

Drugs and Biologicals Payment Policy

Payment Rules for Post-Service Claims Edit Drugs for Commercial, Exchange, and Medicaid lines of business*.

***For Medicare Coverage Rules:** Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist, and where they do, MRx determinations are compliant with CMS guidance. CMS guidance can be accessed in the Medicare Coverage Database (MCD) at <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan. Medicare Part B Administrative Contractor (MAC) Jurisdictions can be found at the end of this document.

Policy	Description
Alpha-1 proteinase inhibitors (Aralast®, Glassia®, Prolastin®, Zemaira®)	<p>Fallon Health does not routinely compensate for alpha-1 proteinase inhibitors (J0256 or J0257) when a diagnosis for alpha-1-antitrypsin deficiency (E88.01) or for GVHD (D89.810, D89.812, D89.813, T86.09) is not also present on the claim.</p> <p>Coverage of J0256 or J0257 will be limited to the following maximum:</p> <ul style="list-style-type: none"> • Alpha-1-antitrypsin deficiency: 700 billable units every 7 days • GVHD: 700 billable units for a total of 8 doses in 28 days.
Inotuzumab ozogamicin (Besponsa®)	<p>Fallon Health does not routinely compensate for inotuzumab ozogamicin (J9229) when a diagnosis for Acute lymphoblastic leukemia (not having achieved remission, in remission, or in relapse) (C83.50-C83.59, C91.00, C91.01, C91.02) is not also present on the claim.</p> <p>Coverage of J9229 will be limited to:</p> <ul style="list-style-type: none"> • 63 billable units every 21 days (for up to a maximum of 6 cycles)
OnabotulinumtoxinA (Botox®)	<p>Fallon Health limits coverage of onabotulinumtoxinA (J0585) to the following:</p> <ul style="list-style-type: none"> • Blepharospasm 200 billable units every 84 days • Cervical Dystonia 300 billable units every 84 days • Strabismus 100 billable units every 84 days • Esophageal Achalasia 100 billable units every 168 days • Adult Upper Limb Spasticity 400 billable units every 84 days • Pediatric Upper Limb Spasticity 300 billable units every 84 days • Adult Lower Limb Spasticity 400 billable units every 84 days • Pediatric Lower Limb Spasticity 300 billable units every 84 days • Chronic Migraine 200 billable units every 84 days • Severe Primary Axillary Hyperhidrosis 100 billable units every 112 days • Sialorrhea 100 billable units every 84 days • Neurogenic Bladder/Detrusor Overactivity 200 billable units every 84 days • Overactive Bladder 100 billable units every 84 days • Chronic Anal Fissures 100 billable units every 84 days • Palmar Hyperhidrosis 200 billable units every 168 days • Pediatric Upper Limb Spasticity 200 billable units every 84 days • Laryngeal Dystonia 100 billable units every 84 days • Hemifacial Spasms 100 billable units every 84 days • Oromandibular Dystonia 200 billable units every 84 days • Ventral Hernia 500 billable units one time only • All other indications 400 billable units every 84 days <p>Coverage of J0585 will not be compensated when one of the following diagnosis is not present on the</p>



