Q1 HCPCS Level I and II Update (January 1, 2025)

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.

Q1 Code Additions

Chemotherapy

The following Chemotherapy codes have special billing policies:

J9292, Q5146

J9292

Pemetrexed (avyxa)

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

Pemetrexed is considered medically necessary when the following criteria are met:

Universal Criteria

- Must be used for FDA labelled indications and dosing regimens.
- Patient must be 18 years of age or older.
- Patient must have a diagnosis of malignant pleural mesothelioma or locally advanced or metastatic non-squamous, non-small cell lung cancer (NSCLC) (A or B below).

A. Malignant pleural mesothelioma
   - Patient has a diagnosis of malignant pleural mesothelioma; and
   - Used in combination with a cisplatin- or carboplatin-based regimen; or
   - Used as a single agent therapy; or
   - Used in combination with bevacizumab and either cisplatin or carboplatin followed by single-agent bevacizumab maintenance therapy and
   - Patient has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2; and
   - Patient's disease presentation is unresectable; or

B. Locally advanced or metastatic non-squamous, non-small cell lung cancer (NSCLC)
   - Patient has a diagnosis of locally advanced or metastatic non-squamous NSCLC; and
   - Patient is using as a single agent after prior chemotherapy; or
   - Patient is using as a first-line therapy in combination with platinum-based chemotherapy with or without bevacizumab (or bevacizumab biosimilar); or
   - Patient is using as a single agent for maintenance therapy when disease has not progressed after four cycles of platinum-based, first-line therapy; or

- Patient is using in combination with pembrolizumab and platinum chemotherapy for initial treatment in those confirmed with no EGFR or ALK genomic tumor aberrations; or
- Patient is using as continuous maintenance therapy until disease progression, if given first-line as part of pembrolizumab/platinum chemotherapy/and pemetrexed regimen.
- Pemfetrexed is not approvable for the treatment of patients with squamous cell non-small cell lung cancer.

Initial approval is for six months.

Continuation of therapy:

- Patient continues to meet initial coverage criteria.
- Patient shows positive clinical response as evidenced by disease stabilization or lack of disease progression.
- Patient does not have unacceptable toxicity such as severe hypersensitivity reactions, myelosuppression, renal, skin and gastrointestinal toxicity, etc.

Reauthorization is for 12 months.

Must be 18 years of age or older.

Suggested ICD-10-CD Diagnosis Codes: C34.00 thru C34.92 or C45.0 thru C45.9.

Frequency of billing is equal to 500 mg/m^2 on day one of each 21-day cycle.

Modifiers SA, UD, U7 and 99 are allowed.

Q5146

Trastuzumab

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

Must be 18 years of age or older.

Required ICD-10-CM Codes:

- C50.111 thru C50.929 (malignant neoplasm of breast)
- C16.0 thru C16.9 (malignant neoplasm of stomach)

Modifiers SA, UD, U7 and 99 are allowable.

Immunization

The following Immunization codes have special billing policies:

90593

90593

IXCHIQ

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

Must be 18 years of age or older.

Modifiers SA, UD, U7 and 99 are allowed.

Injection

The following Injection codes have special billing policies:

A9165, J0139, J0666, J0870, J0870, J1307, J1414, J1552, J2290, J2472, J2802, J3392, J9026, J9028, J9076, Q5139, Q5141, Q5142, Q5143, Q5144, Q5145, Q9996, Q9997, Q9998

A9615

Pegulicianine

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

Must be 18 years of age or older.

ICD-10 Codes: C50.01 thru C50.929

Modifiers SA, U7 and 99 are allowable.

J0139

Adalimumab (HUMIRA)

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

Maximum dosage is equal to 160 mg/160 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0666

Bupivacaine Liposome

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

Must be six years of age or older.

Maximum dosage is equal to 266 mg/266 units.

J0870

Imetelstat (RYTELO)

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA approved indications and dosages.
- Prescribed by or in consultation with an oncologist.
- Patient is at least 18 years of age or older.
- Diagnosis of low to intermediate risk myelodysplastic syndromes (MDS).
- Patient has transfusion-dependent anemia requiring four or more red blood cell units over eight weeks.
- Patient has not responded to or have lost response to or is ineligible for erythropoiesis-stimulating agents (ESA).
- RYTELO will not be used in combination with an erythropoiesis stimulating agent.
- Patient does not have del(5q) cytogenetic abnormality.
- Patient has not received prior treatment with lenalidomide or hypomethylating agents.

Initial authorization is for six months.

Re-authorization criteria:

- Patient has been on RYTELO for at least six months.
- Patient has not experienced disease progression while taking RYTELO.
- Patient has not experienced unacceptable toxicities or side effect while on RYTELO (for example cardiac failure, hemorrhage, etc.).

Re-authorization is for 12 months.

Must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowable.

