Q2 HCPCS Level I and II Update (April 1, 2024)

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Q2 Code Additions

Blood and Blood Derivatives

The following Blood and Blood Derivatives code has special billing policies.

J7165

J7165

Prothrombin complex concentrate, human-lans (BALFAXAR)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals 5,000 iu/5,000 units as a single dose.

Maximum billing unit(s) equals 5,000 iu/5,000 units.

Modifiers SA, UD, U7, and 99 are allowed.

Chemotherapy

The following Chemotherapy codes have special billing policies:

J1323, J1434, J2277, J3055, J9249, J9073, J9074, J9075

J1323

Elranatamab-bcmm (ELREXFIO™)

No *Treatment Authorization Request* (TAR) is required.

ELREXFIO REMS

ELREXFIO is available only through a restricted program under a REMS called the ELREXFIO REMS because of the risks of CRS and neurologic toxicity, including Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS).

Notable requirements of the ELREXFIO REMS include the following:

- Prescribers must be certified with the program by enrolling and completing training.
- Prescribers must counsel patients receiving ELREXFIO about the risk of CRS and neurologic toxicity, including ICANS and provide patients with ELREXFIO Patient Wallet Card.
- Pharmacies and healthcare settings that dispense ELREXFIO must be certified with the ELREXFIO REMS program and must verify prescribers are certified through the ELREXFIO REMS program.

- Wholesalers and distributers must only distribute ELREXFIO to certified pharmacies or healthcare settings.

Further information about the ELREXFIO REMS program is available at www.ELREXFIOREMS.com or by telephone at 1-844-923-7845.

Must be 18 years of age or older.

Suggested ICD-10-CM Diagnosis Codes: C90.00, C90.02

Maximum billing units equals 76 mg/76 units.

Modifiers SA, UD, U7, 99 are allowed.

J1434

Fosaprepitant (FOCINVEZ)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Focinvez is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages.
- Patient must be 6 months of age or older.
- Drug is being used under one of the following conditions (A or B below):

A. Prevention of Nausea and Vomiting Associated with highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin (for example, Anthracycline/cyclophosphamide combination, Carmustine, Cisplatin, Cyclophosphamide at least 1500 mg/m2, Dacarbazine, Mechlorethamine, Streptozocin, etc.).

B. Prevention of Nausea and Vomiting Associated with moderately emetogenic cancer chemotherapy (MEC) (for example, Alemtuzumab, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carboplatin, Clofarabine, Cyclophosphamide less than 1500 mg/m2, Cytarabine more than 1000 mg/m2, Daunorubicin, Daunorubicin and cytarabine liposome, Doxorubicin, Epirubicin, Fam-trastuzumab deruxtecan-nxki, Idarubicin, Ifosfamide, Irinotecan, Irinotecan liposomal injection, Oxaliplatin, Romidepsin, Temozolomide,Thiotepa, Trabectedin, etc.).

- Must be used in combination with a 5-HT3 antagonist (for example, ondansetron, palonosetron, granisetron, etc).
- Must be used in combination with a corticosteroid (for example, dexamethasone as applicable).
- Must use generic fosaprepitant unless intolerant, contraindicated or clinically inappropriate.
- Patient is not taking pimozide.
- Focinvez is not being used for established nausea and vomiting.

Initial approval is for six months.

Reauthorization

- Patient continues to meet initial approval criteria.
- Patient has documented positive clinical response.

- Patient has absence of unacceptable toxicity from the drug such as severe hypersensitivity reactions, severe infusion site reactions, etc.

Reauthorization is for six months.

Frequency equals 150 mg/150 units for one dose 30 minutes prior to chemotherapy.

Maximum Dosage equals 150 mg/150 units.

Modifiers SA, UD, U7, 99 are allowed.

