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## DENIED DRUG CODES – PHARMACY BENEFIT DRUGS

Policy Number: CSLA2020D0990F

Effective Date: **TBD**

[Instructions for Use](#)

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### APPLICATION

This Medical Benefit Drug Policy only applies to the state of Louisiana.

### COVERAGE RATIONALE

This Medical Benefit Drug Policy applies to UnitedHealthcare Community Plan Medicaid products.

This policy applies to services reported using both the 1500 Health Insurance Claim Form (a/k/a CMS-1500) and the UB-04 form, their electronic equivalent, and their successor forms. This policy applies to all:

- Network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.
- Network and non-network facilities including, but not limited to, non-network authorized and percent of charge contract facilities.

For UnitedHealthcare Community Plan Medicaid products with a pharmacy benefit that UnitedHealthcare Community Plan manages, there are certain specialty injectable products that are only covered under the members' pharmacy benefit. Therefore, they should not be reimbursed through the medical benefit on a medical claim. This policy serves two purposes:

- Prevent paying for the same medication for the same member twice, once on a pharmacy claim and once on a medical claim.
- Prevent inappropriate and/or excessive use of these medications that is not consistent with current practices and evidence-based literature. This is achieved through a clinical review of the medication, as performed by the UnitedHealthcare Community Plan pharmacy department, prior to claim processing on the pharmacy benefit through the Pharmacy Benefit Administrator.

The following specialty drugs (as identified by their HCPCS code) will be denied from paying on a medical professional and outpatient facility claim:

Medication / Brand Name	HCPCS Description	CPT/HCPCS Code
<a href="#">Avonex</a>	<a href="#">Injection, interferon beta-1a, 30 mcg</a> <a href="#">Injection, interferon beta-1a, 1 mcg for intramuscular use</a>	<a href="#">J1826, Q3027</a>
<a href="#">Betaseron</a>	<a href="#">Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered</a>	<a href="#">J1830</a>

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Medication / Brand Name	HCPCS Description	CPT/HCPCS Code
	<u>under the direct supervision of a physician, not for use when drug is self-administered)</u>	
<u>Cimzia</u>	<u>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)</u>	<u>J0717</u>
<u>Copaxone</u>	<u>Injection, glatiramer acetate, 20 mg</u>	<u>J1595</u>
<u>Enbrel</u>	<u>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)</u>	<u>J1438</u>
<u>Extavia</u>	<u>Injection interferon beta-1b, 0.25 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)</u>	<u>J1830</u>
<u>Firazyr</u>	<u>Injection, icatibant, 1 mg</u>	<u>J1744</u>
<u>Forteo</u>	<u>Injection, teriparatide, 10 mcg</u>	<u>J3110</u>
<u>Glatiramer</u>	<u>Injection, glatiramer acetate, 20 mg</u>	<u>J1595</u>
<u>Glatopa</u>	<u>Injection, glatiramer acetate, 20 mg</u>	<u>J1595</u>
<u>Haegarda</u>	<u>Injection, C1 esterase inhibitor (human), (Haegarda), 10 units</u>	<u>J0599</u>
<u>Humira</u>	<u>Injection, adalimumab, 20 mg</u>	<u>J0135</u>
<u>Increlex</u>	<u>Injection, mecasermin, 1 mg</u>	<u>J2170</u>
<u>Infergen</u>	<u>Injection, interferon alfacon-1, recombinant, 1 mcg</u>	<u>J9212</u>
<u>Pegasys</u>	<u>Injection, PEGylated interferon alfa-2A, 180 mcg per ml</u>	<u>S0145</u>
<u>Peg-Intron</u>	<u>Injection, PEGylated interferon alfa-2B, 10 mcg</u>	<u>S0148</u>
<u>Pulmozyme</u>	<u>Dornase alfa, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg</u>	<u>J7639</u>
<u>Rebif</u>	<u>Injection, interferon beta-1a, 30 mcg</u> <u>Injection, interferon beta-1a, 1 mcg for subcutaneous use</u>	<u>J1826, Q3028</u>
<u>Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Zomacton, Zorbtive (Somatroprin)</u>	<u>Injection, somatropin, 1 mg</u>	<u>J2941</u>
<u>Stelara</u>	<u>Ustekinumab, for subcutaneous injection, 1 mg</u>	<u>J3357</u>
<u>Synagis</u>	<u>Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each</u>	<u>90378</u>
<u>Tobramycin (for inhalation)</u>	<u>Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg</u>	<u>J7682</u>
<u>Tremfya</u>	<u>Injection, guselkumab, 1 mg</u>	<u>J1628</u>
<u>Xolair</u>	<u>Injection, omalizumab, 5 mg</u>	<u>J2357</u>