	<p>claim: G11.4, G24.3, G24.4, G24.5, G24.8, G24.9, G25.89, G35, G37.0, G43.701, G43.709, G43.711, G43.E01, G43.E09, G43.E11, G43.E19, G43.719, G51.3, G51.31, G51.32, G51.33, G51.39, G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9, G81.10, G81.11, G81.12, G81.13, G81.14, G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54, G83.0, G83.10, G83.11, G83.12, G83.13, G83.14, G83.20, G83.21, G83.22, G83.23, G83.24, G83.4, H49.00, H49.01, H49.02, H49.03, H49.10, H49.11, H49.12, H49.13, H49.20, H49.21, H49.22, H49.23, H49.30, H49.31, H49.32, H49.33, H49.40, H49.41, H49.42, H49.43, H49.881, H49.882, H49.883, H49.889, H49.9, H50.00, H50.011, H50.012, H50.021, H50.022, H50.031, H50.032, H50.041, H50.042, H50.05, H50.06, H50.07, H50.08, H50.10, H50.111, H50.112, H50.121, H50.122, H50.131, H50.132, H50.141, H50.142, H50.15, H50.16, H50.17, H50.18, H50.21, H50.21, H50.22, H50.30, H50.311, H50.312, H50.32, H50.331, H50.332, H50.34, H50.40, H50.411, H50.412, H50.42, H50.43, H50.50, H50.51, H50.52, H50.53, H50.54, H50.55, H50.60, H50.611, H50.612, H50.621, H50.622, H50.629, H50.631, H50.632, H50.639, H50.641, H50.642, H50.649, H50.651, H50.652, H50.659, H50.661, H50.662, H50.669, H50.671, H50.672, H50.679, H50.681, H50.682, H50.689, H50.811, H50.812, H50.89, H50.9, H51.0, H51.11, H51.12, H51.20, H51.21, H51.22, H51.23, H51.8, H51.9, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, J38.3, K11.7, K22.0, K43.6, K43.7, K43.9, K60.1, K60.2, L74.510, L74.512, M43.6, N31.0, N31.1, N31.8, N31.9, N32.81</p>
Cerliponase alfa (Brineura®)	Fallon Health does not routinely compensate for cerliponase alfa (J0567) when a diagnosis for neuronal ceroid lipofuscinosis (E75.4) is not also present on the claim.
	Coverage of J0567 will be limited to 300 billable units every 14 days.
Imiglucerase (Cerezyme®)	Fallon Health does not routinely compensate for imiglucerase (J1786) when a diagnosis for Gaucher disease (E75.22) is not also present on the claim.
	Coverage of J1786 will be limited to 720 billable units every 14 days.
Burosumab-twza (Crysvita®)	Fallon Health does not routinely compensate for burosumab-twza (J0584) when a diagnosis for disorder of phosphorus metabolism (unspecified) or familial hypophosphatemia (E83.30, E83.31) or tumor-induced osteomalacia (E83.39) are not also present on the claim.
	<p>Coverage of J0584 will be limited to:</p> <ul style="list-style-type: none"> • X-Linked Hypophosphatemia (XLH) <ul style="list-style-type: none"> ○ Pediatrics 90 billable units every 14 days ○ Adults 90 billable units every 28 days • Tumor-Induced Osteomalacia (TIO) <ul style="list-style-type: none"> ○ 180 billable units every 14 days
Daxibotulinumtoxin A-lanm (Daxxify®)	Fallon Health limits coverage of daxibotulinumtoxin A (J0589) to the following:
	<ul style="list-style-type: none"> • Cervical Dystonia 300 billable units every 140 days <p>Coverage of J0589 will not be compensated when one of the following diagnosis is not also present on the claim: G24.3, M43.6</p>
AbobotulinumtoxinA (Dysport®)	<p>Fallon Health limits coverage of abobotulinumtoxinA (J0586) to the following:</p> <ul style="list-style-type: none"> • Cervical Dystonia 200 billable units every 84 days • Upper Limb Spasticity 200 billable units every 84 days • Upper Limb Spasticity (Pediatric) 160 billable units every 112 days • Chronic Migraine Prophylaxis 60 billable units every 84 day

	<ul style="list-style-type: none"> • Sialorrhea 100 billable units every 84 days • Chronic Anal Fissure 60 billable units every 84 days • Blepharospasms 100 billable units every 84 days • Lower Limb Spasticity 300 billable units every 84 days • Lower Limb Spasticity (Pediatric) 200 billable units every 84 days • Neurogenic Detrusor Overactivity/OAB 160 billable units every 84 days • Severe Primary Axillary Hyperhidrosis 100 billable units every 84 days • Hemifacial Spasms 60 billable units every 84 days • Ventral Hernia 100 billable units one time only <p>Coverage of J0586 will not be compensated when one of the following diagnosis is not also present on the claim: G11.4, G24.3, G24.5, G35, G37.0, G43.709, G43.719, G43.701, G43.711, G51.3, G51.31, G51.32, G51.33, G51.39, G80.0, G80.1, G80.2, G81.10, G81.11, G81.12, G81.13, G81.14, G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54, G83.0, G83.10, G83.11, G83.12, G83.13, G83.14, G83.20, G83.21, G83.22, G83.23, G83.24, I69.031, I69.032, I69.033, I69.034, I69.039, I69.051, I69.052, I69.053, I69.054, I69.059, I69.131, I69.132, I69.133, I69.134, I69.139, I69.151, I69.152, I69.153, I69.154, I69.159, I69.231, I69.232, I69.233, I69.234, I69.239, I69.251, I69.252, I69.253, I69.254, I69.259, I69.331, I69.332, I69.333, I69.334, I69.339, I69.351, I69.352, I69.353, I69.354, I69.359, I69.831, I69.832, I69.833, I69.834, I69.839, I69.851, I69.852, I69.853, I69.854, I69.859, I69.931, I69.932, I69.933, I69.934, I69.939, I69.951, I69.952, I69.953, I69.954, I69.959, I69.041, I69.042, I69.043, I69.044, I69.049, I69.141, I69.142, I69.143, I69.144, I69.149, I69.241, I69.242, I69.243, I69.244, I69.249, I69.341, I69.342, I69.343, I69.344, I69.349, I69.841, I69.842, I69.843, I69.844, I69.849, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, K11.7, K43.6, K43.7, K43.9, K60.1, N31.0, N31.1, N31.8, N31.9, N32.81, L74.510, M43.6</p>
Idursulfase (Elaprase®)	<p>Fallon Health does not routinely compensate for idursulfase (J1743) when a diagnosis for mucopolysaccharidosis type II (E76.1) is not also present on the claim.</p> <p>Coverage of J1743 will be limited to 60 billable units every 7 days.</p>
Taliglucerase alfa (Elelyso®)	<p>Fallon Health does not routinely compensate for taliglucerase alfa (J3060) when a diagnosis for Gaucher disease (E75.22) is not also present on the claim.</p> <p>Coverage for J3060 will be limited to 700 billable units every 14 days.</p>
Fosaprepitant dimeglumine (Emend®; Focinvez)	<p>Coverage of fosaprepitant dimeglumine (J1434; J1453; J1456) will not be compensated when one of the following diagnosis is not also present on the claim: R11.0, R11.10, R11.11, R11.12, R11.2, T45.1X5A, T45.1X5D, T45.1X5S, T45.95XA, T45.95XD, T45.95XS, T50.905A, T50.905D, T50.905S, Z51.11, Z51.12</p> <p>Coverage of J1453 will be limited to 450 billable units per 7 days.</p>
Agalsidase beta (Fabrazyme®)	<p>Fallon Health does not routinely compensate for agalsidase beta (J0180) when a diagnosis for Fabry (-Anderson) disease (E75.21) is not also present on the claim.</p> <p>Coverage of J0180 will be limited to 115 billable units every 14 days.</p>
Fulvestrant (Faslodex®)	<p>Fallon health limits coverage of fulvestrant (J9393; J9394; J9395) to the following:</p> <ul style="list-style-type: none"> • Endometrial Cancer 10 units every 28 days • Ovarian Cancer <ul style="list-style-type: none"> ○ Loading Dosing: 20 units on day 1 and 10 units on days 15 and 29 ○ Maintenance Dosing: 10 units every 28 days • Breast Cancer/Uterine Sarcoma <ul style="list-style-type: none"> ○ Loading Dosing: 20 units every 14 days for 3 doses ○ Maintenance Dosing: 20 units every 28 days <p>Coverage of J9395 will not be compensated when one of the following diagnosis is not also present on the claim: C48.1, C48.2, C48.8, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229,</p>