J2277

Motixafortide (APHEXDA™)

An approved *Treatment Authorization Request* (TAR) is required.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient must have a diagnosis of histologically confirmed Multiple Myeloma.
- Patient is eligible for autologous hematopoietic stem cell transplantation.
- Motixafortide will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation.
- It will be used in combination with filgrastim.
- Patient does not have a history of autologous or allogeneic-HCT.

Approval duration: One treatment cycle (Two doses only)

Must be 18 years of age or older.

Frequency of billing equals 1.25 mg/kg, 10 to 14 hours prior to initiation of apheresis. Can administer a second dose 10 to 14 hours prior to a third apheresis.

Modifiers SA, UD, U7, 99 are allowed.

J3055

Talquetamab-tgvs (TALVEY™)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

TECVAYLI and TALVEY REMS

TALVEY is available only through a restricted program under a REMS called the TECVAYLI and TALVEY REMS because of the risks of CRS and neurologic toxicity, including ICANS [see Warnings and Precautions (5.1, 5.2)]. Notable requirements of the TECVAYLI and TALVEY REMS include the following:

- Prescribers must be certified with the program by enrolling and completing training.
- Prescribers must counsel patients receiving TALVEY about the risk of CRS and neurologic toxicity, including ICANS and provide patients with Patient Wallet Card.
- Pharmacies and healthcare settings that dispense TALVEY must be certified with the TECVAYLI and TALVEY REMS program and must verify prescribers are certified through the TECVAYLI and TALVEY REMS program.

- Wholesalers and distributers must only distribute TALVEY to certified pharmacies.

Further information about the TECVAYLI and TALVEY REMS program is available at www.TEC-TALREMS.com or by telephone at 1-855-810-8064.

Must be 18 years of age or older.

Suggested ICD-10-CM Diagnosis Codes: C90.00, C90.02

Modifiers SA, UD, U7, 99 are allowed.

J9249

Melphalan Injection (Apotex)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Melphalan will be considered medically necessary when **all** of the following criteria are met:

- Must be used for FDA-approved indications and dosages.
- Must be prescribed by or in consultation with an oncologist or hematologist.
- Patient is 18 years of age or older.
- Patient has a diagnosis of multiple myeloma.
- Patient is taking this drug for palliative treatment.
- Documentation that the patient is unable to tolerate oral therapy.

Initial authorization is for 12 months.

Re-authorization Criteria:

- Patient continues to meet the initial criteria.
- Positive clinical response as evident by stabilization of disease.
- Patient has no disease progression or unacceptable toxicity (for example, severe myelotoxicity, etc.).

Re-authorization is for 12 months.

Must be 18 years or older.

Modifiers SA, UD, U7, 99 are allowed.

J9073

Cycophosphamide Injection (Ingenus)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7, 99 are allowed.

J9074

Cycophosphamide Injection (Sandoz)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years or older.

Modifiers SA, UD, U7, 99 are allowed.

J9075

Cycophosphamide Injection (Not Otherwise Specified)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7, 99 are allowed.

Durable Medical Equipment (DME)

The following DME codes have special billing policies:

A4271, E2104, E2298

A4271

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals one per month.

Modifier NU is required.

This code is nontaxable.

E2104

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals one every five years.

Modifier NU is required.

This code is nontaxable.

E2298

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals one every five years.

This code is not reimbursable with codes K0830 or K0831 during the same month.

Modifiers NU and RB are required.

This code is nontaxable.

Injection

The following Injection codes have special billing policies:

C9166, C9167, C9168, J0577, J0578, J0650, J0651, J0652, J1010, J1202, J1203, J2277, J2801, J2919, J3424, J9376, Q5133, Q5134

C9166

Secukinumab (COSENTYX)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The TAR must include clinical documentation that demonstrates the following:

- Must be used for an FDA-approved indication and dosage.
- Must be administered intravenously.
- Must be 18 years of age or older.