J1307

Crovalimab-akkz (PIASKY)

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

Crovalimab-akkz is considered medically necessary in appropriate patients when the following criteria are met:

- Must be used for FDA approved indications and dosages.
- Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.
- Patient must be vaccinated against meningococcal infections within three years prior to, or at the time of initiating Crovalimab-akkz (at least two weeks prior to treatment, if not previously vaccinated). In emergent situations, antibiotics may be appropriate with vaccination less than two weeks prior to treatment.
- Patient must be 13 years of age or older.
- Prescriber is enrolled in the PIASKY REMS program.
- Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) is established by flow cytometry that demonstrates a population of granulocytes and red blood cells (RBCs) that are deficient in glycosylphosphatidylinositol (GPI)-linked proteins (e.g., CD55, CD59) in an appropriate clinical setting, such as direct antiglobulin testing (DAT)-negative hemolytic anemia, thrombosis, unexplained abdominal pain, aplastic anemia (AA), or myelodysplastic syndrome (MDS).

For Treatment Naive Patients:

- Lactate dehydrogenase (LDH) level greater than or equal to two times the upper limit of normal (ULN) at the screening and at least one or more of PNH-related signs or symptoms in the past three months of screening (e.g., fatigue, dyspnea, transfusion dependence, episodic hemoglobinuria, thrombosis, abdominal pain, bone marrow suppression and/or organ dysfunction). (Documentation is required).

For Eculizumab or Ravulizumab Conversion Patients:

- Lactate dehydrogenase (LDH) level less than or equal to 1.5 times the upper limit of normal (ULN) and patient has received approved eculizumab doses for at least six months. (Documentation is required).

Initial authorization is for up to six months.

- Continuation of therapy in appropriate patients is considered medically necessary for the treatment of a patient with documented PNH who is currently receiving treatment with Crovalimab-akkz AND one of the following:
  - Improvement in hemolysis (LDH level less than or equal to 1.5 times the ULN)
  - Hemoglobin stabilization
  - Transfusion avoidance
  - improvement in FACIT

Reauthorization for up to 12 months

REMS

Due to the risk of meningococcal infections, PIASKY is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

Prescribers must enroll in the program. Enrollment and additional information are available by telephone: 1-866-4My-Skyy (469-7599) or at www.PIASKYREMS.com.

Must be 13 years old or older.

Modifiers SA, UD, U7 and 99 are allowable.

J1414

Fidanacogene elaparvovec-dzkt (BEQVEZ)

A *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.
- Must be prescribed or in consultation with a hematologist.
- Patient is under the care of hematology/oncology or Hemophilia Treatment Center (HTC).
- Patient is 18 to 64 years of age with a confirmed diagnosis of moderate to severe Hemophilia B (less than or equal to 2 IU/dL or less than or equal 2 percent endogenous factor IX) meeting all of the following:
  - Currently use factor IX prophylaxis therapy (minimum of 50 exposure days to factor IX replacement therapy), or
  - Have current or historical life-threatening hemorrhage, or
  - Have repeated, serious spontaneous bleeding episodes, and
  - Do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test.
- Patient does not have any of the following:
  - Prior treatment with any gene therapy for Hemophilia B
  - History of chronic infection including active hepatitis B, hepatitis C or HIV
    - ❖ Positive hepatitis B surface antigen, hepatitis B virus deoxyribonucleic acid positivity, or hepatitis C virus ribonucleic acid

        - Currently on antiviral therapy for hepatitis B or C
        - Serological evidence of HIV-1 or HIV-2 with CD4 counts less than or equal to 200/mm^3 and/or a viral load greater than 20 copies/mL
    - Signs of liver disease:
        - Ascites
        - Encephalopathy
        - Coagulopathy
        - Hypoalbuminemia (levels less than the normal limits)
        - Gastrointestinal varices
        - Jaundice
        - Cirrhosis
        - Portal hypertension
        - Splenomegaly
        - Liver fibrosis-FibroScan score greater than 8 kPa units
        - FibroTest/FibroSure greater than 0.48
        - Aspartate aminotransferase (AST)-to-Platelet ratio greater than one
        - Alanine aminotransferase (ALT), AST (aspartate aminotransferase), or alkaline phosphatase greater than two times the upper limit of normal (ULN).
        - Bilirubin greater than 1.5 times the ULN
    - Renal impairment
    - Any conditions associated with increased thromboembolic risk
    - Neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid titer greater than or equal to 1:1 as detected by an FDA-approved test. More information can be found on the List of Cleared or Approved Companion Diagnostic Devices (In Vitro and Imaging Tools) of the FDA website.
    - History of or current inhibitor to FIX (greater than or equal to 0.6 Bethesda units)
    - Participated in a gene transfer trial or in a clinical trial with an investigational drug.
- Required lab:
    - Liver function tests (ALT, AST, alkaline phosphatase, bilirubin)
    - Elastography and/or ultrasound and other laboratory assessments for liver fibrosis such as Liver fibrosis-FibroScan score, FibroTest/FibroSure or AST-to-Platelet ratio if signs of liver disease are present
    - Anti-AAVRh74var neutralizing antibodies (nAb) titer
    - Inhibitor to Factor IX
    - Hepatitis B and C, and HIV screening tests
- Patient is utilizing contraception method until three consecutive samples are negative for vector shedding or six months after receiving Beqvez.