	<p>C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, Z85.3, Z85.42, Z85.43</p>
Canakinumab (Ilaris®)	<p>Fallon health limits coverage of canakinumab (J0638) to the following:</p> <ul style="list-style-type: none"> • Cryopyrin-Associated Periodic Syndromes 150 billable units every 8 weeks (56 days) • Adult Onset Still's Disease/Systemic Juvenile Idiopathic Arthritis 300 billable units every 4 weeks (28 days) • Tumor Necrosis Factor Receptor Associated Periodic Syndrome 300 billable units every 4 weeks (28 days) • Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency 300 billable units every 4 weeks (28 days) • Familial Mediterranean Fever 300 billable units every 4 weeks (28 days) • Gout Flare 150 billable units every 12 weeks (84 days) <p>Coverage of J0638 will not be compensated when one of the following diagnosis is not also present on the claim: M04.1, M04.2, M04.9, M06.1, M08.0A, M08.011, M08.012, M08.019, M08.021, M08.022, M08.029, M08.031, M08.032, M08.039, M08.041, M08.042, M08.049, M08.051, M08.052, M08.059, M08.061, M08.062, M08.069, M08.071, M08.072, M08.079, M08.08, M08.09, M08.20, M08.211, M08.212, M08.219, M08.2A, M08.221, M08.222, M08.229, M08.231, M08.232, M08.239, M08.241, M08.242, M08.249, M08.251, M08.252, M08.259, M08.261, M08.262, M08.269, M08.271, M08.272, M08.279, M08.28, M08.29, M08.3, M08.40, M08.411, M08.412, M08.419, M08.421, M08.422, M08.429, M08.431, M08.432, M08.439, M08.4A, M08.441, M08.442, M08.449, M08.451, M08.452, M08.459, M08.461, M08.462, M08.469, M08.471, M08.472, M08.479, M08.48, M08.80, M08.811, M08.812, M08.819, M08.821, M08.822, M08.829, M08.831, M08.832, M08.839, M08.841, M08.842, M08.849, M08.851, M08.852, M08.859, M08.861, M08.862, M08.869, M08.871, M08.872, M08.879, M08.88, M08.89, M08.9A, M08.911, M08.912, M08.919, M08.921, M08.922, M08.929, M08.931, M08.932, M08.939, M08.941, M08.942, M08.949, M08.951, M08.952, M08.959, M08.961, M08.962, M08.969, M08.971, M08.972, M08.979, M08.98, M08.99, M10.00, M10.011, M10.012, M10.019, M10.021, M10.022, M10.029, M10.031, M10.032, M10.039, M10.041, M10.042, M10.049, M10.051, M10.052, M10.059, M10.061, M10.062, M10.069, M10.071, M10.072, M10.079, M10.08, M10.09, M10.311, M10.312, M10.319, M10.321, M10.322, M10.329, M10.331, M10.332, M10.339, M10.341, M10.342, M10.349, M10.351, M10.352, M10.359, M10.361, M10.362, M10.369, M10.371, M10.372, M10.379, M10.38, M10.39, M10.40, M10.411, M10.412, M10.419, M10.421, M10.422, M10.429, M10.431, M10.432, M10.439, M10.441, M10.442, M10.449, M10.451, M10.452, M10.459, M10.461, M10.462, M10.469, M10.471, M10.472, M10.479, M10.48, M10.49, M10.9</p>
Tildrakizumab-asmn (Ilumya®)	<p>Fallon Health does not routinely compensate for tildrakizumab-asmn (J3245) when a diagnosis for psoriasis vulgaris (L40.0) is not also present on the claim.</p> <p>Coverage of J3245 will be limited to:</p> <ul style="list-style-type: none"> • Loading dose 100 units at week 0 and 4 • Maintenance dose 100 units every 12 weeks
Talimogene laherparepvec (Imlygic®)	<p>Fallon health limits coverage of talimogene laherparepvec (J9325) to the following:</p> <ul style="list-style-type: none"> • Initial treatment 4 billable units • Second treatment 400 billable units occurring 3 weeks after initial treatment • All subsequent treatments 400 billable units occurring 2 weeks after previous treatment <p>Coverage of J9325 will not be compensated when one of the following diagnosis is not also present on the claim: C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9</p>