- Patient has been evaluated and, if applicable, treated for active or latent Tuberculosis infection prior to initiating treatment with seckukinumab.
- Patient's age-appropriate immunizations are current.
- Psoriatic arthritis:
  - Inadequate response, intolerance, or contraindication to at least one of the following: etanercept, infliximab, adalimumab, certolizumab.
- Ankylosing spondylitis or non-radiographic axial spondyloarthritis:
  - Inadequate response, intolerance, or contraindication to at least one of the following: infliximab, etanercept, adalimumab, certolizumab, golimumab and their biosimilars.

Initial authorization is for 12 months.

Continued Therapy:

- Patient continues to meet initial approval criteria.
- Patient has shown positive clinical response as evidenced by disease improvement or stabilization compared to baseline.

Reauthorization is for 12 months.

Must be 18 years of age or older.

Frequency of billing equals every four weeks.

Modifiers SA, UD, U7, and 99 are allowed.

C9167

ADAMTS13, recombinant-krhn (ADZYNMA)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be two years of age or older.

Modifiers SA, UD, U7, and 99 are allowed.

C9168

Mirikizumab (OMVOH)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The TAR must include clinical documentation that demonstrates the following:

- Must be for an FDA-approved indications and dosages.
- Patient must be 18 years old.
- Must be prescribed by or in consultation with a gastroenterologist.
- Patient has been evaluated and, if applicable, treated for active or latent Tuberculosis infection prior to initiating treatment with mirikizumab-mrkz.
- Patient has baseline liver enzymes and bilirubin levels prior to treatment initiation.
- Patient's age-appropriate immunizations are current.
- Inadequate response, intolerance, or contraindication to at least one of the following: infliximab, adalimumab, golimumab, vedolizumab, tofacitinib or ustekinumab.

Initial authorization is for 12 months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced positive clinical response as evidenced by disease improvement or stabilization compared to baseline.
- Liver enzymes and bilirubin levels are being monitored for at least 24 weeks of treatment and routinely thereafter as needed.

Reauthorization is for 12 months.

Age must be 18 years of age or older.

Frequency of billing equals 300 mg/300 units every four weeks.

Maximum billing unit(s) equals 300 mg/300 units.

Modifiers SA, UD, U7, and 99 are allowed.

J0577

Buprenorphine (BRIXADI™)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals once in a week.

Maximum billing units equals 3 syringes (up to 32 mg total dose)/ 3 units.

Suggested ICD-10-CM Diagnosis Codes: F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29

Modifiers SA, UD, U7, and 99 are allowed.

J0578

Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals every 28 days.

Maximum billing units 2 syringes (up to 128 mg total dose)/ 2 units.

Suggested ICD-10-CM Diagnosis Codes: F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29

Modifiers SA, UD, U7, and 99 are allowed.

J0650, J0651, J0652

Levothyroxine Sodium

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals 500 mcg/50 units daily.

Maximum billing unit(s) equals 500 mcg/50 units.

Modifiers SA, UD, U7, and 99 are allowed.

J1010

Methylprednisolone Acetate (DEP-MEDROL)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7, and 99 are allowed.

J1202

Miglustat (OPFOLDA)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Must be 18 years of age or older and weigh at least 40 kg.
- Must be prescribed by or in consultation with a geneticist or other physician with specialty in treating metabolic disorders.
- Patient has a diagnosis of late-onset Pompe disease confirmed by one or both of the following:
  - Enzyme assay from any tissue source (for example skin fibroblast or muscle).
  - demonstrating lysosomal acid alpha-glucosidase (GAA) enzyme deficiency.
  - Genetic testing with two confirmed GAA gene variants.
- Patient has documented baseline results of Forced Vital Capacity (FVC) and/or six Minute Walk Test (6MWT) or motor function.
- Patient has not shown a functional or measurable improvement such as change in FVC or 6MWT after receiving Avalglucosidase Alfa-ngpt (Nexviazyme™) or Alglucosidase alfa (Lumizyme®) at the recommended dose and regimen for at least one year.
- Opfolda will be administered in combination with Pombiliti.
- Patient is not a pregnant female.