- Growth hormone
  - Genotropin (J2941)
  - Humatrope (J2941)
  - Norditropin (J2941)

- Nutropin/Nutropin AQ/Nutropin AQ NuSpin (J2941)
- Omnitrope (J2941)
- Saizen (J2941)
- Serostim (J2941)
- Tev-Tropin (J2941)
- Zomacton (J2941)
- Zorbtive (J2941)
- Insulin-like growth factor
  - Increlex (J2170)
- Interferon alfa
  - Infergen (J9212)
  - Pegasys (S0145)
  - Peg-Intron (S0148)
- Monoclonal antibody
  - Synagis (90378)
  - Xelair (J2357)
- Multiple sclerosis agents
  - Avonex (J1826, Q3027)
  - Betaseron (J1830)
  - Copaxone (J1595)
  - Extavia (J1830)
  - Rebif (J1826, Q3028)
- Osteoporosis treatment
  - Forteo (J3110)
- Tumor necrosis factor (TNF) antagonists
  - Cimzia (J0717)
  - Enbrel (J1438)
  - Humira (J0135)

Some states may include additional drugs as part of this policy, due to specific requirements. See the [State Exceptions](#) section below for details.

#### APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each

*CPT® is a registered trademark of the American Medical Association*

HCPCS Code	Description
J0135	Injection, adalimumab, 20 mg
<a href="#">J0599</a>	<a href="#">Injection, c-1 esterase inhibitor (human), (haegarda), 10 units</a>
J0717	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1438	Injection, etanercept, 25 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)

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HCPCS Code	Description
J1595	Injection, glatiramer acetate, 20 mg
<a href="#">J1628</a>	<a href="#">Injection, guselkumab, 1 mg</a>
<a href="#">J1744</a>	<a href="#">Injection, icatibant, 1 mg</a>
J1826	Injection, interferon beta-1a, 30 mcg
J1830	Injection interferon beta-1b, 0.25 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)
J2170	Injection, mecasermin, 1 mg
J2357	Injection, omalizumab, 5 mg
J2941	Injection, somatropin, 1 mg
J3110	Injection, teriparatide, 10 mcg
<a href="#">J3357</a>	<a href="#">Ustekinumab, for subcutaneous injection, 1 mg</a>
<a href="#">J7639</a>	<a href="#">Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram</a>
<a href="#">J7682</a>	<a href="#">Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligrams</a>
J9212	Injection, interferon alfacon-1, recombinant, 1 mcg
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use
S0145	Injection, pegylated interferon alfa-2a, 180 mcg per ml
S0148	Injection, pegylated interferon alfa-2B, 10 mcg

**Arizona ONLY Non-Covered Drug Codes List**

In addition to the codes listed above, the following codes are also included in the non-covered drug codes list for Arizona.

HCPCS Code*	Description
J0180	Injection, agalsidase beta, 1 mg
J0205	Injection, alglucerase, per 10 units
J0220	Injection, alglucosidase alfa, 10 mg, not otherwise specified
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg
J0598	Injection, C1 esterase inhibitor (human), Cinryze, 10 units
J0800	Injection, corticotropin, up to 40 units
J1300	Injection, eculizumab, 10 mg
J1428	Injection, eteplirsen, 10 mg
J1743	Injection, idursulfase, 1 mg
J1744	Injection, icatibant, 1 mg
J1786	Injection, imiglucerase, 10 units
J1931	Injection, laronidase, 0.1 mg
J2326	Injection, nusinersen, 0.1 mg
J2724	Injection, protein C concentrate, intravenous, human, 10 IU
J3060	Injection, taliglucerase alfa, 10 units
J3385	Injection, velaglucerase alfa, 100 units
<a href="#">J7170</a>	<a href="#">Injection, emicizumab-kxwh, 0.5 mg</a>
<a href="#">J7175</a>	<a href="#">Injection, factor X, (human), 1 IU</a>