Sebelipase alfa (Kanuma®)	Fallon Health does not routinely compensate for sebelipase alfa (J2840) when a diagnosis for other lipid storage disorders (E75.5) is also not present on the claim. Coverage of J2840 will be limited to 340 billable units every 14 days.
Sargramostim (Leukine®)	Fallon Health limits coverage of sargramostim (J2820) to the following: <ul style="list-style-type: none"> • Acute Radiation Syndrome 15 billable units per day • 10 billable units per day on days 1 through 14 of cycles 1, 3 and 5 (cycle length is 24 days) for a maximum of 5 cycles only (high-risk neuroblastoma in combination with dinutuximab) • 10 billable units per day for 10 days of each 28-day cycle for six cycles followed by subsequent cycles every 8 weeks thereafter (high-risk neuroblastoma in combination with naxitamab) • All other indications 10 billable units per day Coverage of J2820 will not be compensated when one of the following diagnosis is not also present on the claim: C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C92.00, C92.02, C92.50, C92.52, C92.60, C92.62, C92.A0, C92.A2, C93.00, C93.02, D61.810, D70.1, D70.9, T45.1X5A, T45.1X5D, T45.1X5S, T66.XXXA, T66.XXXD, T66.XXXS, W88.1, W88.8, Z41.8, Z48.290, Z51.11, Z51.12, Z51.89, Z52.001, Z52.011, Z52.091, Z76.89, Z94.81, Z94.84
Leuprolide acetate (Camcevi™, Eligard®, Lupron Depot®, Lupron Depot-Ped®, Fensolvi™, Leuprolide Acetate Depot [Cipla])	Fallon health limits coverage of leuprolide acetate (J9217; J1954) to the following: <ul style="list-style-type: none"> • Gender Dysphoria <ul style="list-style-type: none"> ○ Lupron Depot 1-Month & Eligard 7.5 mg 2 billable unit per 84 days • Prostate/Breast/Ovarian Cancer <ul style="list-style-type: none"> ○ Lupron Depot 1-Month & Eligard 7.5 mg 1 billable unit per 28 days ○ Lupron Depot 3-Month, Eligard, & Lutrate Depot 22.5 mg 3 billable units per 84 days ○ Lupron Depot 4-Month & Eligard 30 mg 4 billable units per 112 days ○ Lupron Depot 6-Month & Eligard 45 mg 6 billable units per 168 days • Head and Neck Cancer -Salivary Gland Tumors <ul style="list-style-type: none"> ○ Lupron Depot 1-Month & Eligard 7.5 mg 1 billable unit per 28 days ○ Lupron Depot 3-Month & Eligard 22.5 mg 3 billable units per 84 days Fallon health limits coverage of leuprolide acetate (J1950) to the following: <ul style="list-style-type: none"> • Gender Dysphoria <ul style="list-style-type: none"> ○ Lupron Depot 1-Month 3.75 mg 3 billable unit per 84 days ○ Lupron Depot 3-Month 11.25 mg 3 billable units per 84 days ○ Lupron Depot-Ped 11.25 mg 3 billable units per 28 days • Breast/Ovarian Cancer; Endometriosis; Uterine Fibroids <ul style="list-style-type: none"> ○ Lupron Depot 1-Month 3.75 mg 1 billable unit per 28 days ○ Lupron Depot 3-Month 11.25 mg 3 billable units per 84 days • Central Precocious Puberty <ul style="list-style-type: none"> ○ Lupron Depot-Ped 7.5 mg 2 billable units per 28 days ○ Lupron Depot-Ped 11.25 mg 3 billable units per 28 days ○ Lupron Depot-Ped 15 mg 4 billable units per 28 days ○ Lupron Depot-Ped 30 mg 8 billable units per 84 days • Prevention/Management of Menstrual Bleeding / Fertility Preservation Prior to Chemotherapy <ul style="list-style-type: none"> ○ Lupron Depot 1-Month 3.75 mg 1 billable unit per 28 days Fallon health limits coverage of leuprolide acetate (J1951-Fensolvi only) to the following: <ul style="list-style-type: none"> • Central Precocious Puberty; Gender Dysphoria