Initial authorization is for 12 months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has shown clinical benefit as evidenced by at least one of the following:
  - Change in FVC (percent predicted) from baseline.
  - Change in total distance walked in six minutes (six Minute Walk Test, [6MWT]) from baseline.

Reauthorization is for 12 months.

Must be 18 years of age or older.

Frequency equals 260 mg/four units once every two weeks.

Dosage equals 260 mg/four units.

Required ICD-10-CM Diagnosis Code: E74.02

Modifiers SA, UD, U7, and 99 are allowed.

J1203

Cipaglucosidase alfa-atga (POMBILITI)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Must be 18 years of age or older and weigh at least 40 kg.
- Must be prescribed by or in consultation with a geneticist or other physician with specialty in treating metabolic disorders.
- Patient has a diagnosis of late-onset Pompe disease confirmed by one or both of the following:
  - Enzyme assay from any tissue source (for example skin fibroblast or muscle) demonstrating lysosomal acid alpha-glucosidase (GAA) enzyme deficiency.
  - Genetic testing with two confirmed GAA gene variants.
- Patient has documented baseline results of Forced Vital Capacity (FVC) and/or six Minute Walk Test (6MWT) or motor function.
- Patient has not shown a functional or measurable improvement such as change in FVC or 6MWT after receiving Avalglucosidase Alfa-ngpt (Nexviazyme™) or Alglucosidase alfa (Lumizyme®) for at least one year.
- POMBILITI will be administered in combination with Opfolda.

Initial authorization is for six months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has shown clinical benefit as evidenced by at least one of the following:
  - Change in FVC (percent predicted) from baseline.
  - Change in total distance walked in six minutes (six Minute Walk Test, [6MWT]) from baseline.

Reauthorization is for 12 months.

Must be 18 years of age or older.

Frequency of billing equals 20 mg/kg once in two weeks.

ICD-10 Codes include: E74.02

Modifiers SA, UD, U7, and 99 are allowed.

J2801

Risperidone ER (RYKINDO®)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Must be prescribed by or in consultation with a psychiatrist.
- Patient must have a diagnosis of schizophrenia or bipolar I disorder based on DSM criteria.

Drug is used under the following conditions:

- Treatment of Schizophrenia:
  - As monotherapy for the maintenance treatment of bipolar I disorder.
  - As adjunctive therapy to lithium or valproate for the maintenance treatment of bipolar I disorder.
- Patient has an established stability and tolerability of oral risperidone.
- Patient meets one of the following conditions:
  - Has a history of non-adherence, refuses to take oral medication, or oral medication is clinically inappropriate.
  - Treatment was initiated in inpatient during a recent hospitalization, within the last 60 days.
- Must provide documentation justifying why a formulary alternative injection such as Risperdal Consta is not clinically appropriate.
- Patient has no history of hypersensitivity (for example, anaphylaxis, angioedema) to risperidone, paliperidone or any component of the formulation.

Initial authorization is for six months.

Continued Therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced documented positive clinical response from baseline.

Reauthorization is for 12 months.

Must be 18 years of age or older.

Frequency of billing equals 50 mg/100 units every two weeks.

Maximum billing units equals 50 mg/100 units.

Suggested ICD-10-CM Diagnosis Codes: F20.0 thru F20.9, F25.0 thru F25.9 (Schizophrenia), F31.0 thru F31.31 (Bipolar Disorder)

Modifiers SA, UD, U7, and 99 are allowed.

J2919

METHYLPREDNISOLONE SODIUM SUCCINATE

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7, and 99 are allowed.

J3424

Hydroxocobalamin for Injection

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7, and 99 are allowed.

