO	Injection, Patisiran, 0.1 mg	Preferred Specialty	PA; Site of Service
J0223	GIVLAARI	Injection, givosiran, 0.5 mg	Preferred Specialty	PA; Site of Service
J0224	OXLUMO	Injection, lumasiran, 0.5 mg	Preferred Specialty	PA; Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J0225	AMVUTTRA	Injection, vutrisiran, 1 mg	Preferred Specialty	PA; Site of Service
J0591	KYBELLA	Injection, deoxycholic acid, 1 mg	Not Covered	Site of Service
J1809	NULIBRY	Injection, fosdenopterin, 0.1 mg	Preferred Specialty	PA
J1955	CARNITOR INTRAVENOUS	Injection, levocarnitine, per 1 g	Non-Specialty	
J1955	<i>levocarnitine intravenous</i>	Injection, levocarnitine, per 1 g	Non-Specialty	
J3490	FORZINITY	Unclassified drugs	Refer to Approved Drug List (ADL)	
J3490	RIVFLOZA	Unclassified drugs	Not Covered	Site of Service
J9038	NIKTIMVO	Injection, axatilimab-csfr, 0.1 mg	Non-Preferred	PA; Site of Service
Protective Agents				
J7352	SCENESSE	Afamelanotide implant, 1 mg	Preferred Specialty	PA
Oxytocics				
Oxytocics				
J0675	<i>carboprost tromethamine</i>	Injection, carboprost tromethamine, 0.1 mg	Not Covered	Site of Service
J0675	HEMABATE	Injection, carboprost tromethamine, 0.1 mg	Not Covered	Site of Service
J2210	<i>methylergonovine injection</i>	Injection, methylergonovine maleate, up to 0.2 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Radioactive Agents				
<i>Radioactive Agents</i>				
A9513	LUTATHERA	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	Preferred Specialty	PA
A9601	TAUVID	Flortaucipir f 18 injection, diagnostic, 1 millicurie	Non-Specialty	
A9606	XOFIGO	Radium Ra-223 dichloride, therapeutic, per microcurie (For billing prior to 1/1/15 use C9399 or A9699)	Non-Preferred	PA
A9607	PLUVICTO	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	Preferred Specialty	PA; Site of Service
Respiratory Tract Agents				
<i>Alpha And Beta Adrenergic Agonist(Respr)</i>				
J0163	ADRENALIN IN 0.9 % SOD CHLOR	Injection, epinephrine in sodium chloride (endo), 0.1 mg	Non-Specialty	
J0164	<i>epineph bitart in 0.9% sod chl intravenous solution</i>	Injection, epinephrine in sodium chloride (baxter), 0.1 mg	Non-Specialty	
J3490	REZIPRES	Unclassified drugs	Non-Specialty	
<i>Anticholinergic Agents (Respir.Tract)</i>				
J7677	YUPELRI	Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram	Not Covered	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Dual Phosphodiesterase Inhibitor (48:34)				
J7601	OHTUVAYRE	Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg	Refer to Approved Drug List (ADL)	
First Generation Antihist.(Respir Tract)				
J1200	<i>diphenhydramine hcl injection</i>	Injection, diphenhydramine HCl, up to 50 mg	Non-Specialty	
J2550	PHENERGAN	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
J2550	<i>promethazine injection</i>	Injection, promethazine HCl, up to 50 mg	Non-Specialty	
Interleukin Antagonists				
J0517	FASENRA	Injection, benralizumab, 1 mg	Preferred Specialty	PA; Site of Service
J0517	FASENRA PEN	Injection, benralizumab, 1 mg	Refer to Approved Drug List (ADL)	
J0638	ILARIS (PF)	Injection, canakinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9399)	Non-Preferred	PA; Site of Service
J2182	NUCALA SUBCUTANEOUS AUTO-INJECTOR	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPPS billing)	Not Covered	Site of Service
J2182	NUCALA SUBCUTANEOUS RECON SOLN	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPPS billing)	Not Covered	PA; Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J2182	NUCALA SUBCUTANEOUS SYRINGE	Injection, mepolizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9473 for OPSS billing)	Not Covered	Site of Service
J2356	TEZSPIRE SUBCUTANEOUS PEN INJECTOR	Injection, tezepelumab-ekko, 1 mg	Refer to Approved Drug List (ADL)	
J2356	TEZSPIRE SUBCUTANEOUS SYRINGE	Injection, tezepelumab-ekko, 1 mg	Not Covered	Site of Service
J2361	EXDENSUR	Injection, depemokimab-ulaa, 1 mg	Not Covered	Site of Service
J2786	CINQAIR	Injection, reslizumab, 1 mg (For billing prior to 1/1/17 use J3590 or C9481 for OPSS billing)	Non- Preferred	PA; Site of Service
Mucolytic Agents				
J7639	PULMOZYME	Dornase alfa, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose form, per milligram	Refer to Approved Drug List (ADL)	
Prostacyclin & Prostacyclin Derivatives				
Q4074	VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F	Iloprost, inhalation solution, FDA- approved final product, non- compounded, administered through DME, unit dose form, up to 20 micrograms (All NDCs Inactive as of 10/15/2025)	Non- Preferred	Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Q4074	VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F,30'S	Iloprost, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 20 micrograms (All NDCs Inactive as of 10/15/2025)	Non-Preferred	Site of Service
Respiratory Tract Agents, Miscellaneous				
J3590	WINREVAIR	Unclassified biologics	Preferred Specialty	PA
Second Generation Antihist(Respir Tract)				
J1201	QUZYTIR	Injection, cetirizine hydrochloride, 0.5 mg	Not Covered	Site of Service
Select.Beta-2-Adrenergic Agonist(Respir)				
J3105	<i>terbutaline subcutaneous</i>	Injection, terbutaline sulfate, up to 1 mg	Non-Specialty	
J7611	<i>albuterol 2.5 mg/0.5 ml sol</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol 0.083% inhal soln 25's, u-d</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 0.63 mg/3 ml sol</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol 30's,p/f,stri</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol inner</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol outer</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 0.63 mg/3 ml sol u-d, 25's</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 1.25 mg/3 ml sol</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol inner</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol outer</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol p/f,pedia,25's,u-d</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 1.25 mg/3 ml sol p/f,pedia,30's,u-d</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 1.25 mg/3 ml sol u-d, 25's</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 25's, u-d, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 30's, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln 30's, u-d, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCPCS/ CPT Code	Drug Name	HCPCS/CPT Code Description	Coverage Level	Notes & Restrictions
J7613	<i>albuterol sul 2.5 mg/3 ml soln 60's, u-d, p/f</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln inner</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln outer</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln p/f, inner</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	
J7613	<i>albuterol sul 2.5 mg/3 ml soln p/f, outer</i>	Albuterol, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose, 1 mg (Code reinstated effective 4/1/2008)	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
Vasodilating Agents (Respiratory Tract)				
J1325	<i>epoprostenol</i>	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1325	FLOLAN 0.5 MG VIAL	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1325	FLOLAN 1.5 MG VIAL	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1325	VELETRI	Injection, epoprostenol, 0.5 mg (see J3490 or S0155 for billing epoprostenol diluent)	Non-Preferred	PA; Site of Service
J1749	AURLUMYN	Injection, iloprost, 0.1 mcg	Not Covered	Site of Service; CC (No PA Required - Inpatient Use Only)
J3285	REMOTULIN 100 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	REMOTULIN 20 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	REMOTULIN 200 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	REMOTULIN 50 MG/20 ML VIAL	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J3285	<i>treprostinil sodium</i>	Injection, treprostinil, 1 mg	Preferred Specialty	PA; Site of Service
J7686	TYVASO	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7686	TYVASO INSTITUTIONAL START KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service
J7686	TYVASO REFILL KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service
J7686	TYVASO STARTER KIT	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg (For billing prior to 1/1/11 use J7699)	Preferred Specialty	PA; Site of Service
Skin And Mucous Membrane Agents				
Antibacterials (84:04)				
J0736	CLEOCIN INJECTION	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin in 5 % dextrose</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0736	<i>clindamycin phosphate injection</i>	Injection, clindamycin phosphate, 300 mg	Non-Specialty	
J0737	<i>clindamycin in 0.9 % sod chlor</i>	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg	Non-Specialty	
J1271	DOXY-100	Injection, doxycycline hyclate, 1 mg	Non-Specialty	

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Priority Health Employer group & MyPriority Plans

HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1271	<i>doxycycline hyclate intravenous</i>	Injection, doxycycline hyclate, 1 mg	Non-Specialty	
J1836	METRO I.V.	Injection, metronidazole, 10 mg	Non-Specialty	
J1836	<i>metronidazole in nacl (iso-os)</i>	Injection, metronidazole, 10 mg	Non-Specialty	
Antiproliferants				
J7308	LEVULAN	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)	Non-Specialty	
J9190	ADRUCIL	Injection, fluorouracil, 500 mg	Non-Specialty	
J9190	<i>fluorouracil intravenous</i>	Injection, fluorouracil, 500 mg	Non-Specialty	
Antipruritics And Local Anesthetics				
J0879	KORSUVA	Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis)	Preferred Specialty	PA
Antivirals (Skin And Mucous Membrane)				
J7354	YCANTH	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	Non-Specialty	
Cell Stimulants And Proliferants				
J2425	KEPIVANCE	Injection, palifermin, 50 micrograms	Non-Specialty	
Corticosteroids (Skin, Mucous Membrane)				
J7311	RETISERT	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	Not Covered	Site of Service

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J7313	ILUVIEN	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes E08.311, E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E09.311, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E10.311, E10.321-E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3511-E10.3513, E11.311, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E13.3111-E13.3113, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.3513, H30.001-H30.039, H30.20-H30.23, H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7314	YUTIQ 0.18 MG IMPLANT	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	Preferred Specialty	PA; No PA required for ICD-10 codes H30.001-H30.039, H30.20-H30.23, H35.021-H35.029, H35.061-H35.069, H44.111-H44.119.
J7402	SINUVA	Mometasone furoate sinus implant, (sinuva), 10 micrograms	Not Covered	Site of Service
Immunomodulatory Agents (84:06)				
C9399	BIMZELX	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	
C9399	BIMZELX AUTOINJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Refer to Approved Drug List (ADL)	

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
C9399	SKYRIZI 150 MG/ML SYRINGE	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	
C9399	SKYRIZI SUBCUTANEOUS PEN INJECTOR	Unclassified drugs or biologicals (This code should only be used for drugs and biologicals that are approved by the FDA on or after January 1, 2004) (Hospital Outpatient Use ONLY)	Not Covered	Site of Service
J1628	TREMFYA INTRAVENOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Not Covered	Site of Service
J1628	TREMFYA ONE-PRESS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J1628	TREMFYA PEN	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J1628	TREMFYA PEN INDUCTION PK(2PEN)	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	
J1628	TREMFYA SUBCUTANEOUS	Injection, guselkumab, 1 mg (Effective 1/1/2025 Code Level Pricing has been reinstated)	Refer to Approved Drug List (ADL)	

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J1747	SPEVIGO 150 MG/ML SYRINGE INNER, SUV, P/F	Injection, spesolimab-sbzo, 1 mg	Not Covered	Site of Service
J1747	SPEVIGO 150 MG/ML SYRINGE OUTER, SUV, P/F	Injection, spesolimab-sbzo, 1 mg	Not Covered	Site of Service
J1747	SPEVIGO 150 MG/ML SYRINGE SUV, P/F, INNER	Injection, spesolimab-sbzo, 1 mg	Not Covered	Site of Service
J1747	SPEVIGO 150 MG/ML SYRINGE SUV, P/F, OUTER	Injection, spesolimab-sbzo, 1 mg	Not Covered	Site of Service
J1747	SPEVIGO INTRAVENOUS	Injection, spesolimab-sbzo, 1 mg	Not Covered	Site of Service
J2327	SKYRIZI INTRAVENOUS	Injection, risankizumab-rzaa, intravenous, 1 mg	Preferred Specialty	PA; Site of Service
J3245	ILUMYA	Injection, tildrakizumab, 1 mg (Code reused by CMS 1/1/2019)	Non-Preferred	PA
J3590	SILIQ	Unclassified biologics	Refer to Approved Drug List (ADL)	
J3590	SKYRIZI 150 MG/ML SYRINGE	Unclassified biologics	Refer to Approved Drug List (ADL)	Site of Service
J3590	SKYRIZI SUBCUTANEOUS PEN INJECTOR	Unclassified biologics	Not Covered	Site of Service

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

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HCP/CS/CPT Code	Drug Name	HCP/CS/CPT Code Description	Coverage Level	Notes & Restrictions
J3590	SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR	Unclassified biologics	Refer to Approved Drug List (ADL)	
J7525	PROGRAF INTRAVENOUS	Tacrolimus, parenteral, 5 mg	Non-Specialty	
J7525	<i>tacrolimus intravenous</i>	Tacrolimus, parenteral, 5 mg	Non-Specialty	
Skin And Mucous Membrane Agents, Misc.				
J3389	ZEVASKYN	Topical administration, prademagene zamikeracel, per treatment	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J3401	VYJUVEK	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 ⁹ pfu/ml vector genomes, per 0.1 ml	Cellular/Gene Therapy	PA; Cellular/Gene Therapy; Site of Service
J7336	QUTENZA	Capsaicin 8% patch, per square centimeter	Non- Preferred	PA
Sunscreen Agents				
J7352	SCENESSE	Afamelanotide implant, 1 mg	Preferred Specialty	PA
Vitamins				
Vitamin D				
J0636	<i>calcitriol intravenous</i>	Injection, calcitriol, 0.1 mcg	Non-Specialty	

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

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