	<ul style="list-style-type: none"> ○ Fensolvi 45 mg Kit: 180 billable units per 168 days
	<p>Fallon health limits coverage of leuprolide acetate (J1952-Camcevi only) to the following:</p> <ul style="list-style-type: none"> ● Prostate Cancer <ul style="list-style-type: none"> ○ Camcevi 42 mg Kit: 42 billable units (42 mg) per 168 days
	<p>Coverage of J1950 will not be compensated when one of the following diagnosis is not also present on the claim: C48.1, C48.2, C48.8, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, D25.0, D25.1, D25.2, D25.9, E30.1, E30.8, F64.0, F64.1, F64.2, F64.8, F64.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N93.8, N94.89, R10.2, T86.09, Z31.84, Z85.3, Z85.43</p>
	<p>Coverage of J1951 will not be compensated when one of the following diagnosis is not also present on the claim: E30.1, E30.8, F64.0, F64.1, F64.2, F64.8, F64.9</p>
	<p>Coverage of J9217 will not be compensated when one of the following diagnosis is not also present on the claim: C06.9, C07, C08.0, C08.1, C08.9, C48.1, C48.2, C48.8, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C61, D25.0, D25.1, D25.2, F64.0, F64.1, F64.2, F64.8, F64.9, Z85.3, Z85.43, Z85.46</p>
	<p>Coverage of J1950 for endometriosis/ uterine leiomyomata (fibroids) will be limited to a maximum 6 months.</p>
	<p>Coverage of J1952 will not be compensated when one of the following diagnosis is not also present on the claim: C61, Z85.46.</p>
Vestronidase alfa-vjvk (Mepsevii®)	<p>Fallon Health does not routinely compensate for vestronidase alfa-vjvk (J3397) when a diagnosis for other mucopolysaccharidoses (E76.29) is not also present on the claim.</p>
	<p>Coverage of J3397 will be limited to 460 billable units every 14 days.</p>
Methoxy polyethylene glycol-epoetin beta (Mircera®)	<p>Fallon Health limits coverage of Mircera (J0888) to the following (Note: Applicable to ACO members only): 360 billable units every 28 days</p>
	<p>Coverage of J0888 will not be compensated when one of the following diagnosis is not also present on the claim (Note: Applicable to ACO members only): D63.1, I12.9, I13.0, I13.10, N18.30, N18.31, N18.32, N18.4, N18.9.</p>
	<p>Coverage of J0888 will be provided for 45 days (Note: Applicable to ACO members only).</p>
RimabotulinumtoxinB (Myobloc®)	<p>Fallon health limits coverage of rimabotulinumtoxinB (J0587) to the following:</p> <ul style="list-style-type: none"> ● Cervical Dystonia 100 billable units per 12 weeks (84 days) ● Upper Limb Spasticity 150 billable units per 12 weeks (84 days) ● Chronic Migraine Prophylaxis 100 billable units per 12 weeks (84 days) ● Chronic Sialorrhea 50 billable units per 12 weeks (84 days) ● Severe Primary Axillary Hyperhidrosis 100 billable units per 12 weeks (84 days)
	<p>Coverage of J0587 will not be compensated when one of the following diagnosis is not also present on the claim: G24.3, G25.89, G35, G37.0, G43.709, G43.719, G43.701, G43.711, G80.0, G80.1, G80.2, G81.10,</p>