J9376

Pozelimab-bbfg Injection (Veopoz™)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Veopoz will be considered medically necessary if all of the following criteria are met:

1. Must be used for FDA approved indication and dosages.
2. Patient is one year of age or older.
3. Patient has received meningococcal vaccination at least two weeks prior to treatment with Veopoz, unless the risks of delaying Veopoz outweighs the risk of meningococcal infection.
4. Patient is not currently on other complement inhibitors (for example, eculizumab, ravulizumab, pegcetacoplan, etc.).
5. Patient has a diagnosis of CD55-deficient protein losing enteropathy (CHAPLE disease) as documented by:
    A. Confirmed biallelic CD55 loss of function mutation and
    B. Hypoalbuminemia (serum albumin concentration of no more than 3.2 g/dL) and
    C. One or more of the following signs and symptoms of CD-55 PLE for at least six months: abdominal pain, diarrhea, peripheral edema, or facial edema)

Initial authorization is for 6 months.

Re-authorization criteria:

1. Patient continues to meet the initial criteria.
2. Lack of unacceptable toxicities (cardiovascular instability, infections, etc.).
3. Documentation of a clinically significant improvement (for example, improvement in abdominal pain, diarrhea, etc., normalization of serum albumin concentrations, reduced hospitalization).

Re-authorization is for 12 months.

Must be one year of age or older.

Frequency of billing equals once weekly.

Required ICD-10-CM Diagnosis Code: D84.1

Modifiers SA, UD, U7, and 99 are allowed.

Q5133

Tocilizumab-bavi (Tofidence™)

An approved *Treatment of Authorization Request* (TAR) is required for reimbursement.

Tofidence will be considered medically necessary when all of the following criteria is met:

Universal Criteria:

1. Must be used for FDA approved indications and dosages.
2. Must be prescribed by or in consultation with a rheumatologist.
3. Patient must be tested and monitored for latent and active TB initially and during treatment.
4. Must routinely monitor patient for the development of signs and symptoms of infection during and after treatment with Tofidence.
5. Tofidence will not be used in combination with etanercept (Enbrel), adalimumab (Humira), infliximab (Remicade), rituximab (Rituxan), abatacept (Orencia), anakinra (Kineret), certolizumab (Cimzia), or golimumab (Simponi).
6. The absolute neutrophil count (ANC) is above 2000 per mm3, platelet count is above 100,000 per mm3.
7. ALT or AST is not more than 1.5 times the upper limit of normal (ULN).
8. Live vaccines must not be administered during therapy with Tofidence.

Initial Authorization:

<u>Rheumatoid Arthritis (RA):</u>

1. Patient is at least 18 years of age.
2. Diagnosis of moderately to severely active rheumatoid arthritis.
3. Unless contraindicated, patient has tried and failed one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (for example: methotrexate, leflunomide, hydroxychloroquine, etc.), **or**
4. Unless contraindicated, patient has tried and failed at least one tumor necrosis factor (TNF alpha) (for example Enbrel, Humira).

<u>Polyarticular Juvenile Idiopathic Arthritis (PJIA):</u>

1. Patients is two years of age or older.
2. Diagnosis of active polyarticular juvenile idiopathic arthritis.
3. Unless contraindicated, patient has tried and failed at least one oral Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (for example methotrexate, leflunomide, hydroxychloroquine, etc.), **or**
4. Unless contraindicated, patient has tried and failed at least one tumor necrosis factor (TNF alpha) (for example Enbrel, Humira).

<u>Systemic Juvenile Idiopathic Arthritis (SJIA):</u>

1. Patient is two years of age or older.
2. Diagnosis of active systemic juvenile idiopathic arthritis.
3. Unless contraindicated, patient has tried and failed NSAIDs or corticosteroids.

Initial authorization is for 12 months.

Universal Re-Authorization:

1. Patient continues to meet the initial criteria.
2. Normal lab results as documented by routine laboratory monitoring (neutrophils, platelets, lipids and liver function tests).
3. Lack of unacceptable toxicities (serious infections, hepatotoxicity, GI perforation, etc.) and documentation of positive clinical outcome (percent of improvement in JIA ACR core set, physical global assessment, functional ability, etc.).

Re-authorization is for 12 months.

Must be two years of age or older (PJIA and SJIA).

Must be 18 years of age or older (RA).

Modifiers SA, UD, U7 and 99 are allowed.

Q5134

Natalizumab-sztn Injection (Tyruko®)

An approved *Treatment Authorization* (TAR) is required for reimbursement.

Tyruko is considered medically necessary when **all** of the following criteria are met:

Universal Criteria:

- Must be used for FDA approved indications and dosages.
- Must be prescribed by or in consultation with a gastroenterologist or neurologist.
- Patient is at least 18 years of age.
- Prescriber and patient must be enrolled in the Tyruko REMS program.
- Patient is being monitored for the development of progressive multifocal leukoencephalopathy (PML).

Crohn's Disease (CD):

- Confirmed diagnosis of moderate to severe disease utilizing an objective measure/tool (for example, Crohn's Disease Activity Index [CDAI]).
- Unless contraindicated, documented trial and failure of at least one oral immunosuppressive therapy for at least three months (for example, corticosteroids, methotrexate).
- Unless contraindicated, documented trial and failure of at least one inhibitor of TNF-α. for at least three months (for example, infliximab, certolizumab, or adalimumab).
- Must be used as monotherapy (patient is not currently taking immunosuppressants (for example, 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or inhibitors of TNF-α.

Initial authorization is for 12 weeks.

Multiple Sclerosis (MS):

- Confirmed diagnosis of MS (for example, MRI).
- Patient has been diagnosed with a relapsing form of MS (for example, relapsing remitting disease, active secondary progressive disease, or clinically isolated syndrome).

- Must be used as monotherapy.

Initial authorization is for six months.

Universal Re-authorization Criteria:

- Patient continues to meet the initial criteria.
- Absence of unacceptable toxicity (for example, hypersensitivity reactions, signs and symptoms of PML, hepatotoxicity, infections including pneumonias, herpes, vaginal infection, tooth infection, etc.).

Crohn's Disease:

- Initial renewal
  - Remission and clinical response (for example, greater than or equal to 70-point decrease in CDAI from baseline or CDAI score less than 150) is observed by 12 weeks.
- For continued re-authorization:
  - Patient has a clinical response (for example, greater than or equal to 70-point decrease in CDAI from baseline or CDAI score less than 150).
  - If on corticosteroid therapy, patient has been tapered off within six months of starting Tyruko.
  - Patient does not require additional steroid use that exceeds three months in a calendar year to control CD.

Re-authorization is for 12 months.

Multiple Sclerosis (MS):

- Documentation of positive response to therapy as indicated by the acceptable measuring tools (for example, MS disease activity, annualized relapse rate (ARR), improvement in MRI, etc.).

Re-authorization is for 12 months.

Must be 18 years of age or older.

Frequency of billing equals every 28 days.

Maximum billing unit(s) equals 300 mg per 300 units.

One of the following ICD-10-CM codes is required for reimbursement: G35, K50.00-K50.919

Modifiers SA, UD, U7, and 99 are allowed.

Non-Injection

The following Non-Injection code has special billing policies:

J7354

J7354

Cantharidin (YCANTH)

An approved *Treatment Authorization Request* (TAR) is required for.

The TAR must include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indication and dosing regimen.
- Patient must be 2 years of age or older.
- Health care professional preparing and administering treatment received instruction and training on Ycanth.
- Inadequate response, intolerance, or contraindication to cryotherapy, curettage, podofilox, or salicylic acid.

Authorization is for 6 months.

Must be two years of age or older.

Frequency of billing equals two applicators for every two units per treatment every three weeks.

Maximum billing unit(s) equals two applicators per two units.

Modifiers SA, UD, U7, and 99 are allowed.