- Plan of post Beqvez administration hepatic function (ALT and AST) and Factor IX activity monitoring once or twice weekly for at least four months and as indicated per package insert.
- Monitor patients with risk factors for hepatocellular carcinoma following Beqvez administration with regular liver ultrasound and Alpha-fetoprotein testing for five years

Authorization: Three months (one treatment in a lifetime).

Reauthorization: Never.

Must be 18 to 64 years of age.

Frequency of billing is equal to once in a lifetime.

ICD-10 code D67 is required.

Modifiers UD and 99 are allowable.

J1552

Immune globulin (ayglo)

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

TARs may be approved for any of the FDA-approved indications. In many instances, immune globulin is not considered first line therapy and may be used as second line therapy or in special circumstances. The TAR must not only state the diagnoses but also must contain sufficient clinical information to establish medical necessity.

Must be 17 years of age or older.

Modifiers SA, UD, U7 and 99 are allowable.

J2290

Nafcillin

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

Modifiers SA, UD, U7 and 99 are allowable.

J2472

Pantoprazole (baxter)

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

Must be 18 years of age or older.

Maximum dosage is equal to 80 mg/two units.

Modifiers SA, UD, U7 and 99 are allowable.

J2802

Romiplostim

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

Suggested ICD-10-CM Diagnosis codes: D69.3, T66.XXXA

Frequency of billing is equal to 10 micrograms/10 units weekly.

Maximum dosage is equal to 10 micrograms/10 units

Modifiers SA, UD, U7 and 99 are allowable.

J3392

Exagamglogene autotemcel (CASGEVY)

Modifiers SA, UD, U7 and 99 are allowable.

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

Universal Criteria:

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 12 years of age or older.
- Patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT).
- Patient does not have any of the following:
  - A willing and healthy 10/10 human leukocyte antigen (HLA)-matched related donor
  - Prior hematopoietic stem cell transplant (HSCT) or gene therapy.
  - Advanced liver disease:
    - Persistent aspartate transaminase [AST] or alanine transaminase [ALT] greater than three times the upper limit of normal [ULN], **OR**
    - Persistent direct bilirubin value greater than 2.5 times the ULN, **OR**
    - Liver biopsy demonstrated bridging fibrosis or cirrhosis [liver biopsy was performed if liver iron content was greater than or equal to 15 mg/g by MRI]).
  - Active Human Immunodeficiency Virus (HIV-1, HIV-2), Hepatitis B Virus (HBV) or Hepatitis c Virus (HCV)
  - Allergy or contraindications to dimethyl sulfoxide (DMSO), plerixafor, or busulfan
- Patient is not pregnant or breastfeeding.
- Patient will not receive therapy concomitantly with any of the following as applicable:
  - Disease-modifying agents (e.g., vexelotor or crizanlizumab) for at least eight weeks prior to mobilization.
  - Hydroxyurea for at least two months prior to mobilization.
  - Iron chelators at least seven days prior to initiation of myeloablative conditioning, non-myelosuppressive iron chelators for at least three months and myelosuppressive iron chelators for at least six months after Casgevy infusion.
- Provider attests to monitor hemoglobin S (HbS) levels prior to apheresis, absolute neutrophil counts (ANC) and platelet count (PLT) during and after treatment.
- Patient meets the criteria of diagnoses A or B below:

A. Transfusion-dependent β-thalassemia (TDT):

- Must be prescribed by or in consultation with hematologist with expertise in the diagnosis and treatment β-thalassemia.
- Patient must have a diagnosis of transfusion-dependent β-thalassemia (TDT):

- Documented homozygous β-thalassemia or compound heterozygous β-thalassemia including β-thalassemia/hemoglobin E (HbE).
- History of at least 100 mL/kg/year or greater than or equal to 10 units/year of packed RBC transfusions

- Patient does not have:
  - α-thalassemia and greater than one alpha deletion or alpha multiplications
  - Sickle cell beta thalassemia variant.
  - HbF level greater than 15.0 percent, irrespective of concomitant treatment
- Patient does not have any of the following:
  - Severely elevated iron in the heart
    - ❖ Cardiac T2* less than 10 msec by magnetic resonance imaging [MRI]
  - Left ventricular ejection fraction [LVEF] less than 45 percent by echocardiogram.
  - White blood cell (WBC) count less than three times 10^9/L or platelet count less than 50 times 10^9/L not related to hypersplenism.
- Patient has a hemoglobin (Hb) greater than or equal to 11 g/dL prior to apheresis procedure.

B. Sickle Cell Disease:

- Must be prescribed by or in consultation with hematologist with expertise in the diagnosis and treatment of sickle cell disease.
- Patient must have a diagnosis of sickle cell disease with documented SCD genotypes of βS/βS, βS/β0, or βS/β+ and greater than or equal to two severe vaso-occlusive crises (VOC) per year for two years prior defined as any of the following requiring intervention at a medical facility:
  - Administration of pain medications or RBC transfusions for an acute pain
  - Acute chest syndrome indicated by the presence of a new pulmonary infiltrate associated with pneumonia-like symptoms, pain, or fever
  - Priapism lasting greater than two hours
  - Splenic sequestration, as defined by an enlarged spleen, left upper quadrant pain, and an acute decrease in hemoglobin concentration of greater than or equal to 2 g/dL
- Normal transcranial Doppler (TCD) velocity (time-averaged mean of the maximum velocity less than 170 cm/sec for non-imaging TCD and less than 155 cm/sec for imaging TCD) in the middle cerebral artery and the internal carotid artery for subjects 12 to 16 years of age
- Maintain hemoglobin S (HbS) levels less than 30 percent of total hemoglobin (Hb) and total Hb concentration less than or equal to 11 g/dL prior to apheresis.

Authorization: 12 months (One dose per lifetime).

Reauthorizations: Not Approvable.

Must be 12 years of age or older.

Required ICD-10-CM Diagnosis Codes:

D56.1, D57.00-D57.819 (except D57.3 which is not reimbursable)

Modifiers UD and 99 are allowable.

J9026

Tarlatamab-dlle for Injection (Imdelltra)

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

Must be 18 years of age or older.

Maximum dosage is equal to 10 mg/10 units.

Modifiers SA, UD, U7 and 99 are allowable.

J9028

Nogapendekin Alfa Inbakicept-pmln (ANKTIVA)

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

The TAR must include clinical documentation that demonstrates the following:

- Must be prescribed by or in consultation with an oncologist or urologist.
- Must be for an FDA-approved indication and dosage.
- Patient must be 18 years of age or older.
- Patient has a diagnosis of Bacillus Calmette-Guérin (BCG)-negative non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.
- Pregnancy testing and advice on contraception are provided to patient of reproductive potential prior to initiating treatment.
- Patient tried and was unresponsive to adequate BCG therapy, defined as administration of at least five of six doses of an initial induction course plus either of at least two of three doses of maintenance therapy or at least two of six doses of a second induction course).
- Must be used in combination with BCG.

Initial authorization is for six months.

Continued Therapy:

- Patient continues to meet initial approval criteria.
- Patient achieved complete response from the induction period, defined by negative results for cystoscopy (with TURBT/biopsies as applicable) and urine cytology.
- Patient has an absence of disease recurrence, disease progression, and unacceptable toxicity.

Reauthorization is for 12 months. Maximum total treatment duration is 37 months.

Must be 18 years of age or older.

Maximum dosage is equal to 400 mcg/400 units.

Modifiers SA, UD, U7 and 99 are allowable.

J9076

Cyclophosphamide (baxter)

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

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

- Must be used for FDA-approved indications and dosing regimens.
- Patient has a diagnosis of one of the following malignant diseases:
  - Malignant lymphomas (Stages III and IV of the Ann Arbor staging system), Hodgkin's disease, lymphocytic lymphoma (nodular or diffuse), mixed-cell type lymphoma, histiocytic lymphoma, Burkitt's lymphoma
  - Multiple myeloma
  - Leukemias: chronic lymphocytic leukemia, chronic granulocytic leukemia (it is usually ineffective in acute blastic crisis), acute myelogenous and monocytic leukemia, acute lymphoblastic (stem-cell) leukemia (cyclophosphamide given during remission is effective in prolonging its duration)
  - Mycosis fungoides (advanced disease)
  - Neuroblastoma (disseminated disease)
  - Adenocarcinoma of the ovary
  - Retinoblastoma
  - Carcinoma of the breast
- Patient does not have hypersensitivity to cyclophosphamide.
- Patient does not have urinary outflow obstruction.

Approval is for 12 months.

Modifiers SA, UD, U7 and 99 are allowable.

Q5139

Eculizumab-aeeb (BKEMV)

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

Eculizumab-aeeb is considered medically necessary in appropriate patients when the following criteria are met:

Universal criteria

- Must be used for FDA approved indications and dosages.
- Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.
- Patient must be vaccinated against meningococcal infections within three years prior to, or at the time of initiating eculizumab-aeeb (at least two weeks prior to treatment, if not previously vaccinated). In emergent situations, antibiotics may be appropriate with vaccination less than two weeks prior to treatment.

- Prescriber is enrolled in the BKEMV REMS program.

A. Paroxysmal Nocturnal Hemoglobinuria (PNH)

- Confirmed Diagnosis of PNH by flow cytometry showing detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or greater than or equal to 10 percent PNH cells
- Patient is 18 years of age or older.
- Provider must submit the documentation for the followings:
  - Patient has at least four transfusions in the prior 12 months, and platelet counts of at least 100,000 per microliter.
    - ❖ To confirm the need for RBC transfusion and to identify the hemoglobin concentration, patient must meet ONE of the following:
      - Hemoglobin less than or equal to 9 g/dL in patients with anemia symptoms
      - Hemoglobin less than or equal to 7 g/dL in patients without anemia symptoms.
  - Patient has at least one transfusion in the prior 24 months and at least 30,000 platelets per microliter

Initial authorization is for up to six months

- Continuation of therapy is considered medically necessary for the treatment of a patient with PNH who is currently receiving treatment with Eculizumab-aeeb and ALL of the following (documentation is required):
  - Improved hemolysis (e.g., reduced serum LDH levels)
  - Hemoglobin stabilization
  - Reduced RBC transfusion
  - Less fatigue

Reauthorization for up to 12 months.

B. Atypical Hemolytic Uremic Syndrome (aHUS)

- Documentation that patient does not have the following:
  - Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).
- Patient is 2 months of age or older.
- Confirmed diagnosis of atypical hemolytic uremic syndrome (aHUS) showing signs of thrombotic microangiopathy (TMA) by all the following:
  - Platelet count less than or equal to 150 times 10^9 /L.
  - Evidence of hemolysis such as an elevation in serum LDH and serum creatinine above the upper limits of normal, without the need for chronic dialysis.
  - A disintegrin and metalloproteinase with thrombospondin type 1 motif, member 13 (ADAMTS13) activity level above five percent.

Initial authorization for up to six months

- Continuation of therapy is considered medically necessary for the treatment of a patient with aHUS who is currently receiving treatment with Eculizumab-aeeb and all the following (documentation is required):
  - Improvement in platelet count.
  - Improved measures of hemolysis (e.g., reduced serum LDH).
  - Reduced need for dialysis.
  - Reduction in thrombocytopenia.

Reauthorization for up to 12 months.

REMS

Due to the risk of meningococcal infections, BKEMV is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

Prescribers must enroll in the program. Enrollment and additional information are available by telephone: 1-866-718-6927 or at www.BKEMVREMS.com.

Frequency of billing is equal to 1200 mg/120 units every week.

Maximum dosage is equal to 1200 mg/120 units.

Modifiers SA, UD, U7 and 99 are allowable.

Q5140

Adalimumab-fkjp

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

Maximum dosage is equal to 160 mg/160 units.

Modifiers SA, UD, U7 and 99 are allowable.

Q5141, Q5142, Q5143, Q5144, Q5145

Adalimumab

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

- Must be used for FDA-approved indications and dosages.
- Inadequate response, intolerance, or contraindication to adalimumab or adalimumab-fkjp.

Initial authorization is for 12 months.

Continued Therapy:

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

Reauthorization is for 12 months.

Maximum dosage is equal to 160 mg/160 units.

Modifiers SA, UD, U7 and 99 are allowable.

Q9996, Q9997

Ustekinumab-ttwe (PYZCHIVA®)

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

Must submit clinical documentation to substantiate the following:

Universal Criteria:

- Must be used for FDA-approved indications and dosages.
- Patient does not have active infection (including tuberculosis and hepatitis B virus [HBV]) or other serious active infection.
- Patient has baseline liver enzymes and bilirubin levels prior to treatment initiation.
- Must avoid use of live vaccines.
- Patient must meet A, B, C or D below:

A. Moderate to Severe Plaque Psoriasis (Ps):

- Must be prescribed by or in consultation with a dermatologist.
- Patient must be 6 years of age or older.
- Patient must have a diagnosis of plaque psoriasis (with or without psoriatic arthritis) for at least six months before treatment initiation.
- Patient has stable moderate to severe chronic plaque-type psoriasis with or without psoriatic arthritis and meets all of the following:
  - Static Physician Global Assessment (sPGA) score of at least three (moderate).
  - Psoriasis Area and Severity Index (PASI) greater than or equal to 12.
  - Body Surface Area (BSA) greater than or equal to 10 percent.
- Patient is a candidate for systemic therapy or phototherapy.
- Patient must have a history of inadequate response to at least one of the following:
  - Systemic therapies up to maximally indicates doses, unless intolerant, contraindicated or clinically inappropriate:
    - ❖ Methotrexate
    - ❖ Cyclosporine
    - ❖ Acitretin
- If patient is 18 years of age or older:
  - Patient must have tried and failed one of the biologic therapies (e.g., Enbrel, Humira, Cosentyx, Remicade) unless intolerant, inadequate response or contraindication.

B. Active Psoriatic Arthritis (PsA):

- Must be prescribed by or in consultation with a dermatologist or rheumatologist.
- Patient must be 6 years of age or older.
- Patient has a clinical diagnosis of PsA with symptom onset at least six months prior based on the Classification Criteria for PsA (CASPAR).
- Patient has active disease at Baseline defined as greater than or equal to five tender joints (based on 68 joint counts) and greater than or equal to five swollen joints (based on 66 joint counts).

- Patient must have a history of failure of a three-month trial of at least one conventional Disease-Modifying Antirheumatic Drug (DMARD) such as methotrexate at maximally indicated doses within the last six months unless intolerant, contraindicated or clinically inappropriate.
- If patient is 18 years of age or older:
  - Patient must have tried and failed one of the biologic therapies (e.g., Enbrel, Humira, Cosentyx, Remicade) unless intolerant, inadequate response or contraindication.

C. Moderately to severely active Crohn's disease (CD):

- Patient must be 18 years of age or older.
- Must be prescribed by or in consultation with a gastroenterologist.
- Patient has a diagnosis of CD for at least three months prior to Baseline.
- Patient has a confirmed diagnosis of moderate to severe CD as assessed by stool frequency (SF), abdominal pain (AP) score and Simple Endoscopic Score for Crohn's Disease (SES-CD).
- Crohn's disease activity index (CDAI) score 220 - 450 at Baseline.
- Inadequate response, intolerance or contraindication to at least one conventional therapy option such as corticosteroids (for example, prednisone, methylprednisolone, budesonide), mercaptopurine (Purinethol), azathioprine (Imuran) or methotrexate (Rheumatrex, Trexall).
- Patient must have tried and failed one of the biologic therapies (for example, Enbrel, Humira, Cosentyx, Remicade) unless intolerant, inadequate response or contraindication.

D. Ulcerative Colitis, Moderate-To-Severe:

- Patient has a documented diagnosis of moderately to severely active ulcerative colitis. for at least three months prior to Baseline.
- Must be prescribed by or in consultation with a gastroenterologist.
- Patient must be 18 years of age or older.
- Patient must have a history of inadequate response, intolerance, or contraindication to one or more of the following conventional therapies: Oral 5-aminosalicylates (e.g., sulfasalazine, mesalamine), glucocorticoids (e.g., prednisone, budesonide), immunomodulators (e.g., azathioprine, 6-mercaptopurine, methotrexate), unless clinically inappropriate.
- Patient must have tried and failed one of the biologic therapies (for example, Enbrel, Humira, Cosentyx, Remicade) unless intolerant, inadequate response or contraindication.

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.

Reauthorization is for 12 months.

Must be 6 years of age or older (Q9996)

Must be 18 years of age or older (Q9997)

For Q9996:

Frequency of billing is 90 mg/90 units every four weeks

Maximum dosage is 90 mg/90 units

For Q9997:

Maximum dosage is 520 mg/520 units

Modifiers SA, UD, U7 and 99 are allowable.

Q9998

Ustekinumab-aekn (SELARSDI™)

Ustekinumab-aekn is considered medically necessary in appropriate patients when the following criteria are met:

Universal Criteria

- Must be used for FDA-approved indications and dosages.
- Patient does not have active infection (including tuberculosis and hepatitis B virus [HBV]) or other serious active infection.
- Patient has baseline liver enzymes and bilirubin levels prior to treatment initiation.
- Must avoid use of live vaccines.

A. Moderate to Severe Plaque Psoriasis (Ps)

- Must be prescribed by or in consultation with a dermatologist.
- Patient must be 6 years of age or older.
- Patient must have a diagnosis of plaque psoriasis (with or without psoriatic arthritis) for at least 6 months before treatment initiation.
- Patient has stable moderate to severe chronic plaque-type psoriasis with or without psoriatic arthritis and meets all of the following:
- Static Physician Global Assessment (sPGA) score of at least three (moderate)
- Psoriasis Area and Severity Index (PASI) greater than or equal to 12
- Body Surface Area (BSA) greater than or equal to 10 percent.
- Patient is a candidate for systemic therapy or phototherapy.
- Patient must have a history of inadequate response to at least one of the following:
  - Systemic therapies up to maximally indicates doses, unless intolerant, contraindicated or clinically inappropriate:
    - ❖ Methotrexate
    - ❖ Cyclosporine
    - ❖ Acitretin

- If patient is 18 years of age or older
  - Patient must have tried and failed one of the biologic therapies (e.g., Enbrel, Humira, Cosentyx, Remicade) unless intolerant, inadequate response or contraindication.

B. Active Psoriatic Arthritis (PsA)

- Must be prescribed by or in consultation with a dermatologist or rheumatologist.
- Patient must be 6 years of age or older.
- Patient has a clinical diagnosis of PsA with symptom onset at least 6 months prior based on the Classification Criteria for PsA (CASPAR).
- Patient has active disease at Baseline defined as greater than or equal to five tender joints (based on 68 joint counts) and greater than or equal to five swollen joints (based on 66 joint counts)
- Patient must have a history of failure of a three-month trial of at least one conventional Disease-Modifying Antirheumatic Drug (DMARD) such as methotrexate at maximally indicated doses within the last six months unless intolerant, contraindicated or clinically inappropriate.
- If patient is 18 years of age or older
  - Patient must have tried and failed one of the biologic therapies (e.g., Enbrel, Humira, Cosentyx, Remicade) unless intolerant, inadequate response or contraindication.

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.

Reauthorization is for 12 months

Must be 6 years of age or older.

Frequency of billing is equal to 90 mg/90 units every four weeks.

Maximum dosage is equal to 90 mg/90 units.

Medicine

The following Medicine codes have special billing policies:

0906T, 0907T, 93896, 93897, 93898

0906T, 0907T, 93896, 93897, 93898

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

Modifiers SA, U7 and 99 are allowable.

Non-Injection

The following Non-Injection codes have special billing policies:

J0601, J0602, J0603, J0605, J0607, J0608, J0609, J0615, J0901, J7514, J7601

J0601

Renvela (Oral Tablets)

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

Must be 6 years of age or older.

Maximum dosage is equal to 13000 mg/650 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0602

Renvela (Oral Powder)

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages.
- Prescribed by or in consultation with a nephrologist.
- Patient is at least 6 years of age or older.
- Documentation of trial and failure, intolerance, or contraindications to calcium acetate or sevelamer tablets.

Authorization is for 12 months.

Must be six years of age or older.

Maximum dosage is equal to 13000 mg/650 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0603

Renagel®

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages.
- Prescribed by or in consultation with a nephrologist.
- Patient is at least 18 years of age or older.
- Documentation of trial and failure, intolerance, or contraindications to generic sevelamer tablets or calcium acetate.

Authorization is for 12 months.

Must be 18 years of age or older.

Maximum dosage is equal to 13000 mg/650 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0605

Velphoro

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages**.**
- Prescribed by or in consultation with a nephrologist.
- Patient is at least 9 years of age or older.
- Documentation of trial and failure, intolerance, or contraindications to calcium acetate or sevelamer tablets.

Authorization is for 12 months

Must be 9 years of age or older.

Maximum dosage is equal to 3000 mg/600 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0607, J0608

Fosrenol

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages.
- Prescribed by or in consultation with a nephrologist.
- Patient is at least 18 years of age or older.
- Documentation of trial and failure, intolerance, or contraindications to calcium acetate or generic sevelamer tablets.

Authorization is for 12 months.

Must be 18 years of age or older.

Maximum dosage is equal to 4500 mg/900 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0609

Ferric Citrate Tablets (Auryxia)

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages.
- Prescribed by or in consultation with a nephrologist.
- Diagnosis of Hyperphosphatemia in Chronic Kidney Disease on Dialysis.
- Patient is at least 18 years of age or older.
- Documentation of trial and failure, intolerance, or contraindications to generic sevelamer tablets or calcium acetate.

Must be 18 years of age or older.

Maximum dosage is equal to 2520 mg/840 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0615

Calcium Acetate

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

Must be 18 years of age or older.

Maximum dosage is equal to 6003 mg/261 units.

Modifiers SA, UD, U7 and 99 are allowable.

J0901

Vadustat (VAFSEO)

A *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 dosage.
- Patient is 18 years of age or older.
- Patient has been receiving dialysis for at least three months.
- Correctable causes of anemia have been assessed and treated.
- Documented assessment of baseline hemoglobin levels, iron status and liver function.
- Patient does not have uncontrolled hypertension.
- Patient is not pregnant.
- Patient does not have an active malignancy.
- Inadequate response, intolerance or contraindication to an erythropoietin stimulating agent (ESA).
- Patient will not use vadadustat in combination with ESA.

Initial approval is for three months.

Continued Therapy:

- Patient continues to meet initial approval criteria.
- Patient has experience positive clinical response as evidenced by an improvement in hemoglobin levels.

Reauthorization is for 12 months.

Must be 18 years of age or older.

Frequency of billing is equal to 600 mg/600 units daily.

Maximum dosage is equal to 600 mg/600 units.

Modifiers SA, UD, U7 and 99 are allowable

J7514

Mycophenolate mofetil (MYHIBBIN)

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA- approved indications and dosages.
- Documentation of trial and failure, intolerance, or contraindications to CellCept or Myfortic

Authorization is for 12 months.

Re-authorization is for 12 months.

Maximum dosage is equal to 3000 mg/30 units.

J7601

Ensifentrine (OHTUVAYRE)

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

The TAR must include clinical documentation that demonstrates all of the following:

- Must be for and FDA-approved indication and dosage.
- Inadequate response, intolerance, or contraindication to a long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA), and inhaled corticosteroid (ICS) therapy.
- Inadequate response, intolerance or contraindication to roflumilast.
- Documented baseline spirometry and pulmonary function tests, including FEV_1 and FVC.

Initial authorization is for six months.

Continued Therapy:

- Patient continues to meet initial approval criteria.
- 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 is equal to three mg/one unit twice daily.

Maximum dosage is equal to three mg/one unit.

Pathology

The following Pathology codes have special billing policies:

81515, 82233, 82234, 84393, 84394, 86581, 87564, 87626, 87594

81515

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

Modifiers 33, 90, 99 and QW are allowable.

87564, 87594

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

Modifiers 33, 90 and 99 are allowable.

87626

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

Modifiers 33, 90 and 99 are allowable.

Minimum age is 21 years.

82233, 82234, 84393, 84394

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

A TAR requires documentation of the following criteria:

For Alzheimer disease

- The patient has signs and symptoms concerning for Alzheimer disease and the test is necessary to aid in diagnosis or the patient has been diagnosed with Alzheimer disease and treatment strategy will be contingent on the test results, and
- The test will be performed on cerebrospinal fluid (CSF) specimen(s) only.

Modifiers 33, 90 and 99 are allowable.

Frequency is limited to once in a lifetime.

86581

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

A TAR requires documentation of the following criteria:

- The patient has signs and symptoms concerning for a possible immunodeficiency, and the test is necessary to aid in diagnosis.

Modifiers 33, 90 and 99 are allowable.

Preventative Services

The following Preventative Services code has special billing policies:

G0537

G0537

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

Frequency of billing is equal to once a year.

Modifiers SA, SB, U7 and 99 are allowable.

Proprietary Laboratory Analyses (PLA)

The following PLA codes have special billing policies:

0523U, 0528U

0523U

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

A 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

Frequency is limited to once in a lifetime.

Modifiers 33, 90 and 99 are allowable.

0528U

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

Frequency is limited to two times per year.

Modifiers 33, 90 and 99 are allowable.

Psychological Services

The following Psychological Service codes have special billing policies:

G0539, G0540, G0542, G0543, G0552, G0553, G0554, G0560, H0052, H0053

G0539, G0540

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

For Procedure. Type Q: Modifiers U7 and 99 are allowable.

For Procedure. Type N: Modifiers SA, U7 and 99 are allowable.

G0542, G0543

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

For Proc. Type Q: Modifiers U7 and 99 are allowable.

For Proc. Type N: Modifiers SA, U7 and 99 are allowable.

G0552, G0553, G0554

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

For Procedure. Type Q: Modifiers U7 and 99 are allowable.

For Procedure. Type N: Modifiers SA, U7 and 99 are allowable.

G0560

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

For Procedure. Type Q: Modifiers U7 and 99 are allowable.

For Procedure. Type N: Modifiers SA, U7 and 99 are allowable.

H0052, H0053

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

For Procedure. Type Q: Modifiers U7 and 99 are allowable.

For Procedure. Type N: Modifiers SA, U7 and 99 are allowable.

Radiology

The following Radiology codes have special billing policies:

0944T, 0945T, 0946T, 0947T, 76014, 76015, 76016, 76017, 76018, 76019, G0562, G0563, C8001

0944T

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

Modifiers SA, U7 and 99 are allowable.

Minimum age is 18 years.

0945T, 0946T, 0947T, 76014, 76015, 76016, 76017, 76018, 76019

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

Modifiers SA, U7 and 99 are allowable.

G0563, C8001

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

Modifiers SA, U7 and 99 are allowable.

G0562

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

Modifiers U7 and 99 are allowable.

Must provide documentation of previous PET and CT imaging data which is required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling).

Surgery

The following Surgery codes have special billing policies:

15012, 15013, 15014, 15015, 15016, 15017,15018, 25448, 38225, 38266, 38227, 38228, 49186, 49187, 49188, 49189, 49190, 61715, 64466, 64467, 64468, 64469, 64473, 64474, 66683 C7563, C7564, C7565, C8002, C8003, G0555, G0561

15012, 15013, 15014, 15015, 15016, 15017,15018, 25448, 38225, 38226, 38227, 38228, 49186, 49187, 49188, 49189, 49190, 61715

A *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.

64466, 64467, 64468, 64469, 64473, 64474

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.

Assistant Surgeon not payable.

66683

A *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.

Assistant Surgeon not payable.

C7563, C7564, C7565

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 allowable.

C8002, C8003

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 allowable.

G0555

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

Modifiers U7 and 99 are allowable.

G0561

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 allowable.

Skin Substitutes

The following Skin Substitute codes have special billing policies:

15011, Q4346, Q4347, Q4348, Q4349, Q4350, Q4351, Q4352, Q4353

15011

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

Modifiers SA, U7 and 99 are allowed.

Q4346, Q4347, Q4348, Q4349, Q4350, Q4351, Q4352, Q4353

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

Modifiers SA, U7, 99 are allowable.

Vision

The following Vision codes have special billing policies:

92137

92137

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

Modifiers LT, RT and 50 are required. Modifiers SA, U7 and 99 are allowable.

Do not report with 92133 or 92134 at the same patient encounter.

Q1 Code Deletions

Table of HCPCS Q1 Code Deletions

Effective January 1, 2025

Subject	Deleted Code
California Child Services (CCS) Program Service Code Groupings	G9892, G9893, J0135
Chemotherapy	C9169 (replaced with J9028), C9170 (replaced with J9026), J2796 (replaced with J2802), J9058, J9059, J9259
Clinical Decision Support Mechanism (CDSM)	G1020 thru G1023
Evaluation and Management	93890, 96003, 96040 (replaced with 96041), 99441 thru 99443
Injection	90630, 90654, C9171, C9172 (replaced with J1414), C9290 (replaced with J0666), J2806
Modifier	MA, MB, MC, MD, ME, MF, MG, MH
Non-Injection	J0570
Pathology	81433, 81436, 81438, 86327, 86490, 88388
Proprietary Laboratory Analyses	0346U, 0352U, 0380U, 0428U, 0448U, 0456U
Radiology	0398T, C9794, C9795
Surgery	15819, 33737, C9769
Telehealth	G2012