	G81.11, G81.12, G81.13, G81.14, G82.53, G82.54, G83.0, G83.20, G83.21, G83.22, G83.23, G83.24, I69.031, I69.032, I69.033, I69.034, I69.039, I69.051, I69.052, I69.053, I69.054, I69.059, I69.131, I69.132, I69.133, I69.134, I69.139, I69.151, I69.152, I69.153, I69.154, I69.159, I69.231, I69.232, I69.233, I69.234, I69.239, I69.251, I69.252, I69.253, I69.254, I69.259, I69.331, I69.332, I69.333, I69.334, I69.339, I69.351, I69.352, I69.353, I69.354, I69.359, I69.831, I69.832, I69.833, I69.834, I69.839, I69.851, I69.852, I69.853, I69.854, I69.859, I69.931, I69.932, I69.933, I69.934, I69.939, I69.951, I69.952, I69.953, I69.954, I69.959, K11.7, L74.510, M43.6												
Galsulfase (Naglazyme®)	Fallon Health does not routinely compensate for galsulfase (J1458) when a diagnosis for other mucopolysaccharidoses (E76.29) is not also present on the claim.												
	Coverage of J1458 will be limited to 115 billable units every 7 days.												
Colony Stimulating Factors - Pegfilgrastim (Neulasta®; Fulphila™)	Fallon Health limits coverage of Neulasta (J2505/J2506*); Fulphila (Q5108); to the following (Note: Applicable to ACO members only):												
	<table border="1"> <thead> <tr> <th></th> <th>Neulasta (J2505/J2506)*</th> <th>Fulphila (Q5108)</th> </tr> </thead> <tbody> <tr> <td>Acute Radiation Exposure</td> <td>1 billable unit weekly x 2 doses</td> <td>12 billable units weekly x 2 doses</td> </tr> <tr> <td>BMT failure or engraftment delay/ PBPC mobilization and transplant</td> <td>1 billable unit x 1 dose</td> <td>12 billable units x 1 dose</td> </tr> <tr> <td>All other indications</td> <td>1 billable unit per 14 days</td> <td>12 billable units per 14 days</td> </tr> </tbody> </table>		Neulasta (J2505/J2506)*	Fulphila (Q5108)	Acute Radiation Exposure	1 billable unit weekly x 2 doses	12 billable units weekly x 2 doses	BMT failure or engraftment delay/ PBPC mobilization and transplant	1 billable unit x 1 dose	12 billable units x 1 dose	All other indications	1 billable unit per 14 days	12 billable units per 14 days
		Neulasta (J2505/J2506)*	Fulphila (Q5108)										
	Acute Radiation Exposure	1 billable unit weekly x 2 doses	12 billable units weekly x 2 doses										
	BMT failure or engraftment delay/ PBPC mobilization and transplant	1 billable unit x 1 dose	12 billable units x 1 dose										
	All other indications	1 billable unit per 14 days	12 billable units per 14 days										
<i>*Note: J2506 is effective 1/1/2022 with a corresponding billable unit equivalent to 0.5 mg. (Discontinue J2505 on 1/1/2022)</i>													
Coverage of Neulasta (J2505/J2506); Fulphila (Q5108); Udenyca (Q5111); Ziextenzo (Q5120); Nyvepria (Q5122) will not be compensated when one of the following diagnosis is not also present on the claim (Note: Applicable to ACO members only) : C64.1, C64.2, C64.9, D61.81, D70.1, D70.9, T45.1X5A, T45.1X5D, T45.1X5S, T66.XXXA, T66.XXXD, T66.XXXS, W88.1, W88.8, Z41.8, Z48.290, Z51.11, Z51.12, Z51.89, Z52.011, Z76.89, Z94.81, Z94.84.													
Coverage of Neulasta (J2505/J2506); Fulphila (Q5108); Udenyca (Q5111); Ziextenzo (Q5120); Nyvepria (Q5122) is limited to the following (Note: Applicable to ACO members only):													
<ul style="list-style-type: none"> Bone marrow transplantation (BMT) failure or engraftment delay: Coverage will be provided for 1 dose only and may not be renewed. Peripheral blood progenitor cell (PBPC) mobilization and transplant: Coverage will be provided for 1 dose only and may not be renewed. <p>All other indications: Coverage will be provided for four months and may be renewed unless otherwise specified.</p>													
Edaravone (Radicava®)	Fallon Health does not routinely compensate for edaravone (J1301) when a diagnosis for amyotrophic lateral sclerosis (G12.21) is not also included on the claim.												
	Coverage of J1301 will be limited to: <ul style="list-style-type: none"> Initial dose: 60 billable units daily for 14 days, followed by 14 days off per 28-day cycle Subsequent doses: 60 billable units daily for 10 days out of 14, followed by 14 days off per 28-day cycle 												
Octreotide acetate (Sandostatin®)	Coverage of octreotide acetate (J2354) will be limited to 24 billable units daily.												
	Coverage of J2354 will not be compensated when one of the following diagnosis is not also present on the claim: C25.4, C37, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094,												