HCPCS Code*	Description
<a href="#">J7177</a>	<a href="#">Injection, human fibrinogen concentrate (fibryga), 1 mg</a>
<a href="#">J7178</a>	<a href="#">Injection, human fibrinogen concentrate, not otherwise specified, 1 mg</a>
<a href="#">J7179</a>	<a href="#">Injection, Von Willebrand factor (recombinant), (Vonvendi), 1 IU VWF:RCo</a>
<a href="#">J7180</a>	<a href="#">Injection, factor XIII (antihemophilic factor, human), 1 IU</a>
<a href="#">J7181</a>	<a href="#">Injection, factor XIII A-subunit, (recombinant), per IU</a>
<a href="#">J7182</a>	<a href="#">Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU</a>
<a href="#">J7183</a>	<a href="#">Injection, Von Willebrand factor complex (human), Wilate, 1 IU VWF:RCO</a>
<a href="#">J7185</a>	<a href="#">Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU</a>
<a href="#">J7186</a>	<a href="#">Injection, antihemophilic factor VIII/Von Willebrand factor complex (human), per factor VIII I.U.</a>
<a href="#">J7187</a>	<a href="#">Injection, Von Willebrand factor complex (Humate-P), per IU, VWF:RCO</a>
<a href="#">J7188</a>	<a href="#">Injection, factor VIII (antihemophilic factor, recombinant), (Obizur), per IU</a>
<a href="#">J7189</a>	<a href="#">Factor VIIa (antihemophilic factor, recombinant), per 1 microgram</a>
<a href="#">J7190</a>	<a href="#">Factor VIII (antihemophilic factor [human]) per IU</a>
<a href="#">J7192</a>	<a href="#">Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified</a>
<a href="#">J7193</a>	<a href="#">Factor IX (antihemophilic factor, purified, non-recombinant) per IU</a>
<a href="#">J7194</a>	<a href="#">Factor IX, complex, per IU</a>
<a href="#">J7195</a>	<a href="#">Injection factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified</a>
<a href="#">J7198</a>	<a href="#">Anti-inhibitor, per IU</a>
<a href="#">J7199</a>	<a href="#">Hemophilia clotting factor, not otherwise classified</a>
<a href="#">J7200</a>	<a href="#">Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU</a>
<a href="#">J7201</a>	<a href="#">Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1 IU</a>
<a href="#">J7202</a>	<a href="#">Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, 1 IU</a>
<a href="#">J7203</a>	<a href="#">Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu</a>
<a href="#">J7205</a>	<a href="#">Injection, factor VIII, Fc fusion protein (recombinant), per IU</a>
<a href="#">J7207</a>	<a href="#">Injection, factor VIII, (antihemophilic factor, recombinant), pegylated, 1 IU</a>
<a href="#">J7208</a>	<a href="#">Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.</a>
<a href="#">J7209</a>	<a href="#">Injection, factor VIII, (antihemophilic factor, recombinant), (Nuwig), 1 IU</a>
<a href="#">J7210</a>	<a href="#">Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU</a>
<a href="#">J7211</a>	<a href="#">Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU</a>

**\*Coding Clarification:** When a drug product does not have its own assigned J code or Q code, claim submission with either of the miscellaneous codes, J3490 or J3590, is also not reimbursable on a professional or UB claim.

## REFERENCES

1. American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services.
2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

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- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

#### POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
<b>TBD</b>	<ul style="list-style-type: none"><li><a href="#">The following codes were added: Firazyr (J1744), Haegarda (J0599); Pulmozyme (J7639), Tobramycin for Inhalation (J7682); Stelara (J3357), Tremfya (J1628)</a></li><li><a href="#">Glatiramer and Glatopa were added to J1595</a></li><li><a href="#">Hemophilia agents were added to the AZ list (codes J7170 through J7211)</a></li></ul>

#### INSTRUCTIONS FOR USE

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.