Ophthalmology

The following Ophthalmology code has special billing policies:

J0177, J2782

J0177

Aflibercept (EYLEA® HD)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The TAR must include documentation that demonstrates the following:

- The patient is 18 years of age or older.
- The patient has tried and failed or is intolerant to less expensive, clinically appropriate alternatives (for example, bevacizumab, aflibercept before aflibercept hd).
- The patient does not have an active ocular or periocular infection.
- The patient does not have an active intraocular inflammation.
- Aflibercept is used for FDA-approved indications, dosages and usages.
- The initial approval is for 12 months.

Note: The TAR is renewable if the patient continues to meet the criteria for medical necessity.

Age must be 18 years or older.

Dosage equals eight mg/ eight units per eye.

Modifiers LT and RT are required. Modifiers UD and 99 are allowed. CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.

J2782

Avacincaptad-pegol (IZERVAY)

A *Treatment Authorization* Request (TAR) is required.

Izervay is medically necessary when all of the following criteria are met:

- Must be used for FDA approved indications and dosages.
- Patient must be 50 years of age or older.
- Must be prescribed by or in consultation with an ophthalmologist.
- Patient has a diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).
- Diagnosis has been confirmed by geographic atrophy secondary to age-related macular degeneration sensitive tests (for example, optical coherence tomography [OCT], fundus autofluorescence [FAF] imaging).
- The GA is not secondary to any conditions other than AMD (for example, Stargardt disease, cone rod dystrophy, toxic maculopathies).
- Patient does not have ocular or periocular infections; active intraocular inflammation.

Initial authorization is for 12 months.

Continuation of therapy:

- Patient continues to meet initial coverage criteria.
- Patient has experienced positive response to therapy (for example, disease stabilization or slowing of the rate of disease progression compared to pre-treatment baseline or reduction in total area of GA lesions.)

Reauthorization is for 12 months.

Must be 50 years or older.

Frequency of billing equals two mg/20 units every 21 days for up to 12 months per eye.

Maximum billing unit(s) equals two mg/20 units.

Suggested ICD-10-CM Diagnosis Codes: H35.3113, H35.3123, H35.3133, H35.3114, H35.3124, H35.3134

Modifiers RT and LT are required. Modifiers UD and 99 are allowed.

Proprietary Laboratory Analyses (PLA)

The following PLA code has special billing policies:

0448U

0448U

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to once in a lifetime.

An approved TAR requires documentation of the following criteria:

- The patient has been diagnosed with either non-small cell lung cancer (NSCLC) or colorectal cancer, and

- Management is contingent on the test results.

Radiology

The following Radiology code has special billing policies:

C9797

C9797

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 52, 53, 54, 55, 62, 66, 76, 77, 78, 79, 80, and 99 are allowed.

Skin Substitutes

The following Skin Substitute codes have special billing policies:

A2026, Q4305, Q4306, Q4307, Q4308, Q4309, Q4310

A2026, Q4305, Q4306, Q4307, Q4308, Q4309, Q4310

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, U7 and 99 are allowed.

Surgery

The following Surgery code has special billing policies:

A4564, C9796

A4564

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, SB, U7 and 99 are allowed.

C9796

No *Treatment Authorization Request* (TAR) is required.

Modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 52, 53, 54, 55, 62, 66, 76, 77, 78, 79, 80 and 99 are allowed.

Q2 Code Deletions

Table of HCPCS Q2 Code Deletions

Effective April 1, 2024

Subject	Deleted Code
Chemotherapy	C9163 (replaced with J3055), C9165 (replaced with J1323), J9070 (replaced with J9075)
Durable Medical Equipment	E2300 (replaced with E2298)
Injection	C9159 (replaced with J7165), C9161 (replaced with J0177), C9162 (replaced with J2782), J0576 (replaced with J0577, J0578), J1020 (replaced with J1010), J1030 (replaced with J1010), J1040 (replaced with J1010), J1840, J1850, J2920 (replaced with J2919), J2930 (replaced with J2919)
Non-Injection	C9164 (replaced with J7354)
Proprietary Laboratory Analyses	0354U, 0416U
Surgery	Q4244