	C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, D15.0, D38.4, D3A.00, D3A.010, D3A.011, D3A.012, D3A.019, D3A.020, D3A.021, D3A.022, D3A.023, D3A.024, D3A.025, D3A.026, D3A.029, D3A.090, D3A.091, D3A.092, E16.3, E16.4, E16.8, E22.0, E24.0, E24.2, E24.3, E24.4, E24.8, E24.9, E31.21, E34.0, E34.4, I85.01, I85.11, K52.2, K52.89, K91.2, R19.7, Z85.020, Z85.030, Z85.238, Z85.858
Octreotide suspension (Sandostatin® LAR)	<p>Fallon Health limits coverage of octreotide suspension (J2353) is limited to:</p> <ul style="list-style-type: none"> • Carcinoid Tumors and Acromegaly: 40 units every 28 days • Neuroendocrine Tumors: 60 units every 28 days • CNS Cancers and VIPomas: 30 units every 28 days • Thymoma: 20 units every 14 days <p>Coverage of J2353 will not be compensated when one of the following diagnosis is not also present on the claim: C25.4, C37, C70.0, C70.1, C70.9, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.5, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.8, D15.0, D32.0, D32.1, D32.9, D38.4, D3A.00, D3A.010, D3A.011, D3A.012, D3A.019, D3A.020, D3A.021, D3A.022, D3A.023, D3A.024, D3A.025, D3A.026, D3A.029, D3A.090, D3A.091, D3A.092, D3A.094, D3A.095, D3A.096, D3A.098, D42.0, D42.1, D42.9, E16.1, E16.3, E16.4, E16.8, E22.0, E34.0, Z85.020, Z85.030, Z85.040, Z85.060, Z85.07, Z85.110, Z85.230, Z85.238, Z85.841, Z85.848, Z85.858</p>
Afamelanotide (Scenesse®)	<p>Fallon Health limits coverage of afamelanotide subcutaneous implant (J7352) to 16 billable units (16 mg or 1 implant) every 2 months</p> <p>Coverage will not be compensated when one of the following diagnosis is not also present on the claim: E80.0.</p>
Pasireotide (Signifor® LAR)	<p>Fallon Health does not routinely compensate for pasireotide (J2502) when a diagnosis for acromegaly and pituitary gigantism, constitutional tall stature, or pituitary-dependent Cushing's disease (E22.0, E34.4, E24.0) are not also present on the claim.</p> <p>Coverage of J2502 is limited:</p> <ul style="list-style-type: none"> • Acromegaly 60 units every 28 days • Cushing's disease 40 units every 28 days
Lanreotide (Somatuline Depot®)	<p>Fallon Health limits coverage of lanreotide (J1930) to 120 billable units every 28 days.</p> <p>Coverage of J1930 will not be compensated when one of the following diagnosis is not also present on the claim: C25.4, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.8, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.5, D3A.00, D3A.010, D3A.011, D3A.012, D3A.019, D3A.020, D3A.021, D3A.022, D3A.023, D3A.024, D3A.025, D3A.026, D3A.029, D3A.090, D3A.091, D3A.092, D3A.094, D3A.095, D3A.096, D3A.098, E16.1, E16.3, E16.4, E16.8, E22.0, E24.8, E34.0, Z85.020, Z85.030, Z85.040, Z85.060, Z85.07, Z85.110, Z85.230, Z85.858</p>
Triptorelin (Trelstar®)	<p>Fallon Health limits coverage of triptorelin (J3315) to:</p> <ul style="list-style-type: none"> • Prostate Cancer 6 units every 168 days • Gender Dysphoria 1 unit at weeks 0,2, and 4 and every 28 days thereafter • All other indications 1 unit every 28 days <p>Coverage of J3315 will not be compensated when one of the following diagnosis is not also present on the claim: C61, D25.0, D25.1, D25.2, D25.9, E30.1, E30.8, F64.0, F64.1, F64.2, F64.8, F64.9, N80.0, N80.1, N80.2, N80.3, N80.8, N80.9, Z85.46</p> <p>Coverage of J3315 for endometriosis/ uterine leiomyomata (fibroids) will be limited to a maximum 6 months.</p>
Triptorelin	Fallon Health does not routinely compensate for triptorelin (J3316) when a diagnosis for precocious puberty or other disorders of puberty (E30.1, E30.8) or gender dysphoria (F64.0, F64.1, F64.2, F64.8,

(Triptodur®)	F64.9) are not also present on the claim.
Ibalizumab-uiyk (Trogarzo®)	Fallon Health does not routinely compensate for ibalizumab-uiyk (J1746) when a diagnosis for human immunodeficiency virus (HIV) disease (B20) is not also present on the claim. Coverage of J1746 will be limited to: <ul style="list-style-type: none"> • Load: 200 billable units one time only • Maintenance: 80 billable units every 14 days
Bortezomib (Velcade®; Bortezomib™)	Fallon Health limits coverage of bortezomib (J9041) to the following: <ul style="list-style-type: none"> • Multiple Myeloma & Systemic Light Chain Amyloidosis: 280 billable units every 35 days • Kaposi Sarcoma & Waldenström’s Macroglobulinemia: 210 billable units every 28 days • Pediatric Hodgkin Lymphoma: 105 billable units every 21 days • All other indications: 140 billable units every 21 days <p>Coverage of J9041 will not be compensated when one of the following diagnoses is not also present on the claim: C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C88.0, C90.00, C90.01, C90.02, C90.10, C90.12, C90.20, C90.22, C90.30, C90.32, C91.00, C91.01, C91.50, C91.52, D47.9, D47.Z2, D47.Z9, E31.9, E85.3, E85.4, E85.81, E85.89, E85.9, G62.9, G90.0, L98.9, , Z85.71</p> <p>Coverage of J9041; J9046; J9048; J9049 will be provided for 6 months and may be renewed unless otherwise specified.</p> <ul style="list-style-type: none"> •Initial treatment for Multiple Myeloma: Coverage will be provided for a total of 9 cycles (42-days/cycle). •Re-treatment of Multiple Myeloma, initial treatment of Mantle Cell Lymphoma, & Adult T-Cell Leukemia/Lymphoma: Coverage will be provided for a total of 8 cycles (21-days per cycle). •Systemic Light Chain Amyloidosis as a single agent or in combination with cyclophosphamide and/or dexamethasone: Coverage will be provided for a total of 8 cycles (35-days per cycle as a single agent; 21- or 28-days per cycle in combination with cyclophosphamide and/or dexamethasone). •Systemic Light Chain Amyloidosis in combination with melphalan and dexamethasone: Coverage will be provided for a total of 9 cycles (21-days per cycle) •Systemic Light Chain Amyloidosis in combination with lenalidomide and dexamethasone: Coverage will be provided for a total of 8 cycles (28-days per cycle). •Systemic Light Chain Amyloidosis in combination with daratumumab and hyaluronidase-fihj, cyclophosphamide, and dexamethasone: Coverage will be provided for a total of 2 years. •Waldenström’s Macroglobulinemia in combination with rituximab and/or dexamethasone: Coverage will be provided for a total of 6 cycles (28-days per cycle) or 8 cycles (21-days per cycle). •Pediatric Hodgkin Lymphoma: Coverage will be provided for a total of 4 cycles (21-days per cycle).
Elosulfase alfa (Vimizim®)	Fallon Health does not routinely compensate for elosulfase alfa (J1322) when a diagnosis for Morquio A mucopolysaccharidoses (E76.210) is not also present on the claim. Coverage of J1322 will be limited to 230 billable units every 7 days.
Velaglucerase alfa (Vpriv®)	Fallon Health does not routinely compensate for velaglucerase alfa (J3385) when a diagnosis for Gaucher disease (E75.22) is not also present on the claim. Coverage of J3385 will be limited to 72 billable units every 14 days.

<p>IncobotulinumtoxinA (Xeomin®)</p>	<p>Fallon Health limits coverage of incobotulinumtoxinA (J0588) to the following:</p> <ul style="list-style-type: none"> • Cervical dystonia 200 billable units every 84 days • Blepharospasms 100 billable units every 84 days • Upper limb spasticity 400 billable units every 84 days • Prophylaxis for chronic migraines 200 billable units every 84 days • Incontinence due to neurogenic detrusor overactivity 200 billable units every 84 days • Overactive bladder (OAB) 100 billable units every 84 days • Severe primary axillary hyperhidrosis 100 billable units every 112 days • Sialorrhea 100 billable units every 112 days • Ventral Hernia 500 billable units one time only <p>Coverage of J0588 will not be compensated when one of the following diagnosis is not also present on the claim: G24.3, G24.5, G25.89, G35, G37.0, G43.709 G43.719, G43.701, G43.711, G80.0, G80.1, G80.2, G81.10, G81.11, G81.12, G81.13, G81.14, G82.53, G82.54, G83.0, G83.20 G83.21, G83.22, G83.23, G83.24, I69.031, I69.032, I69.033, I69.034, I69.039, I69.051, I69.052, I69.053, I69.054, I69.059, I69.131, I69.132, I69.133, I69.134, I69.139, I69.151, I69.153, I69.154, I69.159, I69.231, I69.232, I69.233, I69.234, I69.239, I69.251, I69.252, I69.253, I69.254, I69.259, I69.331, I69.332, I69.333, I69.334, I69.339, I69.351, I69.352, I69.353, I69.354, I69.359, I69.831, I69.832, I69.833, I69.834, I69.839, I69.851, I69.852, I69.854, I69.859, I69.931, I69.932, I69.933, I69.934, I69.939, I69.951, I69.952, I69.953, I69.954, I69.959, K11.7, K43.6, K43.7, K43.9, M43.6, N31.0, N31.1, N31.8, N31.9, N32.81, L74.510</p>
<p>Ondansetron (Zofran®)</p>	<p>Fallon health limits coverage of ondansetron (J2405) to the following:</p> <ul style="list-style-type: none"> • Chemotherapy related nausea and vomiting 48 billable units per day • All other indications 4 billable units per day <p>Coverage of J2405 will not be compensated when one of the following diagnosis is not also present on the claim: R11.0, R11.10, R11.11, R11.12, R11.2, T41.0X5A, T41.1X5A, T41.205A, T41.295A, T41.45XA, T45.1X5A, T45.1XD, T45.1X5S, T45.95XA, T45.95XD, T45.XS, T50.905A, T50.905D, T50.905S, T50.995A, T88.59XA, Z51.11, Z51.12</p>
<p>Goserelin acetate (Zoladex®)</p>	<p>Fallon health limits coverage of goserelin acetate (J9202) to the following:</p> <ul style="list-style-type: none"> • Prostate & Breast Cancer 3 units every 84 days • All other indications 1 unit every 28 days <p>Coverage of J9202 will not be compensated when one of the following diagnosis is not also present on the claim: C48.1, C48.2, C48.8, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C61, F64, F64.1, F64.2, F64.8, F64.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N92.4, N92.5, N93.8, Z85.3, Z85.43, Z85.46</p> <p>Coverage of J9202 for endometriosis will be limited to a maximum of 6 months.</p>
<p>Hyaluronic acid derivatives (Euflexxa; Synvisc; Synvisc-One)</p>	<p>Fallon health limits coverage of hyaluronic acid derivatives to the following:</p> <ul style="list-style-type: none"> • Euflexxa J7323 6 units per 180 days; Synvisc/Synvisc-One J7325 96 units per 180 days (based on administration into both knees) <p>Coverage of hyaluronic acid derivatives will not be compensated when one of the following diagnosis is not also present on the claim: M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9</p>

Medicare Part B Administrative Contractor (MAC) Jurisdictions

Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC