Drug Code List
Version 9.0
Revised 5/14/15
List will be updated routinely

Disclaimer: For drug codes that require an NDC, coverage depends on the drug NDC status (rebate eligible, Non-DESI, non-termed, etc) on the date of service.

Note: Physician/Facility-administered medications are reimbursed using the Centers for Medicare and Medicaid Services'(CMS) pricing file found on the CMS website--www.cms.hhs.gov. In the absence of a fee, pricing may reflect the methodolgy used for retail pharmacies.

Highlights represent updated material for each specific revision of the Drug Code List.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
90281	human ig, im	Gamastan	Yes	ML	Antisera	NONE	X	X	X	X									**Closed 3/31/13.**
90283	human ig, iv	Gamimune, Flebogamma, Gammagard	Yes	ML	Antisera	NONE	X	X	X	X									**Closed 3/31/13**. Cost invoice required with claim. Restricted to **ICD-9** diagnoses codes 204.10 - 204.12, 279.02, 279.04, 279.06, 279.12, 287.31, and 446.1, and must be included on claim form, effective 10/1/09.
90287	botulinum antitoxin		N/A		Antisera														Not Covered
90288	botulism ig, iv		No	ML		NONE	X	X	X	X									Requires documentation and medical review
90291	cmv ig, iv	Cytogam	Yes	ML	Antisera	NONE	X	X	X	X									**Closed 3/31/13.**
90296	diphtheria antitoxin		No	ML		NONE	X	X	X	X									
90371	hep b ig, im	Bayhep B, Hyperhep B, Nabi-HB	Yes	ML	Antisera	NONE	X	X	X	X									**Closed 3/31/13.**
90375	rabies ig, im/sc	BayRab	Yes	ML	Antisera	NONE	X	X	X	X									
90376	rabies ig, heat treated	Imogam	Yes	ML	Antisera	NONE	X	X	X	X									
90378	Respiratory syncytial virus immune globulin(RSV-IgIM), for intramuscular use, 50 mg., each	Synagis	Yes	ML	Antisera	NONE	X	X	X										Pends for manual review. Requires prior authorization from Rational Drug Therapy Program (RDTP), at 1-800-847-3859.
90379	Respiratory syncytial virus immune globulin(RSV-IgIV), human, for intravenous use	Respigam	Yes	ML	Antisera	NONE	X	X	X										Closed.
90384	Rho(D) immune globulin (RhIg), human, full-dose, 300 mcg., intramuscular use	Gamulin RH	Yes	EA=UN SOL=ML	Immune globulin	NONE	X	X	X	X	X								**Code closed 3/31/13. See J2790 after this date.**
90385	Rho(D) immune globulin (RhIg), human, mini-dose, 50 mcg., intramuscular use	BayRho-D MicrhoGam Hyprho-D	Yes	SOL=ML EA=UN	Immune globulin	NONE	X	X	X	X									**Code closed 3/31/13. See J2788 after this date.**

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
90386	Rho(D) immune globulin (RhIgIV), human, intravenous use	BAYrho-D Winrho SDF	Yes	EA=UN SOL=ML	Immune globulin	NONE	X	X	X	X									**Closed 3/31/13.**
90393	vaccina ig, im		No	ML		NONE	X	X	X	X									Requires documentation and medical review
90396	varicella-zoster ig, im	Varicella-Zoster	Yes	ML	Antisera	NONE	X	X	X	X									
90399	immune globulin	Gammagard Polygam	Yes	ML	Antisera	NONE	X	X	X	X									Requires documentation and medical review
Radiopharmaceuticals																			
A4641	Radiopharmaceutical, diagnostic, not otherwise classified																		Not Covered
A4642	In111 satumomab INDIUM IN-111 SATUMOMAB PENDETIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 6 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78801, 78802, 78803, 78804; Attach copy of invoice to claim.
A9500	Tc99m sestamibi TECHNETIUM TC-99M SESTAMIBI, DIAGNOSTIC, PER STUDY DOSE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78070,78451, 78452, 78453, 78454, 78605, 78606, 78607, 78800, 78801, 78802, 78803, 78804,
A9501	Technetium TC-99M Teboroxime, Diagnostic, per Study Dose		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78451, 78452, 78453, 78454; Attach copy of invoice to claim
A9502	Tc99m tetrofosmin TECHNETIUM TC-99M TETROFOSMIN, DIAGNOSTIC, PER STUDY DOSE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78451, 78452, 78453, 78454

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9503	Tc99m medronate TECHNETIUM TC-99M MEDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78300, 78305, 78306, 78315, 78320
A9504	Tc99m apcitide TECHNETIUM TC-99M APCITIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 20 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78456; Attach copy of invoice to claim
A9505	TL201 thallium THALLIUM TL-201 THALLOUS CHLORIDE, DIAGNOSTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78070, 78451, 78452, 78453, 78454, 78800, 78801, 78802, 78803, 78804
A9507	In111 capromab INDIUM IN-111 CAPROMAB PENDETIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES	Prostascint Kit	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78801, 78802, 78803, 78804; Attach copy of invoice to claim
A9508	I131 iodobenguate, dx IODINE I-131 IOBENGUANE SULFATE, DIAGNOSTIC, PER 0.5 MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78075, 78800, 78801, 78802, 78803, 78804; Attach copy of invoice to claim
A9509	IODINE I-123 Sodium Iodide, Diagnostic, Per Millicurie		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014, 78015, 78016, 78018, 78020, 78070, 78071, 78072; Attach copy of invoice to claim
A9510	Tc99m disofenin TECHNETIUM TC-99M DISOFENIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78201, 78202, 78205, 78206, 78215, 78216, 78226, 78227; Attach copy of invoice to claim

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9512	Tc99m pertechnetate TECHNETIUM TC-99M PERTECHNETATE, DIAGNOSTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014, 78015, 78016, 78018, 78020 78230; 78231; 78232; 78261; 78290; 78600; 78601; 78605; 78606; 78607; 78610; 78660 78730; 78740; 78761; Attach copy of invoice to claim
A9516	I123 iodide cap, dx IODINE I-123 SODIUM IODIDE CAPSULE(S), DIAGNOSTIC, PER 100 MICROCURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014, 78015, 78016, 78018; 78020; 78070; Attach copy of invoice to claim
A9517	I131 iodide cap, rx IODINE I-131 SODIUM IODIDE CAPSULE(S), THERAPEUTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 79005; Attach copy of invoice to claim
A9520	Technetium tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper claim. Send copy of the invoice which includes the NDC billed. Only covered when billed with the following CPT codes on the same claim: 78195
A9521	Tc99m exametazime TECHNETIUM TC-99M EXAMETAZIME, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78600; 78601; 78605; 78606; 78607; 78610, 78805, 78806, 78807; Attach copy of invoice to claim
A9524	I131 serum albumin, dx IODINE I-131 IODINATED SERUM ALBUMIN, DIAGNOSTIC, PER 5 MICROCURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78110, 78111; 78122; 78460, 78461, 78464, 78465, 78472, 78473; 78481, 78483, 78580, 78598, 78600; 78601; 78605; 78606; 78607, 78610, 78800, 78801, 78802, 78803, 78804; Attach copy of invoice to claim
A9526	Nitrogen N-13 ammonia NITROGEN N-13 AMMONIA, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814,78815, 78816; Attach copy of invoice to claim

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9527	Iodine I-125 sodium iodide IODINE I-125, SODIUM IODIDE SOLUTION, THERAPEUTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 79101, 79005; Attach copy of invoice to claim
A9528	Iodine I-131 iodide cap, dx IODINE I-131 SODIUM IODIDE CAPSULE(S), DIAGNOSTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014, 78015, 78016, 78018, 78020; Attach copy of invoice to claim
A9529	I131 iodide sol, dx IODINE I-131 SODIUM IODIDE SOLUTION, DIAGNOSTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014, 78015, 78016, 78018, 78020; Attach copy of invoice to claim
A9530	I131 iodide sol, rx IODINE I-131 SODIUM IODIDE SOLUTION, THERAPEUTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 79005; Attach copy of invoice to claim
A9531	I131 max 100uCi IODINE I-131 SODIUM IODIDE, DIAGNOSTIC, PER MICROCURIE (UP TO 100 MICROCURIES)		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014, 78015, 78016, 78018, 78020; Attach copy of invoice to claim
A9532	I125 serum albumin, dx IODINE I-125 SERUM ALBUMIN, DIAGNOSTIC, PER 5 MICROCURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78110, 78111; 78122; Attach copy of invoice to claim
A9535	Injection, methylene blue INJECTION, METHYLENE BLUE, 1 ML	Methylene Blue	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		**Closed 1/1/10.** Paper Claim. Send copy of the invoice which includes the NDC billed
A9536	Tc99m depreotide TECHNETIUM TC-99M DEPREOTIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 35 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78012, 78013, 78014; Attach copy of invoice to claim

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9537	Tc99m mebrofenin TECHNETIUM TC-99M MEBROFENIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78226 and 78227; Attach copy of invoice to claim
A9538	Tc99m pyrophosphate TECHNETIUM TC-99M PYROPHOSPHATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78300, 78305, 78306, 78315, 78320; 78466, 78468, 78469; Attach copy of invoice to claim
A9539	Tc99m pentetate TECHNETIUM TC-99M PENTETATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES	CA-DTPA ZN-DTPA	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78291; 78481,78483; 78579, 78580; 78582, 78597, 78598, 78600, 78601, 78605, 78606, 78607; 78608, 78609, 78610; 78630, 78635, 78645, 78647, 78650; 78700, 78701, 78707, 78708, 78709, 78710, 78725; 78730; 78740; 78761; Attach copy of invoice to claim
A9540	Tc99m MAA TECHNETIUM TC-99M MACROAGGREGATED ALBUMIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78216, 78291, 78428, 78579, 78580, 78582, 78597, 78598, 78645
A9541	Tc99m sulfur colloid TECHNETIUM TC-99M SULFUR COLLOID, DIAGNOSTIC, PER STUDY DOSE, UP TO 20 MILLICURIES	Sulfer Powder-Colloidal	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78102, 78103, 78104, 78185, 78195, 78201, 78202, 78205, 78206, 78215, 78216, 78226, 78227, 78258,78262, 78264,78278, 78291, 78640, 78645, 78730, 78740
A9542	In111 ibritumomab, dx INDIUM IN-111 IBRITUMOMAB TIUXETAN, DIAGNOSTIC, PER STUDY DOSE, UP TO 5 MILLICURIES	Zevalin	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78001, 78802, 78003, 78804, and 79403 ICD-9 restriction: 200.80 - 200.88, 202.00 - 202.08, and 202.80 - 202.88
A9543	Y90 ibritumomab, rx YTTRIUM Y-90 IBRITUMOMAB TIUXETAN, THERAPEUTIC, PER TREATMENT DOSE, UP TO 40 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78001, 78802, 78003, 78804, and 79101, 79403. ICD-9 restriction: 200.80 - 200.88, 202.00 - 202.08, and 202.80 - 202.88.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9544	I131 tositumomab, dx IODINE I-131 TOSITUMOMAB, DIAGNOSTIC, PER STUDY DOSE	Bexxar	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78001, 78802, 78003, 78804, and/or 79403. ICD-9 restriction: 200.80 - 200.88, 202.00 - 202.08, and 202.80 - 202.88.
A9545	I131 tositumomab, rx IODINE I-131 TOSITUMOMAB, THERAPEUTIC, PER TREATMENT DOSE	Bexxar	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78001, 78802, 78003, 78804, and/or 79101, 79403. ICD-9 restriction: 200.80 - 200.88, 202.00 - 202.08, and 202.80 - 202.88.
A9546	Co57/58 COBALT CO-57/58, CYANOCOBALAMIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 1 MICROCURIE	Various Generic	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78270, 78271, 78272
A9547	In111 oxyquinoline INDIUM IN-111 OXYQUINOLINE, DIAGNOSTIC, PER 0.5 MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78185, 78190, 78191, 78805, 78806, and/or 78807.
A9548	In111 pentetate INDIUM IN-111 PENTETATE, DIAGNOSTIC, PER 0.5 MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78630, 78635, 78645, 78650, 78800, 78801, 78802, 78803.
A9550	Tc99m gluceptate TECHNETIUM TC-99M SODIUM GLUCEPTATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78600, 78601, 78605, 78606, 78607, 78610, 78647, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78805, 78806, 78807; Attach copy of invoice to claim
A9551	Tc99m succimer TECHNETIUM TC-99M SUCCIMER, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES	DMSA Powder	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78800, 78801, 78802, 78803, 78804

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9552	F18 fdg FLUORODEOXYGLUCOSE F-18 FDG, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78459, 78491, 78492, 78608, 78609, 78610, 78811, 78812, 78813, 78814,78815, 78816
A9553	Cr51 chromate CHROMIUM CR-51 SODIUM CHROMATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 250 MICROCURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78110,78111, 78120, 78121, 78122, 78130, 78135, 78140, 78190, 78191
A9554	I125 iothalamate, dx IODINE I-125 SODIUM IOTHALAMATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MICROCURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78707, 78708, 78709, 78725.
A9555	Rb82 rubidium RUBIDIUM RB-82, DIAGNOSTIC, PER STUDY DOSE, UP TO 60 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78459, 78491, 78492, 78608,78609, 78811, 78812, 78813, 78814,78815, 78816; Attach copy of invoice to claim
A9556	Ga67 gallium GALLIUM GA-67 CITRATE, DIAGNOSTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78195, 78800, 78801, 78802, 78803, 78804; 78805, 78806, 78807; Attach copy of invoice to claim
A9557	Tc99m bicisate TECHNETIUM TC-99M BICISATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78600, 78601, 78605, 78606, 78607, 78610, 78647; Attach copy of invoice to claim
A9558	Xe133 xenon 10mci XENON XE-133 GAS, DIAGNOSTIC, PER 10 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78491, 78492, 78494, 78579,78580 78582, 78597,78598; Attach copy of invoice to claim
A9559	Co57 cyano COBALT CO-57 CYANOCOBALAMIN, ORAL, DIAGNOSTIC, PER STUDY DOSE, UP TO 1 MICROCURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78270, 78271, 78272.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9560	Tc99m labeled rbc TECHNETIUM TC-99M LABELED RED BLOOD CELLS, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78110, 78111, 78120, 78120, 78121, 78122, 78130, 78135, 78140, 78185, 78201, 78202, 78205, 78215, 78216,78258, 78278, 78414, 78428, 78445, 78451, 78452, 78453, 78454, 78457, 78458, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496
A9561	Tc99m oxidronate TECHNETIUM TC-99M OXIDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78300, 78305, 78306, 78315, 78320, 78350; Attach copy of invoice to claim
A9562	Tc99m mertiatide TECHNETIUM TC-99M MERTIATIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78700, 78701, 78707, 78708, 78709, 78710, 78725; Attach copy of invoice to claim
A9563	P32 Na phosphate SODIUM PHOSPHATE P-32, THERAPEUTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 79005, 79101; Attach copy of invoice to claim
A9564	P32 chromic phosphate CHROMIC PHOSPHATE P-32 SUSPENSION, THERAPEUTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 79200; 79300; 79445; Attach copy of invoice to claim
A9565	In111 pentetreotide INDIUM IN-111 PENTETREOTIDE, DIAGNOSTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		**Code closed effective 12/31/07. Claims will deny when A code is billed for dates of service after 12/31/07**. Paper Claim. Send copy of the invoice which includes the NDC billed Only covered when billed with the following CPT codes on the same claim: 78800, 78801, 78802, 78803, 78804; 78075; 78015, 78016, 78018.
A9566	Tc99m fanolesomab TECHNETIUM TC-99M FANOLESOMAB, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78805, 78806, 78807

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9567	Technetium TC-99m aerosol TECHNETIUM TC-99M PENTETATE, DIAGNOSTIC, AEROSOL, PER STUDY DOSE, UP TO 75 MILLICURIES		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78579, 78580,78582, 78597, 78598; Attach copy of invoice to claim
A9568	Technetium tc-99m arcitumomab per dose up to 45 millicuries		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78800, 78801, 78802, 78803, 78804; Attach copy of invoice to claim
A9569	Technetium TC-99M Exametazime Labeled Autologous White Blood Cells, Diagnostic		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78647, 78805, 78806, 78807; Attach copy of invoice to claim
A9570	Indium IN-111 Labeled Autulogous White Blood Cells, Diagnostic, Per Study Dose		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78805, 78806, 78807, 78185; Attach copy of invoice to claim
A9571	Indium IN-111 Labeled Autulogous Platelets, Diagnostic, Per Study Dose		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78190, 78191, 78456, 78457, 78458; Attach copy of invoice to claim
A9572	Indium IN-111 Pentetreotide, Diagnostic, Per Study Dose, up to 6 Millicuries		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78015, 78016, 78018, 78075, 78800, 78801, 78802, 78803, 78804; Attach copy of invoice to claim
A9575	Injection, gadoterate meglumine, 0.1ml		No		Contrast agent		X	X	X								X		Paper claim. Send copy of the invoice which includes the NDC billed. Only covered when billed with one of the following CPT codes on the same claim: 70544, 70545, 70546, 70551, 70552, 70553, 70554, 70555, 70557, 70558, 70559, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, or 72159
A9576	Injection, Gadoteridol, (Prohance multipack), per ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Special instructions no longer apply.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9577	Injection, Gadobenate Dimeglumine (Multihance), Per ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Special instructions no longer apply.
A9578	Injection, Gadobenate Dimeglumine (Multihance Multipack), Per ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Special instructions no longer apply.
A9579	Injection, Gadolinium-Based Magnetic Resonance Contrast Agent, Not Otherwise Classified		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Special instructions no longer apply.
A9581	Injection Gadoxetate Disodium, 1ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 70540, 70542, 70543, 70551, 70552, 70553, 70557, 70558, 70559, 72141, 72142, 73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 77058, 77059, 77084,
A9582	Iodine I-123 Iobenguane, diagnostic, per study dose, up to 15 Millicuries		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 78075, 78201, 78202, 78205, 78206, 78215, 78216, 78600, 78601, 78605, 78606, 78607, 78647, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807; Attach copy of invoice to claim
A9583	Injection Gadofosvese T Trisodium, 1 ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 72198, 73725.
A9584	Iodine I-123 Ioflupane, diagnostic, per study dose, up to 5 Millicuries		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 70460, 70552, 70558, 70559, 78600, 78601, 78605, 78606, 78607; Attach copy of invoice to claim
A9585	Injection, gadobutrol, 0.1 ml.		No		Contrast agent		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 70542, 70544, 70545, 70546, 70548, 70552, 70553, 71551, 72142, 72147, 72149, 72156, 72157, 72158, 73219, 73222, 73719, 75561, 75563; Attach copy of invoice to claim

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
A9599	Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose.		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed. Only covered when billed with the following CPT codes on the same claim: 78608, 78609, or 78610
A9600	Sr89 strontium STRONTIUM SR-89 CHLORIDE, THERAPEUTIC, PER MILLICURIE		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 77750, 79101; Attach copy of invoice to claim
A9604	Samarium SM-153 Lexidronam, Therapeutic, per treatment dose, up to 150		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Only covered when billed with one of the following CPT codes on the same claim: 77750, 79101; Attach copy of invoice to claim
A9605	Sm 153 lexidronm SAMARIUM SM-153 LEXIDRONAMM, THERAPEUTIC, PER 50 MILLICURIES	Quadramet	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		**Closed 12/31/09. See A9604.** Paper Claim. Send copy of the invoice which includes the NDC billed Only covered when billed with the following CPT codes on the same claim: 79101.
A9606	Radium ra-223 dichloride, therapeutic, per microcurie				Radio-pharmaceutical		X	X	X										Requires Prior authorization through the UMC. Paper Claim. Send copy of the invoice which includes the NDC billed
A9698	Nonradioactive contrast imaging material, not otherwise classified, per study																		Not Covered
A9699	Radiopharmaceutical, therapeutic, not otherwise classified																		Not Covered
A9700	Contrast Material Supply of injectable contrast material for use in echocardiography, per study		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Attach copy of invoice to claim
C9003	Palivizumab, per 50 mg	Synagis	N/A		Antisera														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
C9021	Injection, obinutuzumab, 10 mg.	Gazyva	Yes	ML	Antineoplastic	none	X	X											**Closed 12/31/14. See J9301 after this date.** Effective 4/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 204.10. Minimum age restriciton of 16 years.
C9022	Injection, elosulfase alfa, 1 mg.	Vimizim	Yes	ML	Enzymatic	none	X	X											**Closed 12/31/14. See J1322 after this date.** Effective 7/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 277.5. Minimum age restriction of 5 years.
C9025	Injection, ramucirumab, 5 mg.	Cyramza	Yes	ML	Antineoplastic		X	X											**Effective 12/12/14, ICD-9 diagnosis restriction of 162.0 - 162.8 added.** Effective 10/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 151.0 - 151.9. Minimum age restriction of 16 years.
C9026	Injection, vedolizumab, 1 mg.	Entyvio	Yes	UN	Anti-Infective		X	X											**Effective 10/1/14. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis of 555.0 - 556.9. Minimum age restriction of 16 years.
C9027	Injection, pembrolizumab, 1 mg	Keytruda	Yes	UN	Antineoplastic		X	X											**Effective 1/1/15. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis of 172.0 - 172.9 or 173.0 - 173.9. Minimum age restriciton of 16 years.
C9113	Inj pantoprazole sodium, via	Protonix	N/A		Gastric Reflux, Esophogitis														Not Covered
C9121	Injection, argatroban	Argatroban	N/A		Thrombin Inhibitor														Not Covered
C9131	Injection, ado-traztuzumab emtansine, 1 mg.	Kadcyla	Yes		Anti-neoplastic	none	X	X											**Closed 12/31/13. See J9354**. Effective 7/1/13. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 174.0 - 174.9 or 175.0 - 175.9. Minimum age restriction of 16 years.
C9132	Prothrombin complex concentrate (human), per i.u. of factor ix activity	Kcentra	Yes	UN	Coagulation factor		X	X											**Effective 10/1/13. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis code of 286.7. Minimum age restriction of 16 years.
C9133	Factor IX (antihemophilic factor, recombinant), per i.u.	Rixubis	Yes	UN	Anti-hemophilic	none	X	X											**Closed 12/31/14. See J7200 after this date.** Effective 1/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 286.1. Minimum age restriction of 16 years.
C9134	Injection, Antihemophilic factor XIIIA, recombinant	Tretten	Yes	UN	Anti-hemophilic	none	X	X											**Closed 12/31/14. See J7181 after this date.** Effective 7/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 286.3.
C9135	Injection, factor ix (antihemophilic factor, recombinant), per IU	Alprolix	Yes	UN	Anti-hemophilic		X	X											**Closed 12/31/14. See J7201 after this date.** Effective 10/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 286.1.
C9136	Injection, factor viii, fc fusion protein, (recombinant), per IU	Eloctate	Yes	UN	Anti-hemophilic		X	X											**Effective 1/1/15. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis of 286.0. Minimum age restriciton of 2 years.
C9232	Injection, idursulfase	Elaprase	N/A		Metabolic Enzyme Replacement														Not Covered. Closed 12/31/07. See J1743 Effective 1/1/08

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
C9233	Injection, ranibizumab	Lucentis	N/A		neovascular-Age related Macular Degeneration														Not Covered. Closed 12/31/07 - remove from J3490 list. See J2778 effective 1/1/08
C9234	Inj, alglucosidase alfa	Myozyme	N/A		Metabolic Enzyme Replacement														Not Covered. Closed 12/31/07 See J0220 effective 1/1/08
C9235	Injection, panitumumab	Vectibix	N/A		Colorectal Cancer														Not Covered. Closed 12/31/07 See J9303 effective 1/1/08
C9236	Injection, Eculizumab 10 mg																		Not Covered. Closed 12/31/07 See J1300 effective 1/1/08
C9239	Injection, temsirolimus, 1 mg.	Torisel	Yes	UN	Anti-neoplastic		X	X	X										Opened 1/1/08. Closed 12/31/08. Cost invoice required with **ICD-9** diagnosis of 189.0-189.9, advanced renal cell carcinoma See J9330.
C9240	Injection, ixabepilone, 1 mg.	Ixempra	Yes	UN	Anti-neoplastic		X	X	X										Opened 1/1/08. Closed 12/31/08. Cost invoice required with I**CD-9** diagnosis of 174.0-174.9, metastatic/locally advanced breast cancer. See J9207
C9245	Injection, romiplostim, 10 mcg.	Nplate	Yes	UN															Closed 12/31/09. See J2796.
C9246	Injection, gadoxetate disodium, per ml.	Eovist																	
C9248	Injection, clevidipine butyrate, 1 mg.	Cleviprex																	
C9249	Injection, certolizumab pegol, 1 mg.	Cimzia	Yes	UN	TNF blocker														Closed 12/31/09. See J0718.
C9250	human plasma ,fibrin sealant, 2 ml.	Artiss																	
C9251	Injection, C1 esterase inhibitor (human), 10 U	Cinryze	Yes	UN	C1 protein inhibitor														Closed 12/31/09. See J0598.
C9252	Injection, plerixafor, 1 mg.	Mozobil	Yes	ML	Hematopoietic														Closed 12/31/09. See J2562.
C9253	Injection, temozolomide, 1 mg.	Temodar	Yes	UN															Closed 12/31/09. See J9328.
C9254	Injection, lacosamide, 1 mg.	Vimpat	Yes	ML	Anti-convulsive	400 units per day	X	X											Effective 1/1/10. Cost invoiice with NDC is required with claim. **ICD-9** restriction 345.00 - 345.91. Approved for age 17 and above. See J3490 for coverage of other providers.
C9255	Injection, paliperidone palmitate, 1 mg.	Invega Sustenna	Yes	SOL=ML	Anti-psychotic	234 units	X	X											**Closed 12/31/10. See J2426.** Effective 1/1/10. Cost invoice with NDC is required with claim. **ICD-9** restriction 295.00 - 295.95. Approved for age 18 and above. See J3490 for coverage of other providers.
C9256	Injection, dexamethasone intravitreal, implant, 0.1 mg.	Ozurdex	Yes	EA	Anti-inflammatory		X	X											**Closed 12/31/10. See J7312.** Effective 1/1/10. Cost invoice with NDC is required with claim. **ICD-9** restriction 362.83 and 362.35, or 362.83 and 362.36. Approved for age 16 and above. See J3490 for coverage of other providers.
C9257	Injection, bevacizumab, 0.25 mg.	Avastin	Yes	SOL=ML	Anti-neoplastic	20 u. per month	X	X											**Opthalmologists use J3490.** Effective 1/1/10. **ICD-9** restriction 362.01 - 362.07, 362.15, 362.16, 362.29, 362.30, 362.35, 362.36, 362.42, 362.52, 362.53, 362.83, 362.84, 365.63, and 365.89.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
C9258	Telavancin HCl., inj., 10 mg.	Vibativ	Yes	UN	Anti-Infective	None	X	X											**Closed 12/31/10. See J3095.** Effective 4/1/10. Cost invoice with NDC required with claim. **ICD-9** restriction of 680.0 - 686.9 and 041.0 - 041.9. Minimum age restriction of 18 years. See J3490 for coverage of other providers.
C9259	Pralatrexate, inj., 1mg.	Folotyn	Yes	ML	Anti- neoplastic	None	X	X											**Closed 12/31/10. See J9307.** Effective 4/1/10. Cost invoice with NDC is required with claim. **ICD-9** restriction of 202.70 - 202.78. Minimum age restriction of 18 years. See J3490 for coverage of other providers.
C9260	Ofatumumab, inj., 10 mg.	Arzerra	Yes	ML	Anti-neoplastic	200 u. Daily	X	X											**Closed 12/31/10. See J9302.** Effective 4/1/10. Cost invoice with NDC is required with claim. **ICD-9** restriction of 204.10 - 204.12**.** Minimum age restriction of 18 years. See J3490 for coverage of other providers.
C9261	Ustekinumab, inj., 1 mg.	Stelara	N/A		Anti-neoplastic														Not covered.
C9262	Fludarabine phosphate, oral, 1 mg.	Oforta	N/A		Anti-metabolite														Not covered.
C9263	Injection, ecallantide 1 mg..	Kalbitor	Yes	ML	Hematological	30 u. daily	X	X											**Closed 12/31/10. See J1290 after this date.** Effective 4/1/10. Cost invoice with NDC is required with claim. ICD-9 restriction of 277.6. Minimum age restriction of 16 years. See J3490 for coverage of other providers.
C9264	Injection, tocilizumab, 1 mg.	Actemra	Yes	ML	Immunologic	Maximum servicd limit of 800 u. monthly	X	X											**Closed 12/31/10. See J3262.** Effective 7/1/10. Cost invoice with NDC requried with claim. ICD-9 restriction of 714.0 - 714.2. Minimum age restriction of 16 years.
C9265	Injection, romidepsin, 1 mg.	Istodax	Yes	UN	Antineoplastic	None	X	X											**Closed 12/31/10. See J9315.** Effective 7/1/10. Cost invoice with NDC required with claim. ICD-9 restricton of 202.10 - 202.28. Minimum age restriction of 18.
C9266	Injection, Collagenase clostridium histolyticum, 0.1 mg.	Xiaflex	Yes	UN	Enzymatic	None	X	X											**Closed 12/31/10. See J0775.** Effective 7'/1/10. Cost invoice with NDC required with claim. ICD-9 restriction of 728.6. Minimum age restriction of 18 years.
C9267	Injection, von Willebrand factor complex(human), per 100 IU	Wilate	Yes	UN	Coagulation factor	None	X	X											**Closed 12/31/10. See J7184.** Effective 7/1/10. Cost invoice with NDC required with claim. ICD-9 restriction of 286.4. Minimum age restriction of 5 years.
C9268	Capsaicin patch	Qutenza	Yes	UN	Anallgesic	1 patch per 90 days	X	X											**Closed 12/31/10. See J7335.** Effective 7/1/10. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 053.19. Minimum age restriction of 18 years.
C9269	Injection, C-1 Esterase inhibitor (human), 10 u.	Berinert	Yes	UN	Protein C-1 inhibitor	Maximum service limit 28 u. daily	X	X											**Closed 12/31/10. See J0597.** Effective 10/1/10. Cost invoice with NDC required with claim. ICD-9 restriction of 277.6. Minimum age restriction 4 years and above.
C9270	Injection, Immune globulin, IV, non-lyophilized (e.g. liquid), 500 mg.	Gammaplex	N/A		Immune globulin														Not covered.
C9271	Injection, velaglucerase alfa, 100 u.	Vpriv	Yes	UN	Enzymatic	Maximum service limit 1650 u. monthly	X	X											**Closed 12/31/10. See J3385.** Effective 10/1/10. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 272.7. Minimum age restriction of 4 years.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
C9272	Injection, denosumab, 1 mg.	Prolia Xgeva	Yes	ML	Osteoporotic	Maximum service limit of 60 u. twice yearly	X	X											**Closed 12/31/11.** Effective 10/1/10. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 733.01.
C9273	Sipuleucel-T, minimum of 50 millioin autologous cells, including all preparatory procedures, per infusion	Provenge																	Not covered. See Q2043.
C9274	Crotalidae polyvalent immune fab (ovine), 1 vial	Crofab																	Not covered.
C9276	Injection, cabazitaxel, 1 mg.	Jevtana	Yes	ML	Antineoplastic	None	X	X											**Closed 12/31/11. See J9043.** Effective 1/1/11. Cost invoice with NDC requred with claim. ICD-9 restricition of 185.0.
C9277	Injection, alglucosidase alfa, 1 mg.	Lumizyme	Yes	UN	Enzymatic	None	X	X											**Closed 12/31/11. See J0221.** Effective 1/1/11. Cost invoice with NDC requred with claim. ICD-9 restriction of 271.0. Minimum age restriction of 8
C9278	Injection, incobotulinimtoxins, 1 u	Xeomin	N/A																Not covered. See Q2040.
C9279	Injection, ibuprofen, 100 mg.		N/A																Not covered.
C9280	Injection, eribulin mesylate, 1 mg.	Halaven	Yes	ML	Antineoplastic	8 u. in 21 days	X	X											**Closed 12/31/11. See J9179**. Effective 4/1/11. Cost invoice with NDC required with claim. ICD-9 restriction of **174.0 - 175.9 or 198.81**. Minimum age restriction of 18 years.
C9281	Injection, pegloticase, 1 mg.	Krystexxa	Yes	ML	Hyperuricemic	16 u. monthly	X	X											**Closed 12/31/11. See J2507.** Effective 4/1/11. Cost invoice with NDC required with claim. ICD-9 restriction of 274.0 - 274.89. Minimum age restriction of 18 years.
C9282	Injection, cetaroline fosamil, 10 mg.	Teflaro	Yes	UN	Antibiotic	12 units per dose	X	X											**Closed 12/31/11. See J0712.** Effective 4/1/11. Cost invoice with NDC required with claim. ICD-9 restriction of 041.00 - 041.89 or 482.0 - 482.89. Minimum age restriction of 18 years.
C9284	Injection, ipilimumab, 1 mg.	Yervoy	Yes	UN	Antineoplastic	400 units per 21 days	X	X											**Closed 12/31/11. See J9228.** Effective 7/1/11. Restricted to ICD-9 diagnosis of 154.2, 154.3, 172.0 - 172.9, 184.0 - 184.4, 187.1 - 187.9, 196.0 - 196.9, 197.0 - 197.8, 198.0 - 198.8. Minimum age restriction of 16 years.
C9285	Patch, lidocaine, 70 mg. & tetracaine, 70 mg.	Synera	Yes	UN	Anallgesic	None	X	X											**Effective 7/1/11.**
C9286	Injection, belatacept, 250 mg.	Nulojix	Yes	UN	Immunosuppressive	5.4 units daily maximum	X	X											**Closed 12/31/12. See J0485 after this date.** Effective 10/1/11. Must submit V42.0 with claim. Minimum age restriction of 18 years.
C9287	Injection, brentuximab vedotin, 1 mg.	Adcetris	Yes	UN	Antineoplastic	180 units per day	X	X											**Closed 12/31/12. See J9042 after this date.** Effective 1/1/12. Cost invoice with NDC required with claim. ICD-9 restriction of 200.60 - 200.68 or 201.00 - 201.98. Minimum age restriction of 18 years.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
C9289	Injection, asparaginase erwinia chrysanthemia, 1000 U.	Erwinaze	Yes	UN	Antineoplastic	None	X	X											**Closed 12/31/12. See J9019 after this date.** Effective 4/1/12. Cost invoice with NDC requried with claim. ICD-9 restriction of 204.00 - 204.02.
C9291	Injection, aflibercept, 2 mg.	Eylea	Yes	ML	neovascular-Age related Macular Degeneration	2 units weekly	X	X											**Closed 6/30/12. See Q2046 after this date.** Effective 4/1/12. Cost invoice with NDC requried with claim. **ICD-9** restriction of 362.52. Minimum age restriction of 16 years.
C9292	Injection, pertuzumab, 10 mg.	Perjeta	Yes	ML	Antineoplastic	84 units per 21 days	X	X											**Closed 12/31/13. See J9306.** Effective 10/1/12. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 174.0 - 174.9 or 175.0 - 175.9. Minimum age restriction of 16 years.
C9294	Injection, taliglucerase alfa, 10 units	Elelyso	Yes	UN	Enzymatic	82 units per 14 days	X	X											**Closed 12/31/12. See J3060.** Effective 1/1/13. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 272.7. Minimum age restriction of 16 years.
C9295	Injection, carfilzomib, 1 mg	Kyprolis	Yes	UN	Antineoplastic	None	X	X											**Closed 12/31/13. See J9047.** Effective 1/1/13. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 203.02. Minimum age restriction of 16 years.
C9296	Injection, ziv-aflibercept, 1 mg	Zaltrap	Yes	ML	Antineoplastic	550 units per 14 days	X	X											**Closed 12/31/13. See J9400.** Effective 1/1/13. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 153.0 - 153.9, 154.0, 154.1, or 154.8. Minimum age restriction of 16 years.
C9297	Injection, omacetazine mepesuccinate, 0.01 mg.	Synribo	Yes	UN	Antineoplastic	None	X	X											**Closed 12/31/13. See J9262.** Effective 4/1/13. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 205.10 - 205.12. Minimum age restriction of 16 years.
C9298	Injection, ocriplasmin, 0.125 mg.	Jetrea	Yes	ML	Ophthalmic	None	X	X											**Closed 12/31/13. See J7316.** Effective 4/1/13. Cost invoice with NDC required with claim. ICD-9 diagnosis restriction of 379.27. Minimum age restriction of 16 years.
C9399	Unclassified drugs or biolog	Misc Drugs	N/A																Not Covered
C9441	Injection, ferric carboxymaltose, 1 mg	Injectafer	yes	ML	Iron supplement	none	X	X											**Closed 6/30/14. See Q9970 after this date.** Effective 1/1/14. Cost invoice with NDC required. Restricted to ICD-9 diagnosis of 280.1 - 280.9. Minimum age restriction of 16 years.
C9442	Injection, belinostat, 10 mg	Beleodaq	Yes	UN	Antineoplastic		X	X											**Effective 1/1/15. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis of 202.7. Minimum age restriction of 16 years.
C9443	Injection, dalbavancin HCl, 10 mg.	Dalvance	Yes	UN	Anti-infective		X	X											**Effective 1/1/15. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis of 680.0 - 686.9. Minimum age restriction of 16 years.
C9444	Injection, oritavancin, 10 mg	Orbactiv	Yes	UN	Anti-infective		X	X											**Effective 1/1/15. Cost invoice with NDC required with claim.** Restricted to ICD-9 diagnosis of 686.0 - 686.9. Minimum age restriction of 18 years.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
G9017	Amantadine HCL 100mg oral	Symmetrel	N/A		Parkinsons Disease														Not Covered
G9018	Zanamivir,inhalation pwd 10m	Relenza	N/A		Antiviral														Not Covered
G9019	Oseltamivir phosphate 75mg	Tamiflu	N/A		Antiviral														Not Covered
G9020	Rimantadine HCL 100mg oral	Flumadine	N/A		Antiviral														Not Covered
G9033	Amantadine HCL oral brand	Symmetrel	N/A		Parkinsons Disease														Not Covered
G9034	Zanamivir, inh pwdr, brand	Relenza	N/A		Antiviral														Not Covered
G9035	Oseltamivir phosp, brand	Tamiflu	N/A		Antiviral														Not Covered
G9036	Rimantadine HCL, brand	Flumandine	N/A		Antiviral														Not Covered
J0120	Injection tetracycline up to 250mg	Achromycin Sumycin Panmycin	Yes	UN	Antibiotic	4 per day	X	X	X	X									
J0128	Injection abarelix 10mg	Plenaxis	Yes	UN	Gonadotropin	None	X	X	X										**Maximum dosage** 100 mg on days 1, 15 & 29, then maximum 100 mg every 4 weeks thereafter. **ICD-9** code 185 required on claim form.
J0129	Injection, Abatecept, 10 mg	Orencia	Yes	UN	Anti-rheumatic	100 units every 2 weeks	X	X	X	X									New code effective 1/1/07. ICD-9 codes 714.0-714.2 or 714.81 required on claim form.
J0130	Injection abciximab 10mg	ReoPro	N/A		Antiplatelet														Not Covered
J0131	Injection, acetaminophen, 10 mg.		N/A																Not Covered
J0132	Injection, acetylcysteine, 100 mg	Acetadote Mucomyst	Yes	ML	Antidote	None	X	X	X										**ICD-9** codes required on claim form: 965.4, E850.4, E935.4, E950.0, E962.0, E980.0.
J0133	Injection, acyclovir, 5mg	Zovirax	Yes	PWD=UN SOL=ML	Antiviral	None	X	X	X	X									Nurse practitioner added 1/1/09.
J0135	Injection adalimumab 20mg	Humira	N/A		Anti-rheumatic														Not Covered
J0150	Injection adenosine 6mg	Adenoscan Adenocard	Yes	ML	Anti-arrhythmic	None													Not Covered
J0151	Injection, adenosine for diagnostic use, 1 mg (Not to be used to report any adenosine phosphate compounds, instead use a9270)	Adenocard	Yes	ML	Diagnostic Agent	None	X	X	X								X		**Closed 12/31/14. See J0153 after this date.** Effective 1/1/14.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0152	Injection adenosine for diag. use 30mg	Adenocard	Yes	PWD=UN SOL=ML	Diagnostic Agent	None	X	X	X								X		**Closed 12/31/13. See J0151**. Replaces J0151. **Use only for stress testing**. Separate billing when test provided in physician's office or IDTF. Adults only.
J0153	Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds)	Adenocard	Yes	ML	Diagnostic Agent	None	X	X	X								X		**Effective 1/1/15.**
J0170	Injection adrenalin epi-nephprine up to 1ml ampule	Epipen Adrenalin Chloride, SusPhrine	Yes	ML	Respiratory	1 per day	X	X	X	X									Closed 12/31/10. See J0171 after this date.
J0171	Injection, epinephrine, 0.1 MG.	Adrenalin	Yes	ML	Antidote	None	X	X	X	X									New code effective 1/1/11.
J0178	Injection, aflibercept, 1 mg	Eylea	Yes	ML	neovascular-Age related Macular Degeneration	4 units per week	X	X							X				**Effective 10/6/14, ICD-9 diagnosis restriction of 362.83 and 386.36 added.** Effective 7/29/14, ICD-9 diagnosis restriction of 362.07 added. Effective 1/1/13. Restricted to ICD-9 diagnosis of 362.52, or 362.83 and 362.35. Minimum age restriction of 16 years
J0180	Injection agalsidase beta 1mg	Fabrazyme	Yes	UN	Enzyme	None	X	X	X										**Requires Prior Authorization for children 16<years of age.** Submit copies of physician's medical records, specialist's medical records (as appropriate), member's weight, signs and symptoms and diagnostic test results to confirm diagnosis of ICD-9-CM code 272.7 to BMS Medical Director. **Children 16> years of age**, do not require prior authorization. ICD-9-CM Code 272.7 must be documented on the claim form.
J0190	Injection biperiden lactate 5mg	Akineton	Yes	UN	Anti-dyskinetic	4 per day	X	X	X										
J0200	Injection alatroflaxacin mesylate 100mg	Trovan IV Trova-floxacin	N/A		Antibiotic														Not Covered
J0205	Injection alglucerase 10U	Ceredase	Yes	ML	Enzyme	None	X	X	X										**ICD-9** code 272.7 required on claim form.
J0207	Injection amifostine 500mg	Ethyol	Yes	UN	Anti-neoplastic	None	X	X	X										
J0210	Injection methyldopate HCl up to 250mg	Aldomet Aldoril	Yes	ML	Anti-hypertensive	None	X	X	X										
J0215	Injection alefacept 0.5mg	Amevive	Yes	UN	Monoclonal Antibody	30 units per week X 12 weeks in 6 month period per lifetime	X	X	X										30 units per week X 12 weeks in a 6 month period per lifetime.
J0220	Injection, alglucosidase alfa, 10 mg.	Myozyme	Yes	UN	Metabolic Enzyme Replacement	None	X	X	X										New code effective 1/1/08. Replaces C9234.
J0221	Injection, alglucosidase alfa, 10 mg.	Lumizyme	Yes	UN	Enzymatic	none	X	X	X							X			**Effective 8/1/14, minimum age restriction removed.** Effective 1/1/12. Restricted to ICD-9 diagnosis 271.0. Minimum age restriction of 8 years.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0256	Injection alpha 1 proteinase inhibitor human 10mg	Prolastin-C Aralast	Yes	UN	Alpha-1 antitrypsin	800 u. weekly	X	X	X										Service limit adjusted upward, 10/1/10.
J0257	Injection, alpha-1 proteinase inhibitor (human), 10 MG	Glassia	Yes	UN	Enzymatic	820 units per week	X	X	X							X			**Effective 1/1/12.** Restricted to ICD-9 diagnosis 492.8. Minimum age restriction of 16 years.
J0270	Injection alprostadil 1.25mcg	Caverject Muse Prostin VR Pediatric	Yes	PWD=UN SOL=ML	Pro-staglandin	None	X	X	X										Not for self administration. **IV only**
J0275	Alprostadil urethral suppository	Muse	N/A		Pro-staglandin														Not Covered
J0278	Injection, amikacin sulfate, 100 mg	Amikin	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X	X				X					Nurse practitioner added 1/1/09.
J0280	Injection aminophyllin up to 250mg	Phyllocontin	Yes	PWD=UN SOL=ML	Broncho-dilator	None	X	X	X									X	
J0282	Injection amiodarone HCl 30 mg	Cordarone	N/A		Anti-arrhythmic														Not Covered
J0285	Injection amphotericinB 50mg	Abelcent, Amphocin, Fungizonef	Yes	UN	Anti-fungal	None	X	X	X										
J0287	Injection amphotericinB lipid complex 10mg	Abelcet	Yes	ML	Anti-fungal	None	X	X	X										
J0288	Injection amphotericinB cholesteryl sulfate com-plex 10mg	Amphotec	Yes	UN	Anti-fungal	None	X	X	X										
J0289	Injection amphotericinB liposome 10mg.	Ambisome	Yes	UN	Antibiotic	None	X	X	X										
J0290	Injection ampicillin sodium 500mg.	Totacillin-N Omnipen-N	Yes	UN	Antibiotic	None	X	X	X	X								X	
J0295	Injection ampicilllin sodium sulbactam sodium 1.5g	Unasyn	Yes	UN	Antibiotic	None	X	X	X	X									
J0300	Injection amobarbital up to 125mg.	Amytal	Yes	UN	Anti-convulant	None	X	X	X										
J0330	Injection succinylcholine chloride up to 20mg.	Anectine Quelicin Sucostrin	Yes	PWD=UN SOL=ML	Neuro-muscular blocker	None	X	X	X										
J0348	Injection, anidulafungin, 1 mg	Eraxis	Yes	UN	Anti-fungal	200 units per day	X	X	X	X									New code effective 1/1/07. Nurse practitioner added 1/1/09.
J0350	Injection anistreplase 30U	Eminase	N/A		Thrombolytic agent														Not Covered
J0360	Injection hydralazine HCl up to 20mg	Apresoline	Yes	PWD=UN SOL=ML	Anti-hypertensive	None	X	X	X										
J0364	Injection, apomorphine HCl, 1 mg	Apokyn	Yes	PWD=UN SOL=ML	Dopamine Agonist	20 units per day	X	X	X	X									New code effective 1/1/07. ICD-9 code 332.0 required on claim form. Nurse practitioner added 1/1/09.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0365	Injection, aprotonin, 10,000kiu	Trasylol	N/A		Blood Product Derivative														Not covered.
J0380	Injection metaraminol bitartrate 10mg	Aramine	Yes	PWD=UN SOL=ML	Adrenergic agonist	None	X	X	X										
J0390	Injection chloroquine HCl up to 250mg	Aralen	N/A		Anti-infective														Not Covered
J0395	Injection arbutamine HCl 1 mg	GenESA	Yes	UN	Thrombolytic agent	None	X	X	X								X		
J0400	Injection, Aripiprazole IM, 0.25 mg	Abilify	N/A		Atypical anti-psychotic														New code effective 1/1/08. Not covered. See POS pharmacy.
J0401	Injection, aripiprazole, extended release, 1 mg	Abilify Maintena	N/A		Atypical anti-psychotic														New code effective 1/1/14. Not covered. See POS pharmacy.
J0456	Injection azithromycin 500 mg.	Zithromax	Yes	UN	Antibiotic	1 per day	X	X	X										
J0460	Injection atropine sulfate up to 0.3mg	AtroPen	Yes	ML	Anti-cholenergic	3 per day	X	X	X	X									Closed 12/31/09. See J0461.
J0461	Injection, atropine sulfate, 0.01 mg.	AtroPen	Yes	ML	Anti-cholenergic	None	X	X	X	X									Effective 1/1/10.
J0470	Injection dimercaprol 100 mg.	BAL in oil	Yes	ML	Antidote	None	X	X	X										
J0475	Injection baclofen 10mg	Lioresal	Yes	PWD=UN SOL=ML	Skeletal muscle relaxant	4 per day	X	X	X									X	**ICD-9** diagnosis of 342.1 to 342.10, 342.11, 342.12, 343.0 - 344.9, 345.60 - 345.61, 434.91, or 781.0 must be documented on claim form.
J0476	Injection baclofen 50mcg	Lioresal for intrathecal trial	Yes	ML	Skeletal muscle relaxant	1 per week	X	X	X									X	For intrathecal trial only.
J0480	Injection, basiliximab, 20 mg	Simulect	N/A		Immuno-suppressant														Not Covered
J0485	Injection, belatacept, 1 mg	Nulojix	Yes	UN	Immuno-suppressant	1350 units daily	X	X	X										**Effective 1/1/13.** Must be billed with V42.0. Minimum age restriction of 18 years.
J0490	Injection, belimumab, 10 mg.	Benlysta	Yes	UN	Immunlologic	260 units per month	X	X	X							X			**Effective 1/1/12.** Restricted to ICD-9 diagnosis 710.0. Minimum age restriction of 16 years.
J0500	Injection dicyclomine HCl up to 20mg	Bentyl Antispas Dilomine Dibent DiSpaz Neoquess	Yes	PWD=UN SOL=ML	Anti-cholenergic	None	X	X	X										
J0515	Injection benztropine mesylate 1mg	Cogentin	Yes	PWD=UN SOL=ML	Anti-cholenergic	None	X	X	X	X		X							
J0520	Injection bethanechol chloride up to 5mg	Urecholine Mytonachol	Yes	UN	Cholenergic	None	X	X	X										
J0530	Injection penicillinG benzathine & penicillinG procaine up to 600K U	Bicillin CR	Yes	ML	Antibiotic	None	X	X	X	X									Closed12/31/09. See J0559.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0540	Injection penicillinG benzathine & penicillinG procaine up to 1.2m U	Bicillin CR	Yes	ML	Antibiotic	None	X	X	X	X									Closed 12/31/09. See J0559.
J0550	Injection penicillin G benzathine & penicillinG procaine up to 2.4m U	Bicillin CR	Yes	ML	Antibiotic	None	X	X	X	X									Closed 12/31/09. See J0559.
J0558	Injection, penicillin G benzathine & penicillin G procaine, 100,000 U.	Bicillin CR	Yes	ML	Antibiotic	none	X	X	X	X						X			Effective 1/1/11.
J0559	Injection, penicillin G benzathene and penicillin G procaine, 2500 U	Bicillin CR	Yes	ML	Antibiotic	none	X	X	X	X						X			Closed 12/31/10. See J0558 after this date. Original effective date, 1/1/10. Deny with **ICD-9** diagnosis of 090.0 - 097.9
J0560	Injection penicillinG benzathine up to 600K U	Bicillin LA Permapen	Yes	ML	Antibiotic	None	X	X	X	X									Closed 12/31/10. See J0561 after this date.
J0561	Injection, penicillin G benzathine, 100,000 U.	Bicillin LA Permapen	Yes	ML	Antibiotic	None	X	X	X							X			New code effective 1/1/11.
J0570	Injection penicillinG benzathine up to 1.2m U	Bicillin LA Permapen	Yes	ML	Antibiotic	None	X	X	X	X									Closed 12/31/10. See J0561 after this date.
J0580	Injection pennicillinG benzathine up to 2.4m U	Bicillin LA Permapen	Yes	ML	Antibiotic	None	X	X	X	X									Closed 12/31/10. See J0561 after this date.
J0583	Injection bivalirudin 1mg	Angiomax	Yes	UN	Anti-coagulant	None	X	X											
J0585	Botulinum toxin type A per unit.	Botox	Yes	UN	Neuro-muscular blocker	none	X	X	X										**See update to indications on preceding page, effective 3/1/13. Prior authorization required. Contact WVMI at 304-414-2551 or 1-800-296-9849. Effective 1/1/07.** CPT codes 31513, 31570, 31571, 43201, 43236, 46505, **52287, 64616, 64617**, 64614, 64640, **64642, 64643, 64644, 64645, 64646, 64647**, 64650, 64653 or 67345 must be billed on claim form. **See the list of approved ICD-9 diagnoses entitled Botulinim Code Coverage, from the preceding page.**
J0586	Injection, abobotulinumtoxinA, 5 U	Dysport	Yes	UN	Neuro-muscular blocker	none	X	X	X										**Prior authorization required. Contact WVMI at 304-414-2551 or 1-800-296-9849. Effective 1/1/10.** CPT codes 31513, 31570, 31571, 43201, 43236, 46505, **64616, 64617**, 64614, 64640, **64642, 64643, 64644, 64645, 64646, 64647**, 64650, 64653 or 67345 must be billed on claim form. **See the list of approved ICD-9 diagnoses entitled Botulinim Code Coverage, from the preceding page.**

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0587	Botulinum toxin type B per 100 U	Myobloc	Yes	ML	Neuro-muscular blocker	none	X	X	X										**Prior authorization required. Contact WVMI at 304-414-2551 or 1-800-296-9849. Effective 1/1/07.** CPT codes 31513, 31570, 31571, 43201, 43236, 46505, **64616, 64617**, 64614, 64640, **64642, 64643, 64644, 64645, 64646, 64647**, 64650, 64653 or 67345 must be billed on claim form. **See the list of approved ICD-9 diagnoses entitled Botulinim Code Coverage, from the preceding page.**
J0588	Injection, incobotulinimtoxin A, 1 unit	Xeomin	Yes	UN	Neuro-muscular blocker	none	X	X	X										**Prior authorization required. Contact WVMI at 304-414-2551 or 1-800-296-9849. Effective 1/1/12.** CPT codes 31513, 31570, 31571, 43201, 43236, 46505, **64616, 64617,** 64614, 64640, **64642, 64643, 64644, 64645, 64646, 64647**, 64650, 64653 or 67345 must be billed on claim form. **See the list of approved ICD-9 diagnoses entitled Botulinim Code Coverage, from the preceding page. Minimum age restriction of 5 years.**
J0592	Injection buprenorphine HCl 0.1mg	Buprenix	Yes	PWD=UN SOL=ML	Analgesic narcotic	6 per day	X	X	X										
J0594	Injection, busulfan, 1 mg	Busulfex	Yes	ML	Alkylating agent	None	X	X	X										New code effective 1/1/07.
J0595	Injection butorphanol tartrate 1mg	Stadol	Yes	PWD=UN SOL=ML	Analgesic narcotic	None	X	X	X										
J0597	Injection, C-1 esterase inhibitor (human), 10 U.	Berinert	Yes	UN	C1 protein inhibitor	Maximum service limit 280 u. daily	X	X	X							X			**Update to service limit, effective 1/1/11**. New code effective 1/1/11. Restricted to **ICD-9** diagnosis 277.6. Restricted to age 16 and above.
J0598	Injection, C1 esterase inhibitor (human), 10 U	Cinryze	Yes	UN	C1 protein inhibitor	none	X	X	X	X						X			**Service limit update, effective 4/1/11.** Code effective 1/1/10. Restricted to **ICD-9** diagnosis 277.6. Restrict to age 16 and above.
J0600	Injection edetate calcium disodium up to 1000mg.	Calcium Disodium Versenate, Calcium EDTA	Yes	PWD=UN SOL=ML	Antidote	None	X	X	X										
J0610	Injection calcium gluco-nate 10ml	Kaleinate	Yes	UN	Electrolyte Supplement	None	X	X											
J0620	Injection calcium glycer-ophosphate & calcium lactate 10ml	Calphosan	Yes	ML	Electrolyte Supplement	1 per day	X	X	X										
J0630	Injection calcitonin salmon up to 400 U	Miacalcin Caalcimar	N/A		Antidote														Not covered.
J0636	Injection calcitrol 0.1mcg	Calcijex	Yes	ML	Vitamin fat soluble	30 per day	X	X	X									X	
J0637	Injection caspofungin acetate 5mg	Cancidas	Yes	UN	Anti-fungal	14 per day	X	X	X										
J0638	Injection, canakinumab, 1 mg.	Ilaris	Yes	UN	Interleukin-1beta blocker	Maximum service limit 150 u. daily	X	X	X							X			**Code closed 10/31/13. Refer to Pharmcy Point of Sale.** New code effective 1/1/11. Restricted to **ICD-9** diagnosis 708.2. Restricted to age 4 and above.
J0640	Injection Leucovorin calcium 50mg	Wellcovorin	Yes	PWD=UN SOL=ML	Antidote	25 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0641	Injection, Levoleucovorin calcium, 0.5 mg.	Fusilev	Yes	UN	Folate analog		X	X	X										**Physician** added to covered providers, effective 1/1/10. New code effective 1/1/09.
J0670	Injection mepivacine HCL 10ml.	Carbocaine Polocaine Isocaine HCL	Yes	ML	Local Anesthetic	1 per day	X	X	X										
J0690	Injection cefazolin sodium 500mg.	Ancef Kefzol Zolicef	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X	X								X	
J0692	Injection cefepime HCL 500mg	Maxipime	Yes	UN	Antibiotic	8 per day	X	X	X	X									
J0694	Injection cefoxitin sodium 1g	Mefoxin	Yes	PWD=UN SOL=ML	Antibiotic	1 per day	X	X	X	X									
J0696	Injection ceftriaxone sodium 250 mg.	Rocephin	Yes	PWD=UN SOL=ML	Antibiotic	8 per day	X	X	X	X	X							X	
J0697	Injection sterile cefuroxime sodium 750mg	Kefurox Zinacef	Yes	PWD=UN SOL=ML	Antibiotic	2 per day	X	X	X	X								X	
J0698	Cefotaxime sodium per g	Claforan	Yes	PWD=UN SOL=ML	Antibiotic	1 per day	X	X	X	X								X	
J0702	Injection betamethasone acetate & betamethasone sodium phosphate 3mg	Celestone Soluspan	Yes	ML	Anti-inflammatory	9 per day	X	X	X	X				X					
J0704	Injection bemethasone sodium phosphate 4mg.	Adbeon	Yes	UN	Anti-inflammatory	2 per day	X	X	X	X	X			X					
J0706	Injection caffeine citrate 5 mg	Cafcit	Yes	PWD=UN SOL=ML	Analeptic	None	X	X	X										
J0710	Injection cephapirin sodium up to 1g	Cefadyl	Yes	UN	Antibiotic	1 per day	X	X	X									X	
J0712	Injection, ceftaroline fosamil, 10 mg.	Teflaro	Yes	UN	Antibiotic	120 units per day	X	X	X	X						X			**Effective 1/1/12.** Restricted to ICD-9 diagnosis 041.00 - 041.89 or 482.0 - 482.89.
J0713	Injection ceftazidime 500 mg	Ceptaz Fortaz Tazidime	N/A		Antibiotic														Not Covered
J0715	Injection ceftizoxime sodium 500 mg	Ceflzox	Yes	PWD=UN SOL=ML	Antibiotic	2 per day	X	X	X	X									
J0717	Injection, certolizumab pegol, 1 mg	Cimzia	Yes	UN	TNF blocker	400 units per day	X	X	X	X									**Effective 1/1/14.** Restricted to ICD-9 diagnosis 555.0 - 555.9 or 714.0 - 714.9 . Restrict to age 18 and above.
J0718	Injection, certolizumab pegol, 1 mg.	Cimzia	Yes	UN	TNF blocker	400 units per day	X	X	X	X						X			**Closed 12/31/13. See J0717**. Effective 1/1/10. Restricted to **ICD-9** diagnosis 555.0 - 555.9 or 714.0 - 714.9 . Restrict to age 18 and above.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0720	Injection chloramphenicol sodium succinate up to 1 g	Chloromycetin Sodium Succinate	Yes	UN	Antibiotic	None	X	X	X										
J0725	Injection, chorionic gonadotropin per 1000 USP units	Novarel Profasi Pregnyl	Yes	UN	Gonadotropin	10 per day	X	X	X										Not for fertility treatment and diagnosis. Restricted to female, maximum age of 21 years. Service limit updated, effective 11/1/09.
J0735	Injection clonidine HCl 1mg	Catapres Duraclon	Yes	PWD=UN SOL=ML	Alpha Adrenergic Agonist	None	X	X	X										
J0740	Injection cidofovir 375mg	Vistide	Yes	ML	Anti-viral	None	X	X	X										
J0743	Injection cilastatin sodium imipenem 250 mg.	Primaxin	Yes	UN	Anti-infective	None	X	X	X	X								X	
J0744	Injection ciprofloxacin for IV infusion 200mg	Cipro Ciloxan	Yes	ML	Antibiotic	None	X	X	X	X									
J0745	Injection codeine phosphate 30mg	Phenaphen with codeine	Yes	PWD=UN SOL=ML	Analgesic narcotic	None	X	X	X										
J0760	Injection colchicine 1mg		Yes	PWD=UN SOL=ML	Anti-gout	None	X	X	X										
J0770	Injection colistimethate sodium up to 150mg.	Coly-Mycin M	Yes	UN	Antibiotic	None	X	X	X										
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg.	Xiaflex	Yes	UN	Enzymatic	None	X	X	X	X									New code effective 1/1/11. Restricted to **ICD-9** diagnosis 728.6. Restricted to ages 18 years and above.
J0780	Injection prochlorperazine up to 10mg	Compazine Compa-Z Contrazine	Yes	PWD=UN SOL=ML	Antiemetic	None	X	X	X	X									
J0795	Injection, corticorelin ovine triflutate, 1 mcg	ACTHREL	Yes		Diagnostic Agent														New code effective 1/1/06. Bundled into service.
J0800	Injection corticotropin up to 40U	Cortrosyn ACTH Acthar	Yes	ML	Diagnostic Agent	None			X								X		
J0833	Injection, cosyntropin, NOS, 0.25 mg.				Diagnostic Agent														Not covered.
J0834	Injection, cosyntropin, (Cortrosyn), 0.25 mg.	Cortrosyn	Yes	UN	Diagnostic Agent	3 per day	X	X	X	X						X			**Diagnosis restrictions removed, effective 1/1/12**. Code opened 1/1/10. Restricted to **ICD-9** diagnosis 255.41 - 255.42.
J0835	Injection cosyntropin 0.25mg	Cortrosyn	Yes	UN	Diagnostic Agent	3 per day			X								X		Closed 12/31/09. See J0833 & J0834.
J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram	CroFab																	Not covered.
J0850	Injection cytomegalovirus immune globulin IV (human) per vial	CytoGam	N/A		Immune globulin														Not covered.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J0878	Injection daptomycin 1mg.	Cubicin	Yes	UN	Antibiotic	4 units per day X 14 days	X	X	X										Maximum dose 4 units per day X 14 days. Adults only.
J0881	Injection, darbepoetin alfa, 1 mcg(non-ESRD use)	Aranesp	Yes	ML	Colony stimulating factor	None	X	X	X	X									Exclude ICD-9 585.6(End Stage Renal Disease). Nurse practitioner added 1/1/09.
J0882	Injection, darbepoetin alfa, 1 mcg(for ESRD on dialysis)	Aranesp	Yes	ML	Colony stimulating factor	None	X	X	X	X								X	**ICD-9** 585.6(End Stage Renal Disease) needed on claim form. Nurse practitioner added 1/1/09.
J0885	Injection, epoetin alfa, 1000 units(for non-ESRD use)	Epogen, Procrit	Yes	ML	Colony stimulating factor	None	X	X	X	X									Exclude **ICD-9** 585.6(End Stage Renal Disease). Nurse practitioner added 1/1/09.
J0886	Injection, epoetin alfa, 1000 units(for ESRD on dialysis)	Epogen, Procrit	Yes	ML	Colony stimulating factor	None	X	X	X	X								X	**ICD-9** 585.6(End Stage Renal Disease) needed on claim form. Nurse practitioner added 1/1/09.
J0890	Injection, peginesatide, 0. 1 mg	Omontys	Yes	ML	Erythropoieton Stimulating agent	None												X	**Voluntary Drug Recall: Effective 2/24/13, until further notice.** **Effective 1/1/13**. Restricted to ICD-9 diagnosis of 285.21 and 585.6. Minimum age restriction of 16 years.
J0894	Injection, decitabine, 1 mg	Dacogen	Yes	UN	Anti-neoplastic	None	X	X	X										New code effective 1/1/07.
J0895	Injection deferoxamine mesylate 500mg	Desferal	Yes	UN	Antidote	12 per day	X	X	X									X	
J0897	Injection, denosumab, 1 mg.	Prolia Xgeva	Yes	ML	Osteoporotic	120 units per 4 week period	X	X	X	X						X			**Service limit updated, 3/13/14.** Effective 1/1/12. Restricted to 162.0 - 162.9, 174.0 - 174.9, 175.0 - 175.9, 185, 189.0, 189.1, 193, 198.5, 733.01 - 733.19 for Hospital **and Physician.** Restricted to ICD-9 diagnosis 733.01 - 733.19 only for Nurse Practitioner and Home infusion.
J0900	Injection testosterone enanthate & estradiol valerate up to 1cc	Andro-Estro 90-4 Androgyn LA	Yes	UN	Androgen	1 every 3 weeks	X	X	X										Female only.
J0945	Injection brompherinamine maleate10mg	ND Stat	Yes	PWD=UN SOL=ML	Respiratory agent	1 per day	X	X	X										
J0970	Injection estradiol valerate up to 40mg	Delestrogen Estradiol LA Valergen Estra-L	Yes	PWD=UN SOL=ML	Contraceptive	1 every 3 weeks	X	X	X	X									Female only.
J1000	Injection depoestradiol cyplonate up to 5mg	Estradiol Cypionate Estra-D Estra-Cyp Estro-LA	Yes	PWD=UN SOL=ML	Hormonal Replacement	1 per 3 weeks	X	X	X	X									Female only.
J1020	Injection methylprednisolone acetate 20mg	DepoMedrol	Yes	UN	Anti-inflammatory	None	X	X	X	X				X					

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1030	Injection methylprednisolone acetate 40mg	DepoMedrol MPrednisol Rep-Pred	Yes	PWD=UN SOL=ML	Anti-inflammatory	None	X	X	X	X				X					
J1040	Injection methylprednisolone acetate 80mg	DepoMedrol Medralone Prednisol RedPred	Yes	ML	Anti-inflammatory	None	X	X	X	X				X					**Podiatrist** added as covered provider, effective 1/1/10.
J1050	Injection, medroxyprogesterone acetate, 1 mg	Depo-Provera	Yes	ML	Contraceptive	None	X	X	X	X	X								**Effective 1/1/13.**
J1051	Injection medroxyprogesterone acetate 50mg	Depo-Provera	Yes	ML	Contraceptive	20 per day	X	X	X										**Closed 12/31/12. See J1050 after this date.** Female only.
J1055	Injection medroxyprogesterone acetate 150 mg	Depo-Provera	Yes	ML	Contraceptive	1 per day	X	X	X	X	X								**Closed 12/31/12. See J1050 after this date.** Female only.
J1056	Injection medroxyprogesterone acetate/estradiol cypionate 5mg/25mg	Lunelle	Yes	ML	Contraceptive	1 per day	X	X	X	X	X								Female only.
J1060	Injection testosterone cypionate & estradiol cypionate up to 1ml	Depo-Testadiol Andro/Fem	Yes	ML	Androgen	1 per 3 weeks	X	X	X										Female only.
J1070	Injection testosterone cypionate up to 100mg	Depo-Testosterone Depotest	Yes	PWD=UN SOL=ML	Androgen	Male only.	X	X	X	X									**Closed 12/31/14. See J1071 after this date.** Service limit removed 1/1/13. Nurse practitioner added 1/1/09.
J1071	Injection, testosterone cypionate, 1mg	Depo-Testosterone Depotest	Yes	PWD=UN SOL=ML	Androgen	Male only.	X	X	X	X								X	**Effective 1/1/15.**
J1080	Injection testosterone cypionate 1cc 200mg	Depo-Testosterone Depotest Andro-Cyp 200	Yes	ML	Androgen	1 per week	X	X	X	X									**Closed 12/31/14. See J1071 after this date**. Male only. Nurse practitioner added 1/1/09.
J1094	Injection dexamethasone acetate 1mg	Dalalone LA	Yes	PWD=UN SOL=ML	Anti-inflammatory	20 per day	X	X	X					X					
J1100	Injection dexamethosone sodium phosphate 1mg	Cortastat Dalalone	Yes	ML	Anti-inflammatory	None	X	X	X	X				X					Service limit removed, effective 1/1/11.
J1110	Injection dihydroergotamine mesylate 1mg	DHE 45	Yes	PWD=UN SOL=ML	Anti-migraine	3 per day	X	X	X										
J1120	Injection acetazolamide sodium up to 500mg	Diamox	Yes	UN	Glaucoma	None	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1160	Injection digoxin up to 0.5 mg	Lanoxin	Yes	PWD=UN SOL=ML	Anti-arrhythmic	None	X	X	X										
J1162	Injection, digoxin immune fav (ovine), per vial	Digibind, Digifab	Yes	UN	Antidote	10 vials	X	X	X										**ICD-9** code 972.0, 972.01, 972.9, E858.3, E942.1, E950.4, E962.0, or E980.4 required on claim form.
J1165	Injection phenytoin sodium 50mg	Dilantin	Yes	PWD=UN SOL=ML	Anti-convulsant	None	X	X	X										
J1170	Injection hydromorphone up to 4mg	Dilaudid	Yes	PWD=UN SOL=ML	Analgesic narcotic	12 units per day	X	X	X										
J1180	Injection dyphylline up to 500mg	Lufyllin Diler	Yes	PWD=UN SOL=ML	Broncho-dilator	None	X	X	X										
J1190	Injection dexrazoxane HCl per 250mg	Zinecard	Yes	UN	Cardio-protective Agent	None	X	X	X										
J1200	Injection diphenhydramine HCl up to 50mg.	Benadryl	Yes	PWD=UN SOL=ML	Anti-histamine	None	X	X	X	X									
J1205	Injection chlorothiazide sodium 500mg	Diuril Sodium	Yes	UN	Anti-hypertensive	None	X	X	X	X									
J1212	Injection DMSO di-methylsulfoxide 50%, 50 ml	Rimso	Yes	ML	Anti-inflammatory	1 per day	X	X	X										**ICD-9** code 595.1 required on claim form.
J1230	Injection methadone HCl up to 10mg	Dolphine HCL	Yes	PWD=UN SOL=ML	Analgesic narcotic	None	X	X	X										
J1240	Injection dimenhydrinate up to 50mg	Dramamine	N/A		Antiemetic														Not Covered
J1245	Injection dipyridamole 10 mg	Persantine	Yes	PWD=UN SOL=ML	Antiplatelet	None	X	X	X								X		
J1250	Injection dobutamine HCl 250mg.	Dobutrex	Yes	PWD=UN SOL=ML	Adrenergic agonist	None	X	X	X								X		
J1260	Injection dolasetron mesylate 10mg	Anzemet	Yes	ML	Antiemetic	None	X	X	X										
J1265	Injection, dopamine Hcl, 40mg	Hydrochlor-ide Intorpin	Yes	PWD=UN SOL=ML	Adrenergic agonist	None	X	X	X	X									Nurse practitioner added 1/1/09.
J1267	Injection, Doripenem, 10 mg.	Doribax	Yes	UN	Antibiotic	limited to 18 years or older	X	X											New code effective 1/1/09. Approved for maximum dose of 1500 mg. administered over 24 hours.
J1270	Injection doxercalciferol 1mcg.	Hectorol	Yes	ML	Vitamin D analog	20 per day	X	X	X									X	
J1290	Injection, ecallantide 1 mg.	Kalbitor	Yes	ML	Hematological	30 u. daily	X	X	X	X						X			**Effective 6/1/14, minimum age restriction modified to 12 years**. New code effective 1/1/11. Restricted to **ICD-9** diagnosis 277.6. Restricted to age 16 and above.
J1300	Injection, Eculizumab 10 mg	Soliris	Yes	ML	Monoclonal Antibody	None	X	X	X										**ICD-9 diagnosis codes expanded to include 283.11, effective 10/1/11.** New code effective 1/1/08. Replaces C9236. **ICD-9** code 283.2 required on claim form.
J1320	Injection amitriptyline HCl up to 20mg	Elavil Enovil	Yes	PWD=UN SOL=ML	Anti-depressant	1 per day	X	X	X	X		X							

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1322	Injection, elosulfase alfa, 1mg	Vimizim	yes	ML	Enzymatic	None	X	X	X										**Effective 1/1/15.** Restricted to ICD-9 277.5. Minimum age restriction of 5 years.
J1324	Injection, enfuvirtide, 1 mg	Fuzeon	N/A		Fusion inhibitor														Not covered. Refer to Pharmacy Point of Sale.
J1325	Injection epoprostenol 0.5mg.	Flolan	Yes	UN	Prostaglandin	None	X	X	X										Requires **ICD-9** code 416.XX on claim form.
J1327	Injection eptifibatide 5mg	Integrillin	Yes	ML	Antiplatelet	None	X	X											
J1330	Injection ergonovine maleate up to 0.2mg	Ergotrate Maleate	Yes	PWD=UN SOL=ML	Antimigraine	None	X	X	X										
J1335	Injection ertapenem sodium 500mg	Invanz	Yes	UN	Antibiotic	None	X	X	X										
J1364	Injection erythromycin lactobionate 500 mg		Yes	UN	Antibiotic	4 per day	X	X	X										
J1380	Injection estradiol valerate up to 10mg	Delestrogen Estradiol Gynogen	N/A		Contraceptive														Not Covered
J1390	Inection estradiol valerate up to 20mg	Delestrogen Dioval Estradiol Gynogen Valergan Estra L	Yes	ML	Contraceptive	None	X	X	X	X	X								Female only.
J1410	Injection estrogen conjugated 25mg	Premarin IV	Yes	UN	Estrogen Derivative	1 per day	X	X	X										Female only.
J1430	Injection, ethanolamine oleate, 100 mg	Ethatrolin	Yes	ML	Sclerosing Agent	None	X	X	X										**ICD-9** code 456.XX, 578.XX, or 603.9 on claim form.
J1435	Injection estrone 1mg	Theelin Aqueous Estone 5 Kestrone 5	N/A		Hormonal Replacement														Not Covered
J1436	Injection etidronate disod ium 300mg	Didronel	Yes	ML	Bone Restorative Agent	None	X	X	X										
J1438	Injection etanercept 25mg	Enbrel	Yes	PWD=UN SOL=ML	Anti-rheumatic	2 per day	X	X	X										
J1439	Injection, ferric carboxymaltose, 1mg	Injectafer	Yes	ML	iron therapy	none	X	X	X										**Effective 1/1/15.** Restricted to ICD-9 diagnosis of 280.1 - 280.9. Minimum age restriction of 16 years.
J1440	Injection filgrastim (G-CSF) 300mcg	Neupogen	Yes	ML	Colony stimulating factor	5 per day	X	X	X										**Closed 12/31/13**. See J1442.
J1441	Injection filgrastim (G-CSF) 480mcg	Neupogen	Yes	ML	Colony stimulating factor	2 per day	X	X	X										**Closed 12/31/13**. See J1442.
J1442	Injection, filgrastim (g-csf), 1 microgram	Neupogen	Yes	ML	Colony stimulating factor	1500 units per day	X	X	X										**Effective 1/1/14.**

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1446	Injection, tbo-filgrastim, 5 micrograms	Granix	Yes	ML	Colony stimulating factor	140 units per day													**Effective 1/1/14.** Restricted to ICD-9 diagnosis of 288.00 - 288.09. Minimum age restriction of 16 years.
J1450	Injection fluconazone 200mg	Diflucan	Yes	PWD=UN SOL=ML	Antifungal	None	X	X	X										
J1451	Injection, fomepizole, 15 mg	Antizol	Yes	ML	Antidote	None	X	X	X										**ICD-9** code 980.1, 980.9, 982.8, E860.2, E950.9, E862.4, E962.1, or E980.9 required on claim form.
J1452	Injection omivirsen sodium intraocculur 1.65mg.	Vitravene	Yes	ML	Anti-viral		X	X							X				
J1453	Injection, fosaprepitant, 1 mg.	Emend	Yes	UN	Anti-emetic		X	X	X										New code effective 1/1/09.
J1455	Injection foscarnet sodium 1000mg	Foscavir	Yes	ML	Anti-viral	None	X	X	X										
J1457	Injection gallium nitrate 1 mg	Ganite	N/A		Anti-hypercalcemic														Not Covered
J1458	Injection, galsulfase, 1 mg	Naglazyme	Yes	ML	Enzyme replenisher	None	X	X	X										New code effective 1/1/07. Given weekly based on weight. Age restricted to 5 years and older. ICD-9 code 277.5 required on claim form.
J1459	Injection, immune globulin, IV, nonlyophilized(liquid), 500 mg.	Privigen	Yes	SOL=ML	Immune globulin		X	X											New code effective 1/1/09.
J1460	Injection gamma globulin IM 1cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1470	Injection gamma globulin IM 2cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1480	Injection gamma globulin IM 3cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1490	Injection gamma globulin IM 4cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1500	Injection gamma globulin IM 5cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1510	Injection gamma globulin IM 6cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1520	Injection gamma globulin IM 7cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1530	Injection gamma globulin IM 8cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1540	Injection gamma globulin IM 9cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1550	Injection gamma globulin IM 10cc	Gammar Gamastan	Yes	ML	Immune globulin	1 per day	X	X	X										
J1556	Injection, immune globulin, 500 mg	Bivigam	N/A																**New code effective 1/1/14**. Not Covered. See pharmacy POS .

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1557	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg.	Gammaplex	Yes	ML	Immune globulin	none	X	X	X							X			**Effective 3/8/13, new ICD-9 diagnosis restriction of 287.31 added.** Effective 1/1/12**.** Restricted to ICD-9 diagnosis 279.00 - 279.2.
J1559	Injection, immune globulin, 100 mg	Hizentra	N/A																Not covered. Refer to Pharmacy Point of Sale.
J1560	Injection gamma globulin IM over 10cc	Gammar Gamastan	Yes	ML	Immune globulin	5 per day	X	X	X	X									
J1561	Gamunex Injection - Injection, immune globulin (Gamunex), IV, non-lypohilized (e.g., liquid), 500mg	Gamunex-C	Yes	ML	Immune globulin	None	X	X											New code effective 1/1/08. Replaces Q4092.
J1562	Injection, immune globulin, subcutaneous, 100 mg		N/A		Immune globulin														Not covered.
J1565	Injection RSV immune globulin IV 50mg	RespiGam	Yes	ML	Immune globulin	None	X	X	X	X									Closed effective 4/01/08.
J1566	Injection, immune globulin, IV, lyophilized, 500mg	Carimune Gammagard Gamunex-C	Yes	UN	Immune globulin	None	X	X	X										Effective 1/1/09.
J1567	Injection, immune globulin, IV, lyophilized, 500mg		Yes	ML	Immune globulin	None	X	X	X										Closed effective 12/31/07.
J1568	Octagam injection, immune globulin, (Octagam) IV, non-lyophilized (i.e., liquid), 500mg	Octagam	Yes	ML	Immune globulin	None	X	X											New code effective 1/1/08. Replaces Q4087.
J1569	Gammagard liquid, injection, immune globulin (Gammagard Liquid), IV, non-lyophilized (e.g., liquid), 500mg.	Gammagard	Yes	ML	Immune globulin	None	X	X	X										New code effective 1/1/08. Replaces Q4088. Approved for physician billing, effective 1/1/08.
J1570	Injection ganciclovir sodium 500mg	Cytovene	Yes	UN	Anti-viral	None	X	X	X										
J1571	HepaGam B Injection - Injection, hepatitis B immune globulin (HepaGam B), IM, 0.5m	Hepagam B	Yes	ML	Immune globulin	None	X	X											New code effective 1/1/08. Replaces Q4090.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1572	Fiebogamma Injection - Injection, immune globulin (Flebogamma), IV, non-lypohilized (e.g., liquid), 500mg.	Flebogamma	Yes	ML	Immune globulin	None	X	X											New code effective 1/1/08. Replaces Q4091.
J1573	Injection, Hepatitis B immune globulin (Hepagam B) IV 0.5 m.	Hepagam B	Yes	ML	Immune globulin	None	X	X											New code effective 1/1/08.
J1580	Injection Garamycin gentamicin up to 80mg	Gentamine Sulfate Jenamicin	Yes	ML	Antibiotic	None	X	X	X									X	
J1590	Injection gatifloxacin 10 mg	Tequin Zymar	Yes	ML	Antibiotic	40 per day	X	X	X										
J1595	Injection glatiramer acetate	Copaxone	N/A		Multiple Sclerosis														Not Covered
J1599	injection, immune globulin, intravenous, non-lyophilized(liquid), NOS, 500 mg.	N/A	N/A																Not Covered
J1600	Injection gold sodium thiomalate up to 50mg	Aurolate Myochrysine	Yes	PWD=UN SOL=ML	Anti-rheumatic	None	X	X	X										
J1602	Injection, golimumab, 1 mg, for intravenous use	Simponi Aria	Yes	ML	TNF blocker	300 units per month	X	X	X	X									**Effective 1/1/14.** Restricted to ICD-9 diagnosis 714.0 - 714.9. Minimum age restriction of 18 years.
J1610	Injection glucagon HCl 1mg.	Glucagon GlucaGen	Yes	UN	Antidote	None	X	X	X										
J1620	Injection gonadorelin HCl 100mcg	Factrel Lutrepulse	Yes	UN	Gonadotropin	None	X	X	X										Not for fertility treatment and diagnosis.
J1626	Injection granisetron HCl 100mcg	Kytril	Yes	ML	Antiemetic	20 per day	X	X	X										
J1630	Injection haloperidol up to 5mg	Haldol	Yes	PWD=UN SOL=ML	Anti-psychotic	2 per day	X	X	X	X		X							Nurse practitioner added 1/1/09.
J1631	Injection haloperidol decanoate 50mg	Haldol Decanoate 50	Yes	ML	Anti-psychotic	1 per day	X	X	X	X		X							Nurse practitioner added 1/1/09.
J1640	Injection, hemin, 1mg	Panhematin	Yes	UN	Enzyme inhibitor	None	X	X	X										**ICD-9** code 277.1, 270.2, 775.8. 775.81, 775.89 required on claim form.
J1642	Injection heparin sodium (heparin lock flush) 10U.	HepLock HepLock U/P	Yes	PWD=UN SOL=ML	Anti-coagulant	5 per day										X			
J1644	Injection heparin sodium 1000U	Heparin Sodium Liqusemin Sodium	Yes	PWD=UN SOL=ML	Anti-coagulant	1 unit X 7 consecutive days - lifetime	X	X	X	X								X	Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime. Nurse practitioner added 1/1/09.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1645	Injection dalteparin sodium 2500IU	Fragmin	Yes	ML	Anti-coagulant	1 unit X 7 consecutive days - lifetime	X	X	X	X									Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J1650	Injection enoxaparin sodium 10mg	Lovenox	Yes	ML	Anti-coagulant	1 unit X 7 consecutive days - lifetime	X	X	X	X									Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J1652	Injection fondaparinux sodium 0.5 mg	Atrixtra	Yes	ML	Anti-coagulant	1 unit X 7 consecutive days - lifetime	X	X	X	X									Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J1655	Injection tinzaparin sodium 1000 IU.	Innohep	Yes	ML	Anti-coagulant	1 unit X 7 consecutive days - lifetime	X	X	X	X									Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J1670	Injection tetanus immune globulin human up to 250U	HyperTet	Yes	ML	Immune globulin	1 per 10 years	X	X	X	X									
J1675	Injection, histrelin acetate, 10mcg	Vantas	Yes	UN	Gonadotropin	1 per year	X	X	X										**Cost invoice** required with claim form
J1680	Injection, human fibrinogen concentrate, 100 mg.	RiaSTAP	Yes	UN	Antifibrinolytic	none	X	X	X				X			X			**Closed 12/31/12. See J7178 after this date.** Effective 1/1/10. Restricted to **ICD-9** diagnosis 286.3 or 286.6.
J1700	Injection hydrocortisone acetate up to 25mg	Hydrocortone Acetate	Yes	PWD=UN SOL=ML	Anti-inflammatory	None	X	X	X	X									
J1710	Injection hydrocortisone sodium phosphate up to 50mg	Hydrocortone Phosphate	Yes	PWD=UN SOL=ML	Anti-inflammatory	None	X	X	X	X									
J1720	Injection hydrocortisone sodium succinate up to 100mg	Solu-Cortef A-Hydrocort	Yes	UN	Anti-inflammatory	None	X	X	X	X									
J1725	Injection, hydroxyprogesterone caproate, 1 mg.	Makena	Yes	ML		250 u. weekly	X	X	X	X	X								**Effective 1/1/12**. Restricted to ICD-9 diagnosis 644.0 - 644.2 or V23.41. Cost invoice with NDC required with claim. Minimum age restriction of 16 years. Service limit of 250 units weekly at 16 - 36 weeks gestation. ***Please note: If product on cost invoice indicates a multi-dose vial, then reimbursement will be one-fifth invoice amount.***
J1730	Injection diazoxide up to 300mg	Hyperstat IV	Yes	PWD=UN SOL=ML	Anti-hypertensive	1 per day	X	X	X										
J1740	Injection, ibandronate sodium, 1 mg	Boniva	Yes	PWD=UN SOL=ML	Bisphosphonate	3 units every 3 months	X	X	X	X									New code effective 1/1/07. ICD-9 codes 733.00-733.09 are required on claim form. Restricted to females. Providers should be able to document why patient cannot take oral bisphosphonate. Nurse practitioner added 1/1/09.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1742	Injection ibutilide fumarate 1mg	Corvert	Yes	ML	Anti-arrhythmic	None	X	X	X										
J1743	Injection, idursulfase 1 mg	Elaprase	Yes	ML	Metabolic Enzyme Replacement	None	X	X	X										New code effective 1/1/08. Replaces Q9232.
J1745	Injection infliximab 10mg	Remicade	Yes	UN	Anti-rheumatic	None	X	X	X										
J1750	Injection, iron dextran, per 50 mg.	Infed Dexferrum	Yes	ML	iron salt	None	X	X	X	X								X	New code effective 1/1/09. Nurse practitioner added 1/1/09.'
J1751	Injection, iron dextran 165, 50 mg	Infed Dexferrum	Yes	ML	Iron salt	None	X	X	X	X									Code closed effective 6/30/08. See Q4098.
J1752	Injection, iron dextran 267, 50 mg	Infed Dexferrum	Yes	ML	Iron salt	None	X	X	X	X									Code closed effective 6/30/08. See Q4098.
J1756	Injection iron sucrose 1mg IV	Venofer	Yes	ML	Iron supplement	300 u.per 14 days	X	X	X							X		X	Home infusion provider added, effective 4/1/12.
J1785	Injection imiglucerase per unit	Cerezyme	Yes	UN	Enzyme	None	X	X	X										Code closed 12/31/10. See J1786 after this date. **ICD-9** code 272.7 required on claim form.
J1786	injection, imiglucerase, 10 units	Cerezyme	Yes	UN	Enzyme	Maximum service limit 1650 u. monthly	X	X	X							X			**Home Infusion** provider added, effective 1/1/11. New code effective 1/1/11. Restricted to **ICD-9** diagnosis 272.7. Minimum age restriction of 2 years and above.
J1790	Injection droperidol up to 5mg	Inapsine	Yes	PWD=UN SOL=ML	Antiemetic	1 per day	X	X	X										
J1800	Injection propranolol HCl up to 1mg.	Inderal	Yes	PWD=UN SOL=ML	Anti-anginal	None	X	X	X										
J1810	Injection droperidol & fentanyl cit-rate up to 2ml ampule	Innovar	Yes	UN	Antiemetic	None	X	X	X										
J1815	Injection insulin 5U	Humalog Humulin Lispo	Yes	ML	Anti-diabetic	20 per day	X	X	X	X									**ICD-9** code 250.00 - 250.9X required on claim form.
J1817	Insulin for administration thru insulin pump per 50 U	Humalog	N/A		Anti-diabetic														Not Covered
J1825	Injection interferon beta 1a 33mcg	Avonex	N/A		Biological Response Modulator														Not covered. Refer to Pharmacy Point of Sale.
J1826	Injection, interferon beta-1a, 30 mcg.	Avonex Rebif	N/A		Biological Response Modulator														Not covered. Refer to Pharmacy Point of Sale.
J1830	Injection interforon beta 1b 0.25mg	Betaseron	N/A		Biological Response Modulator														Not covered. Refer to Pharmacy Point of Sale.
J1835	Injection itraconazole 50 mg.	Sporonox	Yes	UN	Anti-fungal	None	X	X	X										
J1840	Injection kanamycin sulfate up to 55mg	Kantrex Klebcil	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X										
J1850	Injection kanamycin sulfate up to 75mg	Kantrex Klebcil	Yes	UN	Antibiotic	None	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J1885	Injection ketoralac tro-methamine 15mg	Toradol	Yes	PWD=UN SOL=ML	Analgesic	None	X	X	X	X				X				X	
J1890	Injection cephalothin sodium up to to 1g	Cephalothin Sodium Keflin	Yes	N/A	Antibiotic	None	X	X	X										
J1930	Injection, lanreotide, 1 mg.	Somatuline Depot	Yes	UN	Growth hormone analog		X	X											New code effective 1/1/09.
J1931	Injection laronidase 0.1 mg	Aldurazyme	Yes	ML	Enzyme	None	X	X	X										**ICD-9** code 277.5 required on claim form.
J1940	Injection furosemide up to 20mg.	Lasix Furomide	Yes	PWD=UN SOL=ML	Anti-hypertensive Diuretic	None	X	X	X	X									
J1945	Injection, lelpirudin, 50 mg	Refludan	Yes	UN	Anti-coagulant	None	X	X	X										
J1950	Injection leuprolide acetate 3.75mg.	Lupron Depot	Yes	UN	Anti-neoplastic	None	X	X	X										
J1953	Injection, levetiracetam, 10 mg.	Keppra	Yes	UN	Anti-epileptic	limited to 16 years or older	X	X	X										New code effective 1/1/09.
J1955	Injection levocarnitine1g.	Carnitor	N/A		Nutritional Supplement														Not Covered
J1956	Injection levoflaxacin 250 mg	Levaquin	Yes	ML	Antibiotic	3 per day	X	X	X										
J1960	Injection levorphanol tartrate up to 2mg	Levo Dromoran	Yes	PWD=UN SOL=ML	Analgesic narcotic	1.5 per day	X	X	X										
J1980	Injection hyoscyamine sulfate up to 0.25mg.	Levsin	Yes	PWD=UN SOL=ML	Anti-cholenergic	2 per day	X	X	X	X									
J1990	Injection chlordiazepoxide HCL up to 100mg.	Librium	N/A		Benzodiazepine														Not Covered
J2001	Injection lidocaine HCl IV infusion 10mg	Xylocaine	Yes	PWD=UN SOL=ML	Anti-arrhythmic	None	X	X											
J2010	Injection lincomycin HCl up to 300mg	Lincocin	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X	X									
J2020	Injection linezolid 200 mg	Zyvox	Yes	ML	Antibiotic	6 per day	X	X	X										
J2060	Injection lorazepam 2mg	Ativan	Yes	PWD=UN SOL=ML	Anti-anxiety	2 per day	X	X	X	X		X						X	Nurse practitioner added 1/1/09.
J2150	Injection mannitol in 25% in 50ml	Osmitrol	Yes	PWD=UN SOL=ML	Diuretic	None	X	X	X	X									Nurse practitioner added 1/1/09.
J2170	Injection, mecasermin, 1 mg	Increlex	N/A		Insulin-like growth factor														Not covered.
J2175	Injection meperidine HCl per 100mg	Demerol	Yes	PWD=UN SOL=ML	Analgesic narcotic	2 per day	X	X	X	X									Nurse practitioner added 1/1/09.
J2180	Injection meperidine & promethazine HCl up to 50mg	Mepergan	Yes	ML	Analgesic combo narcotic	2 per day	X	X	X	X									

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J2185	Injection meropenem 100 mg	Merrem	Yes	UN	Antibiotic	None	X	X	X	X									Nurse practitioner added 1/1/09.
J2210	Injection methylergonovine maleate up to 0.2mg.	Methergine	Yes	ML	Ergot alkaloid & derivative	1 per day	X	X	X										
J2248	Injection, micafungin sodium, 1 mg	Mycamine	Yes	UN	Anti-fungal	150 units per day	X	X	X	X									New code effective 1/1/07. Nurse practitioner added 1/1/09.
J2250	Injection midazolam HCl per 1mg	Versed	N/A		Benzodiazepine														Not Covered.
J2260	Injection milrinone lactate 5mg	Primacor	Yes	ML	Enzyme	None	X	X	X										
J2265	Injection, minocycline hydrochloride, 1 mg.	Minocin	N/A																Not covered.
J2270	Injection morphine sulfate up to 10mg	Roxanol	Yes	ML	Analgesic narcotic	5 per day	X	X	X	X									Nurse practitioner added 1/1/09.
J2271	Injection morphine sulfate 100mg.	Roxanol	Yes	PWD=UN SOL=ML	Analgesic narcotic	None	X	X	X										**Closed 12/31/14. See J2274 after this date.**
J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg		Yes	ML	Analgesic narcotic	None	X	X	X									X	**Effective 1/1/15.** Must be billed with CPT 62310, 62311, 62318, 62319, 62360, 62361, 62362, 62365, 62367, 62368, 62369, or 62370.
J2275	Injection,morphine sulfate (preservative-free sterile solution)10mg	Astramorph PF Duramorph	Yes	ML	Analgesic narcotic	None	X	X	X									X	**Closed 12/31/14. See J2274 after this date.**
J2278	Injection, ziconotide, 1mcg	Prialt	Yes	ML	Analgesic	Max. 20 per day	X	X	X										
J2280	Injection moxifloxacin 100 mg	Avelox	Yes	ML	Antibiotic	5 per day	X	X	X	X									
J2300	Injection nalbuphine HCl per 10mg	Nubain	Yes	PWD=UN SOL=ML	Analgesic narcotic	6 per day	X	X	X	X									Nurse practitioner added 1/1/09.
J2310	Injection naloxone HCl per 1mg	Narcan	Yes	PWD=UN SOL=ML	Antidote	None	X	X	X	X									Nurse practitioner added 1/1/09.
J2315	Injection, naltrexone, depot form, 1 mg	Depade, ReVia, Vivitrol	Yes	UN	Opioid receptor antagonist	380 units per 4 weeks	X	X	X			X							New code effective 1/1/07. ICD-9 code 303.XX required on claim form.
J2320	Injection nandrolone decanoate up to 50mg.	Decadura-bolin	Yes	PWD=UN SOL=ML	Anabolic steroid	1 per week	X	X	X										
J2321	Injection nandrolone decanoate up to 100mg.	Decadur-abolin Hybolin Decanoate	Yes	PWD=UN SOL=ML	Anabolic steroid	1 per week	X	X	X									X	
J2322	Injection nandrolone decanoate up to 200mg	Decaduraboli n Neo-burabolic	Yes	ML	Anabolic steroid	1 per week	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J2323	Injection, Natalizumab 1 mg	Tysabri	Yes	ML	Leukocyte Adhesion Inhibitor	None	X	X	X										New code effective 1/1/08. Replaces Q4079.
J2325	Injection, nesiritide, 0.1mg	Natrecor	Yes	UN	Vasodilator	None	X	X											**ICD-9** code 428.0, 428.20, 428.21, 428.23, 428.30, 428.31, 428.33, 428.40, 428.41, or 428.43 required on claim form. Not for office use.
J2353	Injection octreotide depot form for IM 1mg	Sandostatin	Yes	UN	Antidiarrheal	None	X	X	X										
J2354	Injection onctreotide non-depot form for SQ or IV 25 mcg	Sandostatin	Yes	ML	Antidiarrheal	1 unit X 7 consecutive days - lifetime	X	X	X										For IV route only. Physician reimbursement for administration is limited to 1 unit X 7 consecutive days per lifetime.
J2355	Injection oprelvekin 5 mg	Neumega	Yes	UN	Platelet growth factor	2 per day	X	X	X										**ICD-9** code 287.4 required on claim form.
J2357	Injection omalizumab 5 mg.	Xolair	Yes	UN	Anti-asthmatic	None	X	X	X										**Effective 3/21/14, ICD-9 diagnosis of 708.1 added.** ICD-9 code 493.XX required on claim form. Minimum age restriction of 12 years. For children: the first dose may be split into 2 doses the first week.
J2358	Injection, olanzapine, long-acting, 1 mg.	Zyprexa Relprevv	Yes	UN	Antipsychotic	Maximum service limit 405 u. monthly	X	X	X	X		X				X			New code effective 1/1/11. Restricted to **ICD-9** diagnosis 295.00 - 295.95. Restricted to age 18 and above.
J2360	Injection orphenadrine citrate up to 60 mg.	Norflex	Yes	PWD=UN SOL=ML	Muscle relaxant	1 per day	X	X	X										
J2370	Injection phenylephrine HCl up to 1ml	Neo-Synephrine	Yes	ML	Adrenergic agonist	1 per day	X	X	X										
J2400	Injection chloroprocaine HCl 30ml	Nesacaine Nesacaine MPF	Yes	ML	Local Anesthetic	1 per day	X	X	X										
J2405	Injection ondansetron HCl 1mg	Zofran	Yes	PWD=UN SOL=ML	Antiemetic	32 per day	X	X	X										
J2410	Injection oxymorphone HCl up to 1 mg	Numorphan	Yes	ML	Analgesic-narcotic	9 per day	X	X	X										
J2425	Injection, palifermin, 50 mcg	Kepivance Keratinocyte	Yes	UN	Growth factor	None	X	X	X										3 days before + 3 days after chemo.
J2426	Injection, paliperidone palmitate extended release, 1 mg.	Invega Sustenna	Yes	ML	Antipsychotic	Maximum service limit 234 u. daily	X	X	X			X					X		New code effective 1/1/11. Restricted to **ICD-9** diagnosis 295.00 - 295.95. Restricted to age 18 and above.
J2430	Injection, pamidronate disodium 30 mg	Aredia	Yes	PWD=UN SOL=ML	Antidote	None	X	X	X										
J2440	Injection papaverine HCL up to 60 mg.	Para-Time SR	N/A		Vasodilator														Not covered
J2460	Injection oxytetracycline HCl up to 50 mg	Terramycin	Yes	UN	Antibiotic	4 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J2469	Injection palonesetron HCl 25mcg	Aloxi	Yes	ML	Antiemetic	None	X	X	X										ICD-9 code V58.0, V58.1, V58.11, V58.12, 787.01 - 787.03, 783.0, or 783.21 -783.22 and 140.0 - 208.91, 230.0 - 239.9 required on claim form(1 chemotherapy ICD-9 code and nausea/vomiting or anorexia), effective 1/1/10). Maximum dosage 0.25mg per week. Service limit of 10 per week(0.25 mg) removed, effective 7/1/08.
J2501	Injection paricalcitol 1 mcg	Zemplar	Yes	ML	Vitamin D analog	None	X	X	X									X	**ICD-9** code 588.XX required on claim form.
J2503	Injection, pegaptanib sodium, 0.3 mg	Macugen	Yes	ML	Optomalogic Agent	1 every 6 weeks	X	X							X				**ICD-9** code 362.52 plus CPT 67028-RT or 67028-LT required on claim form.
J2504	Injection, pegademase bovine, 25 mcg	Adagen	Yes	ML	Enzyme	None	X	X	X										**ICD-9** code 279.XX required on claim form. **ICD-9** restriction of 279.41 and 279.49 added, effective 10/1/09.
J2505	Injection pegfilgrastim 6mg	Neulasta	Yes	ML	Colony stimulating factor	1 per day	X	X	X										
J2507	Injection, pegloticase, 1 mg.	Krystexxa	Yes	ML	Hyperuricemic	16 units per month	X	X	X	X				X		X			**Effective 1/1/12.** Restricted to ICD-9 diagnosis 274.0 - 274.89. Minimum age restriction of 18 years.
J2510	Injection penicillinG procaine aqueous up to 600K U	Wycillin Pfizerpen AS	Yes	ML	Antibiotic	None	X	X	X										
J2513	Injection, pentastarch, 10% solution, 100 ml	Pentaspan	N/A		Plasma volume expander														Not covered.
J2515	Injection pentobarbital sodium per 50 mg.	Nembutal	Yes	PWD=UN SOL=ML	Anti-convulsant	10 per day	X	X	X										Not covered effective 12/31/07
J2540	Injection penicillinG potassium up to 600K U	Pfizerpen	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X										
J2543	Injection piperacillin sodium/tazobactam sodium 1g/0.125g (1.125 g)	Zosyn	Yes	PWD=UN SOL=ML	Antibiotic	24 per day	X	X	X										
J2545	Pentamidine isethionate inhalation solution 300mg	Nebupent Pentam 300	N/A		Antibiotic														Not Covered
J2550	Injection promethazine HCl up to 50mg	Phenergan Prorex-25	Yes	PWD=UN SOL=ML	Antiemetic	6 per day	X	X	X	X								X	
J2560	Injection phenobarbital sodium up to 120mg	Luminal Sodium	Yes	PWD=UN SOL=ML	Anti-convulsant	3 per day	X	X	X										20/mg/kg for status epilepticus.
J2562	Injection, plerixafor, 1 mg.	Mozobil	Yes	ML	Hematopoietic	None	X	X	X							X			Effective 1/1/10. Restricted to **ICD-9** diagnosis 200.00 - 200.88, 202.00 - 202.98, 203.00 - 203.82. Must be billed with J1440, J1441, **J1442 (added effective 1/1/14),** or J2505 (granulocyte colony stimulating factor). Restrict to 18 years and above.
J2590	Injection oxytocin up to 10U.	Pitocin	Yes	ML	Oxytocic agent	4 per day	X	X	X										May increase to maximum 4 units for post partum hemorrhage.
J2597	Injection desmopressin acetate 1mcg	DDAVP Stimate	N/A		Anti-diuretic														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J2650	Injection prednisolone acetate up to 1ml	AK-Pred Inflammase Forte Pediapred Prelone Key-Pred Predcor Predoject Predalone	Yes	PWD=UN SOL=ML	Anti-inflammatory	None	X	X	X										
J2670	Injection tolazoline HCl up to 25mg	Priscoline	Yes	PWD=UN SOL=ML	Alpha-adrenergic blocking agent	8 per day	X	X	X										
J2675	Injection progesterone 50 mg	Crinone Progestasert	Yes	OIL=ML PWD=UN	Progestin	8 per day	X	X	X	X	X								Not for fertility treatment and diagnosis. For menorrhagia, amenorrhea.
J2680	Injection fluphenazine decanoate up to 25mg	Prolixin Decanoate	Yes	OIL=ML PWD=UN	Anti-psychotic	2 per day	X	X	X	X		X						X	Nurse practitioner added 1/1/09.
J2690	Injection procainamide HCl up to 1g	Pronestyl Procanbid	Yes	PWD=UN SOL=ML	Anti-arrhythmic	None	X	X	X										Weight based 50mg/kg/day.
J2700	Injection oxacillin sodium up to 250mg	Bactocill Prostaphlin PCN Methyl-phenyl Isoxazolyl	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X										
J2704	Injection, propofol, 10 mg	Diprivan	Yes	ML	Sedative Hypnotic	none	X	X	X										**Effective 1/1/15.**
J2710	Injection neostigmine methylsulfate up to 0.5 mg	Prostigmin	Yes	PWD=UN SOL=ML	Acetychol-inesterase inhibitor	4 per day	X	X	X										
J2720	Injection protamine sulfate 10mg		Yes	PWD=UN SOL=ML	Antidote for heparin	None	X	X	X										
J2724	Injection, Protein C Concentrate, IV, Human, 10 IU	Ceprotin	Yes	UN	Thrombolytic agent	None	X	X	X							X			New code effective 1/1/08. **Home Infusion** added as provider, effective 1/1/10. Restricted to **ICD-9** diagnosis code 289.81.
J2725	Injection protirelin 250 mcg	Relefact TRH Thypi-nome	Yes	PWD=UN SOL=ML	Diagnostic agent	2 per day	X	X	X										
J2730	Injection pralidoxime chloride up to 1g	Protopam Chloride	Yes	UN	Antidote	None	X	X	X										
J2760	Injection phentolamine mesylate up to 5mg	Regitine	N/A		Diagnostic agent	1 per day													Not covered
J2765	Injection metoclopramide HCl up to 10mg	Reglan	Yes	PWD=UN SOL=ML	Antiemetic	8 per day	X	X	X	X									
J2770	Injection quinupristin/dalfopristin 500mg (150/350)	Synercid	N/A		Antibiotic														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J2778	Inection, ranibizumab 0.1 mg.	Lucentis	Yes	ML	Neovascular-Age related Macular Degeneration	None	X	X							X				**New ICD-9 diagnosis restriction of 362.01 - 362.07 added, effective 8/10/12**. New code effective 1/1/08. Not billable with J3490 after 12/30/07. Restricted to IDC-9 codes 362.5--362.52. New diagnoisis restriction of 362.52/macular degeneration, wet only after 5/1/09 for **Opthalmology** specialty. New indication approved for 362.83 and 362.35, or 362.83 and 362.36, effective 6/22/10.
J2780	Injection ranitidine HCl 25mg	Zantac	Yes	PWD=UN SOL=ML	Anti-histamine	6 per day	X	X	X										
J2783	Injection rasburicase 0.5 mg	Elitek	Yes	UN	Enzyme	None	X	X	X										
J2785	Injection, regadenoson, 0.1 mg.	Lexiscan	Yes	ML	Vasodilator	limited to 18 years or older	X	X	X								X		New code effective 1/1/09. Approved for physicians and to IDTF. effective 1/1/09.
J2788	Injection Rhod immune globulin human minidose 50 mcg	BAYRho-D MicrhoGam Hyprho-D	Yes	EA=UN SOL=ML	Immune globulin	none	X	X	X	X	X								**Effective 4/1/13. Replacing 90385.**
J2790	Injection Rhod immune globuliln human full dose 300 mcg	Gamulin RH	Yes	EA=UN SOL=ML	Immune globulin	none	X	X	X	X	X								**Effective 4/1/13. Replacing 90384.**
J2791	Rhophylac Injection - Injection, Rho(d) immune globulin (human), 100 IU	Rhophylac	Yes	ML	Immune globulin	None	X	X	X	X	X								New code effective 1/1/08. Replaces Q4089. Open to physician, nurse practitioner, and midwife, effective 3/1/08.
J2792	Injection RhoD immune globulin IV human solvent detergent 100 IU	BAYrho-D Winrho SDF	N/A		Immune globulin														
J2793	Injection, rilonacept, 1 mg.	Arcalyst	Yes	UN	Anti-inflammatory	none	X	X	X	X						X			Effective 1/1/10.
J2794	Injection Risperidone long acting 0.5mg	Risperdal Consta IM	Yes	UN	Anti-psychotic	100 units every 2 weeks	X	X	X	X		X							**ICD-9** code 295XX.required on claim form. Age limit 18>years. Nurse practitioner added 1/1/09.
J2795	Injection ropivacaine HCl 1mg	Naropin	N/A		Local Anesthetic														Not Covered
J2796	Injection, romiplostim, 10 mcg.	Nplate	Yes	UN	Hematopoietic	none	X	X	X	X						X			**Effective 1/1/12, age restriction of 18 years removed.** Effective 1/1/10. Restricted to ICD-9 diagnosis 287.30 - 287.33. Restrict to age 18 and above.
J2800	Injection methocarbamol up to 10ml	Robaxin	Yes	PWD=UN SOL=ML	Skeletal muscle relaxant	3 per day	X	X	X										
J2805	Injection, sincalide, 5 mcg	Kinevac	Yes	UN	Diagnostic agent	None	X	X									X		Use with CPT 78223.
J2810	Injection theophylline 40 mg	Theo-Dur	N/A		Broncho-dilator														Not Covered
J2820	Injection sargramostim (GM-CSF) 50mcg	Leukine Prokine	Yes	PWD=UN SOL=ML	Colony stimulating factor	20 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J2850	Injection, secretin, synthetic, human, 1 mcg		Yes	UN	Hormonal Replacement	None	X	X									X		Use with CPT 43271, 89105, or 82938
J2910	Injection aurothioglucose up to 50mg	Solganal	Yes	ML	Anti-inflammatory	1 per day	X	X	X										
J2912	Injection sodium chloride 0.9% per 2ml		N/A			None													CMS closed code effective 12/31/06
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5mg	Ferrlecit	Yes	ML	Iron supplement	20 per day	X	X	X									X	
J2920	Injection methylprednisolone sodium succinate up to 40mg	SoluMedrol Ametha-Pred	Yes	UN	Anti-inflammatory	None	X	X	X	X									
J2930	Injection methlprednisolone sodium succinate up to 125mg	SoulMedrol Ametha-Pred	Yes	UN	Anti-inflammatory	None	X	X	X	X									
J2940	Injection somatrem 1mg	Protropin	N/A		Growth hormone														Not Covered
J2941	Injection somatropin 1mg	Humatrope Genotropin Nutropin	N/A		Growth hormone														Not Covered
J2950	Injection promazine HCl up to 25mg	Sparine Prozine-50	Yes	PWD=UN SOL=ML	Anti-psychotic Analgesic	40 per day	X	X	X			X							
J2993	Injection reteplase 18.1 mg	Retavase	Yes	UN	Fibrinolytic	none	X	X	X										Restricted to **ICD-9** diagnoses 410.00 - 410.92; with minimum age 18 years and above, effective 1/1/10.
J2995	Injection streptokinase per 250KIU	Streptase	Yes	UN	Fibrinolytic	4 per day	X	X	X										
J2997	Injection alteplase recombinant 1mg	Activase	N/A		Fibrinolytic		X	X											Effective 10/1/13.
J3000	Injection streptomycin up to 1g	Streptomy-cin Sulfate	Yes	UN	Antibiotic	2 per day	X	X	X										
J3010	Injection fentanyl citrate 0.1mg	Sublimaze Duragesic	Yes	PWD=UN SOL=ML	Analgesic narcotic	1 per day	X	X											
J3030	Injection sumatriptan succinate 6mg	Imitrex	N/A		Antimigraine	1 per day													Not covered
J3060	Injection, taliglucerace alfa, 10 units	Elelyso	Yes	UN	Enzyme replacement	41 units bi-weekly	X	X	X										**Effective 8/27/14, minimum age restriction reduced to 4 years from 16 years of age**. Effective 1/1/14. Restricted to ICD-9 diagnosis of 272.7. Minimum age restriction of 16 years.
J3070	Injection pentazocine 30 mg	Talwin	Yes	ML	Analgesic narcotic	12 per day	X	X	X									X	
J3095	Injection, televancin, 10 mg.	Vibativ	Yes	UN	Antibiotic	None	X	X	X	X						X			New code effective 1/1/11. Restricted to **ICD-9** diagnosis 680.0 - 686.9. Restricted to age 18 and above.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J3100	Injection tenecteplase 50 mg	TNKase	Yes	UN	Fibrinolytic	1 per day													See J3101.
J3101	Injection, tenecteplase, 1 mg.	TNKase	Yes	UN	Fibrinolytic		X	X											New code effective 1/1/09.
J3105	Injection terbutaline sulfate up to 1mg	Brethine	Yes	ML	Broncho-dilator	2 per day	X	X	X										
J3110	Injection teriparatide 10 mcg	Forteo	N/A		Parathyroid hormone														Not Covered
J3120	Injection testosterone enanthate up to 100mg	Delatestryl	Yes	ML	Androgen	1 per day	X	X	X	X									**Closed 12/31/14. See J3121 after this date.** Nurse practitioner added 1/1/09.
J3121	Injection, testosterone enanthate, 1mg	Delatestryl	Yes	ML	Androgen	400 u. per week	X	X	X	X								X	**Effective 1/1/15.**
J3130	Injection testosterone enanthate up to 200mg	Delatestryl	Yes	OIL=ML PWD=UN	Androgen	2 per week	X	X	X	X								X	**Closed 12/31/14. See J3121 after this date**. Nurse practitioner added 1/1/09.
J3140	Injection testosterone suspension up to 50mg	Andronaq 50	Yes	PWD=UN SOL=ML	Androgen	3 per week	X	X	X	X									May increase to 4 doses for post partum breast engorgement.
J3150	Injection testosterone propionate up to 100mg	Testex	Yes	OIL=ML PWD=UN	Androgen	3 per week	X	X	X	X									May increase to 4 doses for post partum breast engorgement.
J3230	Injection chlorpromazine HCl up to 50mg	Thorazine	Yes	PWD=UN SOL=ML	Anti-psychotic	10 per day	X	X	X	X		X							Nurse practitioner added 1/1/09.
J3240	Injection thyrotropin alpha 0.9 mg provided in 1.1 mg vial	Thyrogen	Yes	UN	Diagnostic agent	3 per day	X	X	X										
J3243	Injection, tigecycline, 1 mg	Tygacil	Yes	UN	Antibiotic	150 units per day	X	X	X	X									New code effective 1/1/07. Nurse practitioner added 1/1/09.
J3246	Injection tirofiban HCL 0.25mg IV	Aggrastat	Yes	ML	Antiplatelet	None	X	X	X										Must be billed daily.
J3250	Injection trimeth-obenzamide HCl up to 200mg	Tigan	N/A		Antiemetic														Not Covered
J3260	Injection tobramycin sulfate up to 80mg	Nebcin	Yes	ML	Antibiotic	None	X	X	X									X	
J3262	Injection, tocilizumab, 1 mg.	Actemra	Yes	ML	Immunologic	Maximum service limit 800 u. monthly													New code effective 1/1/11. Restricted to **ICD-9** diagnosis 714.0 - 714.2. Restricted to age 16 and above.
J3265	Injection torsemide 10mg/ml	Demadex	Yes	ML	Anti-hypertensive		X	X											
J3280	Injection thiethylperazine maleate up to 10mg	Torecan Norzine	Yes	ML	Antiemetic	1 per day	X	X	X										
J3285	Injection, treprostinil, 1 mg	Remodulin	Yes	ML	Vasodilator	None	X	X	X	X									**ICD-9** code 416.XX or 747.83 required on claim form. Nurse practitioner added 1/1/09.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J3300	Injection, triamcinolone acetonide, PF, 1 mg.	Trivaris	Yes	UN	Ophthalmic Anti-inflammatory		X	X							X				New code effective 1/1/09. Covered to **Ophthalmology** physician specialty only**,** effective 10/1/10.
J3301	Injection triamcinolone acetonide 10mg	Kenalog-10 Kenalog-40 Triam-A	Yes	PWD=UN SOL=ML	Anti-inflammatory	4 per day	X	X	X	X				X					
J3302	Injection triamcinolone diacetate 5mg	Aristocort Intralesional Aristocort Forte Cinolone Trilone Clinacort	Yes	PWD=UN SOL=ML	Anti-inflammatory	8 per day	X	X	X	X				X					
J3303	Injection triamcinolone hexacetonide 5mg	Aristospan Intralesional Aristospan Intra-articular	Yes	ML	Anti-inflammatory	4 per day	X	X	X	X				X					
J3305	Injection trimetrexate glucoronate 25mg	Neutraxin	Yes	UN	Anti-inflammatory	None	X	X	X										Weight based.
J3310	Injection perphenazine up to 5mg	Trilafon	Yes	PWD=UN SOL=ML	Anti-psychotic	3 per day	X	X	X	X		X							
J3315	Injection triptorelin pamoate 3.75mg	Trelstar LA	Yes	UN	Luteinizing hormone-releasing hormone	3 per month	X	X	X										
J3320	Injection spectinomycin dihydrochloride up to 2g	Trobicin	Yes	UN	Antibiotic	None	X	X	X										
J3350	Injection urea up to 40g	Ureaphil	N/A		Diuretic														Not Covered
J3355	Injection, urofollitropin, 75 IU	Metrodin Bravelle	N/A		Hormonal Replacement														Not Covered.
J3357	Injection, ustekinumab, 1 mg.	Stelara	Yes	ML	Antipsoriatic	None	X	X	X										New code effective 1/1/11. Restricted to **ICD-9** diagnosis 696.0 - 696.8. Restricted to age 18 and above.
J3360	Injection diazepam up to 5mg	Valium	N/A		Benzodiaze-pine														Not Covered
J3364	Injection urokinase 5000 IU vial	Abbokinase open cath	Yes	UN	Fibrinolytic	2 per day	X	X	X									X	
J3365	Injection IV urokinaase 250000 IU vial	Abbokinase	N/A		Fibrinolytic														Not Covered
J3370	Injection vancomycin HCl 500mg	Varocin Vancocin	Yes	PWD=UN SOL=ML	Antibiotic	None	X	X	X									X	
J3385	Injection, velaglucerase alfa, 100 units.	Vpriv	Yes	UN	Enzyme	Maximum service limit 165 u. monthly	X	X	X							X			New code effective 1/1/11. Restricted to **ICD-9** diagnosis 272.7. Restricted to ages 4 and above.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J3396	Injection, verteporfin 0.1mg	Visudyne	Yes	UN	Macular degeneration	None	X	X							X				**ICD-9** code 115.02, 115.12, 115.92, 360.21, 362.16, OR 362.52 required on claim form. **Only bill CPT codes 67221 or 67225 with J3396**. Must be billed daily.
J3400	Injection triflupromazine HCl up to 20mg	Vesprin	Yes	ML	Anti-psychotic	150 mg per day	X	X	X			X							
J3410	Injection hydroxyzine up to 25mg	Vistaril Hyzine-50 Atarax	Yes	PWD=UN SOL=ML	Antianxiety	None	X	X	X	X		X							
J3411	Injection thiamine HCL 100mg	Thiamilate	Yes	PWD=UN SOL=ML	Vitamin supplement	2 per day	X	X	X										
J3415	Injection pyridoxine HCl 100mg	Nestrex	Yes	PWD=UN SOL=ML	Vitamin supplement	2 per day	X	X	X										
J3420	Injection vitamin B-12 cyanocobalamin up to 1000mcg	Sytobex Residol Rubramin PC	Yes	PWD=UN SOL=ML	Vitamin supplement	1 per day	X	X	X	X									
J3430	Injection phytonadione (viatamin K) per 1mg	Aqua Mephyton Konakion	Yes	PWD=UN SOL=ML	Vitamin supplement	25 per day	X	X	X									X	
J3465	Injection voriconazole 10mg	VFEND	Yes	UN	Anti-fungal	None	X	X	X										
J3470	Injection hyaluronidase up to 150units	Wydase	Yes	PWD=UN SOL=ML	Enzyme	1 per day	X	X	X										
J3471	Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)		Yes	ML	Enzyme	None	X	X							X				
J3472	Injection, hyaluronidase, ovine, preservative free, per 1000 USP units		Yes	UN	Enzyme	None	X	X							X				
J3473	Injection,hyaluronidase, recombinant, 1 USP unit	Vitrase	Yes	ML	Enzyme	300 units per day	X	X	X								X		New code effective 1/1/07.
J3475	Injection magnesium sulfate 500mg	Sulfamag	N/A		Mineral supplement		X	X	X										Effective 1/1/10, coverage restricted to **Oncology** physician specialty only. Restrict to **ICD-9** diagnosis code 275.2. Must be billed with CPT 96365 - 96368(infusion) **or** CPT 96401 - 96411, or 96413 - 96417, or 96420 - 96425, or 96440 - 96450, or 96542 - 96549(chemotherapy).
J3480	Injection potassium chloride 2mEq	Kdur Kaon-Cl	Yes	PWD=UN SOL=ML	Electrolyte Supplement	None	X	X	X	X									
J3485	Injection zidovudine 10mg	Retrovir	N/A		Anti-retroviral														Not Covered
J3486	Injection zipraosidone mesylate 10mg	Geodon	Yes	UN	Anti-psychotic	10 per day	X	X	X	X		X							Nurse practitioner added 1/1/09.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J3487	Injection zoledronic acid 1mg	Zometa	Yes	PWD=UN SOL=ML	Antidote	4 per day	X	X	X										**Closed 12/31/13.** See J3489.
J3488	Zoledronic Acid/Mannitol/Water Reclast, 1 mg. (5 mg/100 ml package)	Reclast	Yes	ML	Bone Resorption Inhibitor	Max. 5 mg. yearly	X	X	X	X									**Closed 12/31/13.** See J3489. New code effective 1/1/08. Replaces Q4095. Nurse practitioner added 1/1/09.
J3489	Injection, zoledronic acid, 1 mg	Zometa Reclast	Yes	ML	Bone Resorption Inhibitor	None	X	X	X	X									**Effective 1/1/14.**
J3490	**Unclassified drugs. Used only if a more specific code is not available.**		Yes	KIT=UN SOL=ML PWD=UN															**Refer to the list of Approved Drugs from preceding page billed with HCPCS Code J3490. Cost invoice may be required with claim form.**
J3520	Edetate disodium 10mg	Endrate Disotate	Yes	PWD=UN SOL=ML	Antidote	None	X	X	X										Covered only for treatment for lead or heavy metal poisoning; duration <2 weeks.
J3530	Nasal vaccine inhalation		N/A																Not Covered
J3535	Drug administered thru a metered dose inhaler.		N/A																Not Covered
J3570	Laetrile amygdalin vitamin B-17.		N/A		Vitamin														Not Covered
J3590	**Unclassified biologics. Used only if a more specific code is not available.**		Yes	KIT=UN SOL=ML PWD=UN															**Refer to the list of Approved Drugs from preceding page billed with HCPCS Code J3490. Cost invoice may be required with claim form.**
J7030	Infusion normal saline solution 1000cc		Yes	ML		None	X	X	X	X									
J7040	Infusion normal saline solution sterile (500ml = 1 unit)		Yes	ML		None	X	X	X	X									
J7042	5% dextrose/normal saline (500ml - 1 unit)		Yes	ML		None	X	X	X	X									
J7050	Infusion normal saline solution 250cc		Yes	ML		None	X	X	X	X									
J7060	5% dextrose/water (500 ml = 1 unit)		Yes	ML		None	X	X	X	X									
J7070	Infusion D-5-W 1000cc		Yes	PWD=UN SOL=ML		None	X	X	X	X									
J7100	Infusion dextran 40 500ml	Rheomacrodex Gentran 75	Yes	ML		None	X	X	X										
J7110	Infusion dextran 75 500ml	Gentran 75	Yes	ML		None	X	X	X										
J7120	Ringer's lactate infusion up to 1000cc		Yes	ML		None	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7130	Hypertonic saline solution 50 or 100 mEq 20cc vial		Yes	ML		None	X	X	X										**Closed 12/31/11. See J7131.**
J7131	Hypertonic saline solution, 1 ml.	N/A	Yes	ML		None	X	X	X							X			**Effective 1/1/12.**
J7178	Injection, human fibrinogen concentrate, 1 mg	RiaSTAP	Yes	EA	Antifibrinolytic	None	X	X	X				X						**Effective 1/1/13.** Restricted to ICD-9 diagnosis 286.3 or 286.6.
J7180	Injection, Factor XIII (antihemophilic factor, human), 1 IU	Corifact	Yes	UN	Anti-hemophilic	None	X	X	X							X			**Effective 1/1/12.** Restricted to ICD-9 diagnosis 286.3.
J7181	Injection, factor xiii a-subunit, (recombinant), per IU	Tretten	Yes	UN	Anti-hemophilic	None	X	X	X										**Effective 1/1/15.** Restricted to ICD-9 diagnosis of 286.3.
J7182	Injection, factor viii, antihemophilic factor, recombinant, per iu	Novoeight	Yes	UN	Anti-hemophilic	none	X	X	X										**Effective 4/1/15.** Restricted to ICD-9 diagnosis restriction of 286.0. Minimum age restriction of 6 years.
J7183	Injection, von Willebrand factor complex (human), 1 IU, VWF:RCO	Wilate	Yes	UN	Anti-hemophilic	None	X	X	X							X			**Effective 1/1/12.** Restricted to ICD-9 diagnosis 286.4. Restrict to age 5 and above.
J7184	Injection, von Willebrand factor complex (human), per 100 IU, VFW:RCO	Wilate	Yes	UN	Coagulation factor	None	X	X	X				X			X			**Closed 12/31/11. See J7183.** Effective 1/1/11. Restricted to **ICD-9** diagnosis 286.4. Restrict to age 5 and above.
J7185	Injection, Factor VIII(antihemophilic factor, recombinant), per IU	Xyntha	Yes	UN	Anti-hemophilic	none	X	X	X				X			X			Effective 1/1/10. Restricted to ICD-9 diagnosis 286.0 or 286.5.
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex(human), per factor VIII I.U.	Alphanate	Yes	UN	Anti-hemophilic		X	X	X										New code effective 1/1/09. Claim form requires ICD-9 codes 286.0 or 286.4, DOS, POS, J code, description of code, brand name of factor, total units dispensed, NDC# and total charges. Physician's order/provider's Rx with units dispensed must be attached.
J7187	Injection, Von Willebrand factor complex, human, ristocetin cofactor, per IU	Biopool Humate-P	Yes	IU	Anti-hemophilic	None	X	X	X				X						New code effective 1/1/07. Claim form requires ICD-9 codes 286.0-286.7, DOS, POS, J code, description of code, brand name of factor, total units dispensed, NDC# and total charges. Physician's order/provider's Rx with units dispensed must be attached.
J7188	Injection, Von Willebrand factor complex, human, IU	Von Willebrand	N/A		Anti-hemophilic	None	X	X	X				X						CMS closed code effective 12/31/06. See J7187.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg	NovoSeven	Yes	F2=IU	Anti-hemophilic	None	X	X	X				X						New code 1/1/06. Replaces Q0187. Requires completed claim form to include documentation of ICD-9 code 286.0 - 286.4; **and ICD-9 code 286.7 added, effective 10/13/06**; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.
J7190	Factor VIII human per IU	Kogenate Monarc-M Koate HP Hemofil-M Alphanate Humate P Koate DVI MonoclateP	Yes	F2=IU	Anti-hemophilic	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.
J7191	Factor VIII porcine per IU	Hyate-C	Yes	UN	Anti-hemophilic	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.
J7192	Factor VIII recombinant per IU	Bioclate Genarc Human Method M Recombinate Kogenate Helixate FS Refacto Advate	Yes	F2=IU	Anti-hemophilic	None	X	X	X				X						Requires completed CMS 1500 claim form to include documentation of ICD-9 code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration.
J7193	Factor IX purified, non-combinant per IU	AlphaNine SD Mononine	Yes	F2=IU	Anti-hemophilic	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.0 dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration.
J7194	Factor IX complex per IU	Alphanine SD Bebulin VH Profilnine HT & SD Konyne-80 Proplex T, SX-T	Yes	F2-IU	Anti-hemophilic	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7195	Factor IX (antihemophilic factor, recombinant) per IU	Proplex T Konyne 80 Benefix	Yes	W/DIL=IU PWD=UN	Anti-hemophilic	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC#and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.
J7197	Antithrombin III human per IU	Throbate III Atnativ	Yes	F2-IU	Anti-hemophilic	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.
J7198	Anti-inhibitor per IU	Autoplex T FEIBA	Yes	F2=IU	Anti-inhibitor coagulant complex	None	X	X	X				X						Requires completed claim form to include documentation of ICD-9 code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim.
J7199	Hemophilia clotting factor NEC. Used only if a more specific code is not available.		N/A		Anti-hemophilic														Not covered
J7200	Injection, factor ix, (antihemophilic factor, recombinant), per IU	Rixubis	Yes	UN	Anti-hemophilic	none	X	X	X										**Effective 1/1/15.** Restricted to ICD-9 diagnosis of 286.1.
J7201	Injection, factor ix, fc fusion protein (recombinant), per IU	Alprolix	yes		Anti-hemophilic	none	X	X	X										**Effective 1/1/15.** Restricted to ICD-9 diagnosis of 286.1.
J7300	Intrauterine copper contraceptive.	Paragard T380A	Yes	UN	Contraceptive	None	X	X	X	X	X								
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	Skyla	Yes	EA	Contraceptive	1 per 3 years	X	X	X	X	X								**Effective 1/1/14.** Minimum age restriction of 16 years.
J7302	Levonorgestrel releasing intrauterine contraceptive system	Mirena Liletta	Yes	UN	Contraceptive	None	X	X	X	X	X								
J7303	Contraceptive supply hormone containing vaginal ring each		N/A		Contraceptive														Not Covered
J7304	Contraceptive supply, hormone containing l patch each		N/A		Contraceptive														Not Covered
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	Norplant	Yes	UN	Contraceptive	1 every 3 years	X	X	X	X	X								**Code closed 6/30/11.** Females only. Cost invoice required with claim form.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7307	Etonogestrel implant system	Implanon	Yes	UN	Contraceptive	1 every 3 years	X	X	X	X	X								New code effective 1/1/08. Replaces S0180. Females only.
J7308	Aminolevulinic acid HCl for topical administra-tion 20%, single unit dosage form (354mg)	Levulan Kerastick	Yes	UN	Photo-sensitivity agent	None			X										Restricted to ICD-9 code 702.0, Actinic keratosis, effective 2/1/09. Covered to physician's only, effective 2/1/09.
J7309	methyl aminolevulinate (mal) for topical administration, 16.8%, 1 gram	Metvixia	Yes	GR	Photo-sensitivity agent	None			X										New code effective 1/1/11. Restricted to **ICD-9** diagnosis 702.0. Restricted to age 18 and above.
J7310	Ganciclovir 4.5 mg long-acting implant	Vitrasert Cytovene	Yes	UN	Anti-viral	None	X	X							X				One per each eye per 5 months.
J7311	Fluocinolone acetonide, intravitreal implant	Retisert	Yes	UN	Corticosteroid	1 per eye per 30 months	X	X							X				New code effective 1/1/07. Claim form requires ICD-9 363.00-363.08, 363.10-363.15, or 363.20. Must bill with CPT 67027.
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg.	Ozurdex	Yes	UN	Anti-inflammatory	None	X	X							X				**Effective 6/30/14, ICD-9 diagnosis of 362.07 added.** New code effective 1/1/11. Restricted to **ICD-9** diagnosis 362.83 and 362.35 or 362.83 and 362.36, or 363.00 - 363.08. Restricted to ages 16 and above.
J7316	Injection, ocriplasmin, 0.125 mg	Jetrea	Yes	ML	Ophthalmic	None	X	X							X				**Effective 1/1/14.** Restricted to ICD-9 diagnosis of 379.27. Minimum age restriction of 16 years.
J7317	Sodium hyaluronate per 20 to 25 mg dose for intra-articular injection	Hyalgan 20 Supartz 25	N/A		Osteoarthritic	10 injections (5 per knee) X 6 months	X	X	X	X									CMS closed code effective 12/31/06. See J7319
J7318	Sodium hyaluronate for intra-articular injection, 30 mg	Orthovisc	N/A		Osteoarthritic	8 injections (4 per knee) X 6 months	X	X	X	X									CMS closed code effective 12/31/06. See J7319. **ICD-9** code 715.16, 715.25, 715.36, or 715.96 billed with CPT 20610 required on claim form. **Cost invoice** required with claim form.
J7319	Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per dose	Hyalgan 20 Supartz 25 Synvisc Orthovisc Euflexxa	No		Osteoarthritic	10 injections (5 per knee) X 6 months	X	X	X	X									New code effective 1/1/07. **ICD-9** code 715.XX or 716.XX required on claim form. Must be billed with 20610 on claim. Code closed effective 10/1/08. See J7321-J7324.
J7320	Hylan G-F20 16mg/2ml for intra-articular injection	Synvisc	N/A		Osteoarthritic	6 injections (3 per knee) X 6 months	X	X	X	X									CMS closed code effective 12/31/06. See J7319. **ICD-9** code 715.XX or 716.XX required on claim form.
J7321	Hyaluronan or derivate, Hyalgan or Supartz, for intra-articular injection	Hyalgan Supartz	N/A	ML	Osteoarthritic	10 injections (5 per knee) per 170 rolling days	X	X	X	X									**Nurse practitioner added, effective 1/1/12.** New code effective 1/1/08. Replaces Q4083. Requires ICD-9 code 715.xx or 716.XX on claim form for payment consideration.
J7322	Hyaluronan or derivate, Synvisc, for intra-articular injections, per dose	Synvisc	N/A	ML	Osteoarthritic	6 injections (3 per knee) per 170 rolling days	X	X	X										New code effective 1/1/08. Replaces Q4084. Requires ICD-9 code 715.XX or 716.XX on claim form for payment consideration. Closed 12/3/109. See J7325.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7323	Hyaluronan or derivate, Euflexxa, for intra-articular injections, per dose	Euflexxa	N/A	ML	Osteoarthritic	10 injections (5 per knee) per 170 rolling days	X	X	X	X									**Nurse practitioner added, effective 1/1/12**. New code effective 1/1/08. Replaces Q4085. Requires ICD-9 code 715..XX or 716.XX on claim form for payment consideration.
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injections, per dose	Orthovisc	N/A	ML	Osteoarthritic	8 injections (4 per knee) per 170 rolling days	X	X	X	X									**Nurse practitioner added, effective 1/1/12**. New code effective 1/1/08. Replaces Q4086. Requires ICD-9 code 715.XX or 716.XX on claim form for payment consideration.
J7325	Hyaluronan or derivative, Synvisc or Synvisc-1, for intra-articular use	Synvisc Synvisc-1	No	ML	Osteoarthritic	6 injections maximum every 180 days	X	X	X	X									Effective 1/1/10. Restricted to ICD-9 diagnosis 715.00 - 715.98 or 716.00 - 716.99.
J7326	Hyaluronan or derivative, for intra-articular injection, per dose	Gel-One	N/A																Not covered**. See J7325.**
J7327	Hyaluronan or derivative, for intra-articular injection, per dose	Monovisc	N/A																Not covered**. See J7325.**
J7335	Capsaicin 8% patch, per 10 square centimeters	Qutenza	Yes	UN	Analgesic	1 patch per 90 days	X	X	X										**Closed 12/31/14. See J7336 after this date.** New code effective 1/1/11. Restricted to **ICD-9** diagnosis 053.19. Restricted to 18 years and above.
J7336	Capsaicin 8% patch, per square centimeter	Qutenza	Yes	UN	Analgesic	1 patch per 90 days	X	X	X										**Effective 1/1/15.** Restricted to ICD-9 diagnosis 053.19. Restricted to 18 years and above.
J7340	Dermal & empidermal(substitute) bioengineered or processed elements with metabolically active elements per square cm.	Apligraf	No			See special intructions	X	X	X					X					**For diabetes: ICD-9** code 250.xx and 707.xx for surgeons; or, **ICD-9** code 250.xx and 707.13, 707.14, or 707.15 for podiatrists. For **venous stasis ulcer: ICD-9** code 454.0, 454.1, or 454.2 and 707.xx for **surgeons**; or **ICD-9** code 454.0, 454.1, or 454.2 and 707.13, 707.14, or 707.15 for **podiatrists** required on claim form. Service limits for diabetic ulcer are: 3 applications in 9 weeks per year per ulcer. Service limits for venous statsis ulcer are: 3 applications in 12 weeks per year per ulcer. Closed 12/31/08. See Q4101
J7341	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, with metabolically active elements, per square cm.		No			None	X	X	X					X					New code 1/1/06. Closed 12/31/08. See Q4102 and Q4103.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7342	Dermal tissue (substitute), human origin with or without other bioengineered or processed elements with metabolically active elements per square cm.	Dermagraft	No			See special instructions	X	X	X					X					**ICD-9** code 250.xx and 707.xx for **surgeons; ICD-9** code 250.xx and 707.13, 707.14, or 707.15 for **podiatrists** required on claim form. Service limits are: 1 application in 8 weeks per year per ulcer. Closed 12/31/08. See Q4106.
J7343	Dermal & epidermal (substitute) tissue nonhuman origin with or without other bioengineered or processed elements without metabolically elements per square cm.		No			None	X	X	X					X					For **surgeons; ICD-9** code 941.30 - 941.39; 941.40 - 941.49; 942.30 - 942.39; 942.40 - 942.49; 943.30 - 943.39; 943.40 - 943.49; 944.30 - 944.38; 944.40 - 944.48; 945.30 - 945.39; 945.40 - 945.49; 946.3; 946.4; 949.3 or 949.4 required on claim form. For **podiatrists; ICD-9** code 945.x2 or 945.x3 required on claim form. Closed 12/31/08. See Q4104 and Q4105.
J7344	Dermal (substitute) human origin with or without bioengineered or processed elements without metabolically active elements per square cm.		No			None	X	X	X					X					Closed 12/31/08. See Q4107.
J7345	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements, per square cm.		No			None	X	X	X					X					New code effective 1/1/07. Closed 12/31/07.
J7346	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabotically active elements, 1 cc		No			None	X	X	X					X					New code effective 1/1/07. Closed 12/31/08.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7347	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements; without metabolically active elements(Integra Matrix); per sq. cm.	N/A	No																Not covered. See Q4108.
J7348	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements; without metabolically active elements(TissueMend); per sq. cm.	N/A	No																Not covered. See Q4109.
J7349	Dermal (substitute) tissue of nonhuman origin; with or without other bioengineered or processed elements; without metabolically active elements (PriMatrix), per sq. cm.	N/A	No																Not covered. See Q4110.
J7350	Dermal (substitute) tissue, human origin, injectable, with or without other bioengineered or processed elements but without metabolized active elements per 10 mg.		No			None	X	X	X					X					CMS closed code effective 12/31/06. See J7346.
J7500	Azathioprine oral 50mg	Imuran	Yes		Immuno-suppressant														Medicare X-over
J7501	Azathioprine parenteral 100mg	Imuran	Yes	UN	Immuno-suppressant	None	X	X	X										
J7502	Cyclosporine oral 100mg	Neoral Sandimmune	Yes		Immuno-suppressant														Medicare X-over
J7504	Lymphocyte immune globulin antihymocyte globulin equine parenteral 250mg	Atgam	Yes	ML	Immune globulin	None	X	X	X										
J7505	Muromonab-CD3 parenteral 5mg	Orthoclone OKT3	Yes	ML	Immuno-suppressant	1 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7506	Prednisone oral per 5mg	Deltasone Meticorten Orasone	Yes		Immuno-suppressant														Medicare X-over
J7507	Tacrolimus, immediate release, oral, 1 mg	Prograf	Yes		Immuno-suppressant														Medicare X-over
J7508	Tacrolimus, extended release, oral, 0.1 mg	Astagraf	N/A																New code effective 1/1/14. Not covered. See pharmacy POS.
J7509	Methylprednisol-one oral per 4mg	Medrol	Yes		Immuno-suppressant														Medicare X-over
J7510	Prednisolone oral per 5mg	Deltacortef	Yes		Immuno-suppressant														Medicare X-over
J7511	Lymphocyte immune globulin antithymocyte globulin rabbit parenteral 25mg	Thymoglob-ulin	Yes	UN	Immune globulin	None	X	X	X										Weight based.
J7513	Daclizumab parenteral 25 mg	Zenapax	Yes	ML	Immuno-suppressant	None	X	X	X										
J7515	Cyclosporine oral 25mg	Neoral Sandimmune	Yes		Immuno-suppressant														Medicare X-over
J7516	Cyclosporine parenteral 250mg	Neoral Sandimmune	Yes	PWD=UN SOL=ML	Immuno-suppressant	6 per day	X	X	X										
J7517	Mycophenolate mofetil oral 250mg	CellCept	Yes		Immuno-suppressant														Medicare X-over
J7518	Mycophenolic acid oral 180mg	Myfortic	Yes		Immuno-suppressant														Medicare X-over
J7520	Sirolimus oral 1mg	Rapamune	Yes		Immuno-suppressant														Medicare X-over
J7525	Tacrolimus parenteral 5 mg	Prograf	Yes	ML	Immuno-suppressant	None	X	X	X										
J7599	Immunosuppressive drug NOS. Used only if a more specific code is not available		Yes																Medicare X-over
J7602	Albuterol, all formulations including separated isomers, inhalation solution, FDA approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol).	Proventil, Ventolin, Xopenex	N/A	ML	Broncho-dilator	None	X	X	X	X									New code effective 1/1/08. Replaces Q4093. Code closed 3/31/08.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7603	Albuterol, all formulations including separated isomers, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose, per 1 mg. (albuterol), or 0.5 mg. (levalbuterol).	Proventil, Ventolin, Xopenex	N/A	ML	Broncho-dilator	None	X	X	X	X									New code effective 1/1/08. Replaces Q4094. Code closed 3/31/08.
J7604	Acetylcysteine inhalation solution compounded product, administered through				Mucolytic	None													Not covered
J7605	Arformoterol, inhalation solution, FDA approved, final product, non-compounded	Brovana	Yes	ML	Broncho-dilator	None	X	X											New code effective 1/1/08
J7606	Formoterol fumarate, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, 20 mcg.	Perforomist	N/A		Broncho-dilator														Not covered.
J7607	Levalbuterol, inhalation solution, compounded product, administered through DME	Xopenex	N/A		Adrenergic bronchodilator														Not covered.
J7608	Acetylcysteine inhalation solution unit dose form per mg.	Mucomyst Mucosil	Yes	ML	Mucolytic		X	X	X	X									New code effective 1/1/08. Nurse practitioner added 1/1/09.
J7609	Albuterol, inhalation solution, compounded product, administered through DME	Proventil, Proventil Repetabs, Ventolin, Volmax	N/A		Broncho-dilator														Not covered.
J7610	Albuterol, inhalation solution, compounded product, administered through DME	Proventil, Proventil Repetabs, Ventolin, Volmax	N/A		Broncho-dilator														Not covered.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7611	Albuterol inhalation concentrated form 1mg	Proventil, Proventil Repetabs, Ventolin, Volmax	Yes		Broncho-dilator	None													Opened effective 1/1/07. ICD-9 codes 464.4, 466-466.19, 480-487.8, 490-491.9, 492-492.8 and 493-493.9 required on claim form. Code closed effective 12/31/07. Code opened 4/1/08 with above ICD-9 restrictions.
J7612	Levalbuterol inhalation solution concentrated form 0.5mg	Xopenex	Yes		Broncho-dilator	None													Opened effective 1/1/07. ICD-9 codes 464.4, 466-466.19, 480-487.8, 490-491.9, 492-492.8 and 493-493.9 required on claim form. Code closed effective 12/31/07. Code opened 4/1/08 with above ICD-9 restrictions.
J7613	Albuterol inhalation solution unit dose 1mg	Accuneb Proventil Respirol Ventolin	Yes	SOL=ML	Broncho-dilator		X	X	X	X									Code change; re-opened 1/1/09. Code closed effective 12/31/07.
J7614	Levalbuterol inhalation solution unit dose 0.5mg	Xopenex	Yes	SOL=ML	Broncho-dilator		X	X	X	X									Code change; re-opened 1/1/09. Code closed effective 12/31/07.
J7615	Levalbuterol, inhalation solution, compounded product, adminstered through DME	Xopenex	N/A		Adrenergic bronchodilator														Not covered.
J7620	Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, non-compounded	Duoneb	N/A		Broncho-dilator														Not covered.
J7622	Betamethasone inhalation solution unit dose form per mg		N/A		Corticosteroid														Not Covered
J7624	Betamethasone inhalation solution unit dose form per mg		N/A		Corticosteroid														Not Covered
J7626	Budesonide inhalation solution, non-compounded, administered thru DME, unit dose, up to 0.5mg.	Pulmicort Respules	N/A		Corticosteroid														Not Covered
J7627	Budesonide, powder, compounded for inhalation solution, administered through DME, unit dose form up to 0.5mg.	Pulmicort	N/A		Corticosteroid														Not covered.
J7628	Bitolterol mesylate inhalation solution con-centrated form per mg	Tornalate	N/A		Sympathomimetic														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7629	Bitolterol mesylate inhalation solution unit dose form per mg	Tornalate	N/A		Sympathomimetic														Not Covered
J7631	Cromolyn sodium inhaltion solution unit dose form per 10mg	Gastrocrom Intal Nasalcrom	Yes	PWD=UN SOL=ML	Anti-allergic	None	X	X	X	X									New code effective 1/1/08. Nurse practitioner added 1/1/09.
J7632	Cromolyn Sodium inhalation solution, compounded product, administered through				Mast cell stabilizer														Not covered.
J7633	Budesonide inhalation solution concentrated form per 0.25mg	Pulmicort	N/A		Cortico steroid														Not Covered
J7634	Budesonide, inhalation solution, compounded product, administered through DME	Rhinocort	N/A		Anti-inflammatory, corticosteroid														Not covered.
J7635	Atropine inhalation solution concentrated form per mg.	Sal-Tropine	N/A		anticholinergics/ antispasmodics														Not Covered
J7636	Atropine inhalation solution administered through DME unit dose form per mg	Sal-Tropine	N/A		anticholinergics/ antispasmodics														Not Covered
J7637	Dexamethasone inhalation solution concentrated form per mg	Decadron	N/A		Corticosteroid														Not Covered
J7638	Dexamethasone inhalation administered through DME unit dose form per mg	Decadron	N/A		Corticosteroid														Not Covered
J7639	Dornase alpha inhalation solution unit dose form per mg	Pulmozyme	N/A		Enzyme														Not Covered
J7640	Formoterol, inhalation solution, administered through DME, unit dose form, 12 micrograms	Foradil	N/A		Corticosteroid														Not covered.
J7641	Flunisolide inhalation solution unit dose per mg	Nasalide	N/A		Corticosteroid														Not Covered
J7642	Glycopyrrolate inhalation solution concentrated form per mg	Robinul	N/A		Anti-cholinergic														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7643	Glycopyrrolate inhalation solution unit dose form per mg	Robinul	N/A		Anti-cholinergic														Not Covered
J7644	Ipratropium bromide inhalation solution unit dose form per mg	Atrovent	N/A		Broncho-dilator														Not Covered
J7645	Ipratropium bromide, inhalation solution, compounded product, administered thru DME	Atrovent	N/A		Broncho-dilator														Not covered.
J7647	Isoetharine HCl, inhalation solution, compounded product, administered through DME	Bronkometer, Bronkosol	N/A		Broncho-dilator														Not covered.
J7648	Isoetharine HCl inhalation solution concentrated form per mg	Bronkometer, Bronkosol	N/A		Broncho-dilator														Not Covered
J7649	Isoetharine HCl inhalation solution unit dose form per mg	Bronkometer, Bronkosol	N/A		Broncho-dilator														Not Covered
J7650	Isoetharine HCl, inhalation solution, compounded product, administered through DME	Bronkometer, Bronkosol	N/A		Broncho-dilator														Not covered.
J7657	Isoproterenol HCl, inhalation solution, compounded product, administered through DME	Isuprel HCl Medihaler-150	N/A		Vasopressor														Not covered.
J7658	Isoproterenol HCl inhalation solution con-centrated form per mg	Isuprel HCl Medihaler-150	N/A		Vasopressor														Not Covered
J7659	Isoproterenol HCl inhalation solution unit dose form per mg	Isuprel HCl Medihaler-150	N/A		Vasopressor														Not Covered
J7660	Isoproterenol HCl, inhalation solution, compounded product, administered through DME	Isuprel HCl Medihaler-150	N/A		Vasopressor														Not covered.
J7665	Mannitol, administered via inhaler, 5 mg.	Aridol	N/A																Not covered.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7667	Metaporterenol sulfate, inhalation solution, compounded product, concentrated	Alupent	N/A		Broncho-dilator														Not covered.
J7668	Metaproterenol sulfate inhalation solution con-centrated form per 10mg	Alupent	Yes	ML	Broncho-dilator	None			X	X									**Code closed 6/30/11.** Opened effective 1/1/07. ICD-9 codes 464.4, 466-466.19, 480-487.8, 490-491.9, 492-492.8 and 493-493.9 required on claim form.
J7669	Metaproterenol sulfate inhalation solution unit dose form per 10 mg	Alupent	Yes	PWD=UNSOL=ML	Broncho-dilator	None			X	X									Opened effective 1/1/07. ICD-9 codes 464.4, 466-466.19, 480-487.8, 490-491.9, 492-492.8 and 493-493.9 required on claim form. Nurse practitioner added 10/1/09.
J7670	Metaproterenol sulfate, inhalation solution, compounded product, administered	Alupent	N/A		Broncho-dilator														Not covered.
J7674	Methacholine chloride as inhalation solution through a nebulizer per 1mg	Provocholine	N/A		Cholinergic broncho-constrictor														Not Covered
J7676	Pentamidine Isethionate inhalation solution, compounded product, administered through				Anti-protozoal														Not covered
J7680	Terbutaline sulfate inhalation solution con-centrated form per mg	Brethine Bricanyl	N/A		Broncho-dilator														Not Covered
J7681	Terbutaline sulfate inhalation solution unit dose form per mg	Brethine Bricanyl	N/A		Broncho-dilator														Not Covered
J7682	Tobramycin unit dose form 300mg inhalation solution	Tobi	N/A		Antibiotic														Not Covered
J7683	Triamcinolone inhalation solution concentrated form per mg	Azmacort	N/A		Corticosteroid														Not Covered
J7684	Triamcinolone inhalation solution unit dose form per mg	Azmacort	N/A		Corticosteroid														Not Covered
J7685	Tobramycin, inhalation solution, compounded product, administered through DME	Tobrex	N/A		Anti-bacterial, opthalmic														Not covered.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J7686	Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg.	Tyvaso	N/A		Pulmonary Anti-hypertensive														Not covered.
J7699	NOC drugs in-halation drugs. Used only if a more specific code is not available.		N/A																Not Covered
J7799	NOC drugs other than inhalation drugs. Used only if a more specific code is not available		N/A																Not Covered
J8498	Antiemetic drug, rectal/suppository, not otherwise specified		N/A																Not covered.
J8499	Prescription drug oral non-chemotherapeutic NOS		N/A																Not Covered
J8501	Aprepitant oral 5mg	Emend Emend Tri-Fold	N/A		Antiemetic														Not Covered
J8510	Bulsulfan oral2 mg	Myleran	N/A		Anti-neoplastic														Not Covered
J8515	Cabergoline, 0.25 mg	Dostinex	N/A																Not Covered.
J8520	Capecitabine oral 150mg	Xeloda	N/A		Anti-neoplastic														Not Covered.
J8521	Capecitabine oral 500mg	Xeloda	N/A		Anti-neoplastic														Not Covered.
J8530	Cyclophosphamide oral 25mg	Cytoxan Procytox	N/A		Anti-neoplastic														Not Covered.
J8540	Dexamethasone, oral, 0.25 mg	Decadron	N/A		Anti-inflammatory														Not Covered.
J8560	Etoposide oral 50mg	VePesid	N/A		Anti-neoplastic														Not Covered.
J8561	Everolimus, oral, 0.25 mg.	Afinitor	N/A																Not Covered.
J8562	Fludarabine phosphate, oral, 10 mg.	Oforta	N/A		Anti-neoplastic														Not covered.
J8565	Gefitnib oral 250mg	Iressa	N/A		Anti-neoplastic														Not Covered.
J8597	Antiemetic drug, oral, not othrwise specified		N/A																Not Covered.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J8600	Melphalan oral 2mg	Alkeran	N/A		Anti-neoplastic														Not Covered.
J8610	Methotrexate oral 2.5mg	Rheumatrex Dose Pack	N/A		Anti-rheumatic														Not Covered.
J8650	Nabilone, oral, 1 mg	Cesamet	N/A		Antiemetic														Not Covered.
J8700	Temozolomide oral 5mg	Temodar	N/A		Anti-neoplastic														Not Covered.
J8705	Topotecan, oral, 0.25 mg.	Hycamtin	N/A		Anti-neoplastic														Not covered.
J8999	Prescription drug oral chemotherapeutic NOS. Used only if a more specific code is not available.		N/A																Not Covered.
J9000	Doxorubicin HCl 10mg	Adriamycin	Yes	PWD=UN SOL=ML	Anti-neoplastic	20 per day	X	X	X										
J9001	Doxorubicin HCl, all lipid formulations, 10mg	Doxil	Yes	ML	Anti-neoplastic	10 per day	X	X	X										**Closed 12/31/12.**
J9002	Injection, doxorubicin hydrochloride, liposomal, 10 mg	Doxil	Yes	ML	Anti-neoplastic	10 per day	X	X	X										**Effective 1/1/13.**
J9010	Injection, alemtuzumab, 10mg	Campath	Yes	ML	Anti-neoplastic	3 per day	X	X	X										**Drug not available on market, effective 9/4/12.**
J9015	Aldesleukin per single use vial.	Proleukin	Yes	UN	Biological Response Modulator	3 per day	X	X	X										
J9017	Arsenic trioxide 1mg	Trisenox	Yes	PWD=UN SOL=ML	Anti-neoplastic	15 per day	X	X	X										
J9019	Injection, asparaginase, 1,000 iu	Erwinaze	Yes	UN	Anti-neoplastic	None	X	X	X										**Effective 1/1/13.** Restricted to ICD diagnosis of 204.00 - 204.02.
J9020	Asparaginase 10000U	Elspar	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9025	Injection, azacitidine, 1 mg	Vidaza	Yes	UN	Anti-neoplastic	None	X	X	X										**ICD-9** code 238.7, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 239.79 or 205.10 required on claim form.
J9027	Injection, clofarabine, 1 mg	Clolar	Yes	ML	Anti-neoplastic	None	X	X	X										New code effective 1/1/06.
J9031	BCG live (intravesical) per instillation	TheraCys Tice BCG	Yes	UN	Biological Response Modulator	3 per day	X	X	X										Code can be used for therapeutic reasons, and claim must include the NDC being billed.
J9033	Injection, bendamustine HCl, 1 mg.	Treanda	Yes	UN	Anti-neoplastic		X	X	X										**New code effective 1/1/09.** Replaces C9239. Restricted to **ICD-9** diagnois 200.00-200.88, 202.00-202.88, 203.00, 203.10, 203.80, 238.6, 204.10 - 204.12, effective 1/1/09.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9035	Injection bevacizumab 10 mg	Avastin	Yes	ML	Anti-neoplastic	None	X	X	X										**Effective 11/14/14, ICD-9 diagnosis restriction of 158.0 - 158.8 and 183.0 - 183.8 added. Effective 8/14/14, ICD-9 diagnosis restriction of 180.0, 180.1, and 180.8** added. Effective 10/1/13, ICD-9 diagnosis restriction of 237.5 added. Effective 4/1/13, approved ICD-9 diagnoses 174.0 - 175.9 removed, per FDA recommendation. ICD-9 codes 153.0-154.8, 173.5, 174.0-174.9 or 175.0-175.9 required on claim form. New ICD-9 diagnois code of 162.0 - 163.0, effective 9/20/07. New ICD-9 diagnosis code of 191.0-192.9, effective 5/5/09. New approved ICD-9 diagnosis of 189.0 - 189.9, effective 8/1/09. Bill J3490 for provider specialty Ophthalmology.
J9040	Bleomycin sulfate 15U	Blenoxane	Yes	UN	Anti-neoplastic	4 per day	X	X	X										
J9041	Injection bortezomib 0.1 mg	Velcade	Yes	UN	Proteasome Inhibitor	None	X	X	X										**ICD-9 diagnosis restriction of 996.81 - 996.87 added, effective 3/1/15. ICD-9** code 203.00 or 203.02, initial or relapsed multiple myeloma, required on claim form. New indication of mantle cell lymphoma added effective 7/1/08. Claim must include **ICD-9** range of 200.40 to 200.48.
J9042	Injection, brentuximab vedotin, 1 mg	Adcetris	Yes	UN	Anti-neoplastic	180 units daily	X	X	X										**Effective 1/1/13**. Restricted to ICD-9 diagnosis of 200.60 - 200.68 or 201.00 - 201.98.
J9043	Injection, cabazitaxel, 1 mg.	Jevtana	Yes	ML	Anti-neoplastic	None	X	X	X										**Effective 1/1/12.** Restricted to ICD-9 diagnosis 185.0.
J9045	Carboplatin 50mg	Paraplatin	Yes	PWD=UN SOL=ML	Anti-neoplastic	18 per day	X	X	X										
J9047	Injection, carfilzomib, 1 mg	Kyprolis	Yes	UN	Anti-neoplastic	None	X	X	X										**Effective 1/1/14.** Restricted to ICD-9 diagnosis of 203.00 - 203.02. Minimum age restriction of 16 years.
J9050	Carmustine 100mg	BICNU	Yes	PWD=UN SOL=ML	Anti-neoplastic	5 per day	X	X	X										
J9055	Injection Cetuximab 10 mg	Erbitux	Yes	ML	Anti-neoplastic	None	X	X	X										**ICD-9** code 140.0-149.9, 153.0-154.8, 160.0-161.9, or 195.0 is required on claim form.
J9060	Cisplatin powder or solution per 10mg	Platinol AQ	Yes	PWD=UN SOL=ML	Anti-neoplastic	18 per day	X	X	X										
J9062	Cisplatin 50mg	Platinol AQ	Yes	ML	Anti-neoplastic	6 per day	X	X	X										
J9065	Injection cladribine per 1 mg	Leustatin	Yes	ML	Anti-neoplastic	40 per day	X	X	X										
J9070	Cyclophosphamide 100mg	Cytoxan Neosar	Yes	UN	Anti-neoplastic	68 per day	X	X	X										
J9080	Cyclophosphamide 200 mg	Cytoxan Neosar	Yes	UN	Anti-neoplastic	34 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9090	Cyclophosphamide 500 mg	Cytoxan Neosar	Yes	UN	Anti-neoplastic	14 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9091	Cyclophosphamide 1g	Cytoxan Neosar	Yes	UN	Anti-neoplastic	7 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9092	Cyclophosphamide 2g	Cytoxan Neosar	Yes	UN	Anti-neoplastic	4 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9093	Cyclophosphamide lyophilized 100mg	Cytoxan Lyophilized	Yes	UN	Anti-neoplastic	68 per day	X	X	X										Closed 12/31/10. See J9070 after this date.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9094	Cyclophosphamide lyophilized 200 mg	Cytoxan Lyophilized	Yes	UN	Anti-neoplastic	34 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9095	Cyclophosphamide lyophilized 500 gm	Cytoxan Lyophilized	Yes	UN	Anti-neoplastic	14 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9096	Cyclophosphamide lyophilized 1g	Cytoxan Lyophilized	Yes	UN	Anti-neoplastic	7 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9097	Cyclophosphamide lyophilized 2g	Cytoxan Lyophilized	Yes	UN	Anti-neoplastic	4 per day	X	X	X										Closed 12/31/10. See J9070 after this date.
J9098	Cytarabine liposome 10 mg	DepoCyt	Yes	ML	Anti-neoplastic	5 per day	X	X	X										
J9100	Cytarabine 100mg	Cytosar-U	Yes	PWD=UN SOL=ML	Anti-neoplastic	75 per day	X	X	X										
J9110	Cytarabine 500mg	Cytosar-U	Yes	PWD=UN SOL=ML	Anti-neoplastic	15 per day	X	X	X										
J9120	Dactinomycin 0.5mg	Cosmegen	Yes	UN	Anti-neoplastic	2 per day	X	X	X										
J9130	Dacarbazine 100mg	DTIC-Dome	Yes	UN	Anti-neoplastic	9 per day	X	X	X										
J9140	Dacarbazine 200mg	DTIC-Dome	Yes	UN	Anti-neoplastic	5 per day	X	X	X										
J9150	Daunorubicin HCl 10mg	Cerubidine	Yes	PWD=UN SOL=ML	Anti-neoplastic	11 per day	X	X	X										
J9151	Daunorubicin citrate liposomal formulation 10 mg	Daunoxome	Yes	ML	Anti-neoplastic	11 per day	X	X	X										
J9155	Injection, degarelix, 1 mg.	Firmagon	Yes	UN	Anti-neoplastic	240 units per day	X	X	X										Effective 1/1/10. Restricted to ICD-9 diagnosis 185. Exclude female. Restrict to age 18 and above.
J9160	Denileukin diftitox 300mcg	Ontak	N/A		Anti-neoplastic														Not Covered
J9165	Diethylstilbestrol diphosphate 250 mg	Stilphostrol	Yes	UN	Palliative therapy prostate cancer	4 per day	X	X	X										**Only for cancer diagnosis**.
J9170	Docetaxel 20mg	Taxotere	Yes	ML	Anti-neoplastic	10 per day	X	X	X										Closed 12/31/09. See J9171.
J9171	Injection, docetaxel, 1 mg.	Taxotere	Yes	ML	Anti-neoplastic	200 u. per day	X	X	X							X			New code effective 1/1/10. The following are **ICD-9** diagnoses approved for this code, including newly approved **ICD-9** diagnoses. effective 7/1/10: 140.0 - 149.9, 150.0 - 150.9, 151.0 - 151.9, 157.0 - 157.9, 158.0, 158.8, 158.9, 160.0 - 160.9, 161.0 - 161. 9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 171.0, 171.2, 171.3, 171.5, 171.8, 171.9, 173.0, 173.2, 173.3, 173.4, 174.0 - 174.9, 175.0 - 175.9, 179, 180.0 - 180.9, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3 - 183.5, 183.8, 183.9, 185, 188.0 - 188.9, 189.1, 189.2, 189.3, 189.8, 189.9, 195.0, 199.0, 199.1, 209.70 - 209.79, 233.7, 235.1, 238.1, 239.0 - 239.2, 239.6, 239.81, 239.89, 239.9.
J9175	Injection, Eliotts' B solution, 1 ml	dextrose/ electsol, IV	Yes	ML		None	X	X											

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9178	Injection epirubicin HCl 2 mg	Ellence	Yes	PWD=UN SOL=ML	Anti-neoplastic	None	X	X	X										
J9179	Injection, eribulin mesylate, 0.1 mg.	Halaven	Yes	ML	Anti-neoplastic	80 units per 21 days	X	X	X										**Effective 1/1/12.** Restricted to ICD-9 diagnosis 198.81 or 174.0 - 175.9. Minimum age restriction of 18 years.
J9181	Etoposide 10mg	VesPesid Toposar	Yes	PWD=UN SOL=ML	Anti-neoplastic	25 per day	X	X	X										
J9182	Etoposide 100mg	VesPesid Toposar	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9185	Fludarabine phosphate 50mg	Fludara	Yes	PWD=UN SOL=ML	Anti-neoplastic	5 per day	X	X	X										
J9190	Fluorouracil 500 mg	Adrucil	Yes	PWD=UN SOL=ML	Anti-neoplastic	5 per day	X	X	X										
J9200	Floxuridine 500 mg	FUDR	Yes	UN	Anti-neoplastic	2 per day	X	X	X										
J9201	Gemcitabine HCl 200mg	Gemzar	Yes	UN	Anti-neoplastic	None	X	X	X										
J9202	Goserelin acetate implant per 3.6mg	Zoladex	Yes	UN	Anti-neoplastic	1 per month	X	X	X										
J9206	Irinotecan 20mg	Camptosar	Yes	ML	Anti-neoplastic	35 per day	X	X	X										**ICD-9 diagnosis code required on claim form: Effective 5/1/10**, the following are approved, 150.0 - 150.9, 151.0 - 151.9, 152.0 - 152.9, 153.0 - 154.8, 157.0 - 157.9, 162.0, 162.2, 162.3, 162.4, 162.5 162.8, 162.9, 180.0, 180.1, 180.8, 180.9, 183.0, 183.2 - 183.5, 183.8, 183.9, 191.0 - 191.9, 199.0 - 199.1, 200.00 - 200.88, 202.00 - 202.88, 202.70 - 202.78, 202.80 - 202.88, 202.90 - 202.98, 209.70 - 209.79, and 239.0 - 239.9.
J9207	Injection, ixabepilone, 1 mg.	Ixempra	Yes	UN	Anti-neoplastic	None	X	X	X										New code effective 1/1/09. Restricted to **ICD-9** code 174.0 - 174.9, metastatic or locally advanced breast cancer. Covered to physicians effetive 1/1/09. Minimum age of 18 years. Replaces C9240.
J9208	Ifosfamide per 1g	Ifex	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9209	Mesna 200mg	Mesnex	Yes	ML	Anti-neoplastic	3 per day	X	X	X										
J9211	Idarubicin HCl 5mg	Idamycin Pfs	Yes	ML	Anti-neoplastic	12 per day	X	X	X										
J9212	Injection interferon alfa-con1 recombinant 1mcg	Infergen	Yes	ML	Anti-viral	1 per day X 7 consecutive days - lifetime	X	X	X										Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J9213	Interferon alfa-2A recombinant 3 million U	Roferon-A	Yes	KIT=UN SOL=ML	Anti-viral	1 per day X 7 consecutive days - lifetime	X	X	X										Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J9214	Interferon alfa-2B recombinant 1 million U	Intron-A	Yes	PWD=UN SOL=ML KIT=UN	Anti-viral	none	X	X	X										**Effective 4/1/14, service limit removed.**

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9215	Interferon alfo-n3 human leukocyte derived 250,000 IU	Alferon-N	Yes	ML	Biological Response Modulator	1 per day X 7 consecutive days - lifetime	X	X	X										Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J9216	Interferon gamma 1B 3 million U	Actimmune	Yes	ML	Biological Response Modulator	1 per day X 7 consecutive days - lifetime	X	X	X										Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J9217	Leuprolide acetate for depot suspension 7.5mg	Lupron Depot Eligard Lupron Depot-Ped	Yes	UN	Anti-neoplastic	None	X	X	X										
J9218	Leuprolide acetate 1mg	Lupron	Yes	PWD=UN SOL=ML	Anti-neoplastic	1 per day X 7 consecutive days - lifetime	X	X	X										Physician reimbursement for administraton is limited to 1 unit X 7 consecutive days per lifetime.
J9219	Leuprolide acetate implant 65mg	Lupron	Yes	UN	Anti-neoplastic	1 per 3 months	X	X	X										Per manufacturer's notification, Viadur is no longer made as of December 2007.
J9225	Histrelin implant, 50 mg	Vantas	Yes	UN	Gonadotropin	1 per year	X	X	X										**ICD-9** code 185 required on claim form. Males only.
J9226	Histrelin implant, 50 mg	Supprelin LA	Yes	UN	Gonadotropin	Age: 2 yrs and older	X	X	X	X									New code effective 1/1/08. Diagnosis restriction, central precocious puberty(259.1). Nurse practitioner added 1/1/09.
J9228	Injection, ipilimumab, 1 mg.	Yervoy	Yes	ML	Antibody(anti-neoplastic)	400 units per 21 days	X	X	X							X			**Effective 1/1/12. Restricted to ICD-9 diagnosis 154.2, 154.3, 172.0 - 172.9, 184.0 - 184.4, 187.1 - 187.9, 196.0 - 196.9, 197.0 - 197.8, 198.0 - 198.8(Date of change: April 2012).** Minimum age restriction of 16 years.
J9230	Mechlorethamine HCl nitrogen mustard 10mg	Mustargen	Yes	UN	Anti-neoplastic	5 per day	X	X	X										
J9245	Injection melphalan HCl 50mg	Alkeran Lphenylala-nine mustard	Yes	UN	Anti-neoplastic	2 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9250	Methotrexate sodium 5mg	Rheumatrex Trexall Methotrexate sodium Lpf	Yes	PWD=UN SOL=ML	Anti-neoplastic	10 per day	X	X	X										
J9260	Methotrexate sodium 50mg	Rheumatrex Trexall Methotrexate sodium Lpf	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9261	Injection, nelarabine, 50 mg	Arranon	Yes	ML	Anti-neoplastic	None	X	X	X										New code effective 1/1/07.
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg	Synribo	Yes	UN	Anti-neoplastic	None	X	X	X										**Effective 1/1/14.** Restricted to IDC-9 diagnosis of 205.10 - 205.12. Minimum age restriction of 16 years.
J9263	Injection oxaliplatin 0.5mg	Eloxatin	Yes	PWD=UN SOL=ML	Anti-neoplastic	None	X	X	X										**Effective 3/19/11, new list of approved ICD-9 diagnosis codes: 150.0 - 150.9, 151.0 - 151.9, 153.0 - 154.8, 155.1, 156.0 - 156.9, 157.0 - 157.3, 157.8, 157.9, 158.8, 183.0 - 183.9, 186.0, 186.9, 200.30 - 200.38, 200.70 - 200.78, 201.90, 202.01 - 202.08, 202.80 - 202.88.** Added ICD-9 code 201.90 effective 1/1/08. ICD-9 code 153.0 - 154.8 required on claim form.
J9264	Injection, paclitaxel protein-bound particles, 1 mg	Abraxane	Yes	UN	Anti-neoplastic	None	X	X	X										**Approved ICD-9 diagnosis codes of 157.0 - 157.9 added, 9/6/13.** Nurse practitioner removed as covered provider, effective 7/1/13. Effective 10/11/12, approved ICD-9 diagnosis 162.0 - 162.9 added. ICD-9 code 174.0 - 175.9 with chemo agent required on claim form. Nurse practitioner added 1/1/09.
J9265	Paclitaxel 20mg	Taxol Onxol	Yes	PWD=UN SOL=ML	Anti-neoplastic	20 per day	X	X	X										**Closed 12/31/14. See J9267 after this date.**
J9266	Pegaspargase per single dose vial	Oncaspar	Yes	ML	Anti-neoplastic	8 per day	X	X	X										
J9267	Injection, paclitaxel, 1 mg	Taxol Onxol	Yes	ml	Anti-neoplastic	400 u. per day	X	X	X										**Effective 1/1/15.**
J9268	Pentostatin per 10mg	Nipent	Yes	UN	Anti-neoplastic	1 per day	X	X	X										
J9270	Plicamycin 2.5mg	Mithracin Mithramycin	Yes	UN	Anti-neoplastic	2 per day	X	X	X										
J9280	Mitomycin 5mg	Mutamycin	Yes	UN	Anti-neoplastic	10 per day	X	X	X										
J9290	Mitomycin 20mg	Mutamycin	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9291	Mitomycin 40mg	Mutamycin	Yes	UN	Anti-neoplastic		X	X	X										
J9293	Injection mitaxan-trone HCl 5mg	Navatrone	Yes	ML	Anti-neoplastic	6 per day	X	X	X										
J9300	Gemtuzumab ozogamicin 5mg	Mylotarg	Yes	UN	Anti-neoplastic	4 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9301	Injection, obinutuzumab, 10 mg	Gazyva	Yes	ML	Anti-neoplastic	100 units maximum dose	X	X	X										**Effevtive 1/1/15.** Restricted to 204.10. Minimum age restriction of 16 years.
J9302	Injection, ofatumumab, 10 mg.	Arzerra	Yes	ML	Anti-neoplastic	Maximum service limit 200 u. weekly													New code effective 1/1/11. Restricted to **ICD-9** diagnosis 204.10 - 204.12. Restricted to age 18 and above.
J9303	Injection, panitumumab	Vectibix	Yes	ML	Anti-neoplastic	None	X	X	X										New code effective 1/1/08.
J9305	Injection pemetrexed 10mg	Alimta	Yes	UN	Anti-neoplastic	None	X	X	X										Restricted to **ICD-9** diagnosis 162-163.9.
J9306	Injection, pertuzumab, 1 mg	Perjeta	Yes	ML	Anti-neoplastic	900 units per 20-day period	X	X	X										**Effective 4/1/14, change to service limit.** Effective 1/1/14. Restricted to ICD-9 diagnosis of 174.0 - 174.9 or 175.0 - 175.9. Minimum age restriction of 16 years.
J9307	Injection, pralatrexate, 1 mg.	Folotyn	Yes	ML	Metabolic inhibitor	None	X	X	X							X			New code effective 1/1/11. Restricted to **ICD-9** diagnosis 202.70 - 202.78. Restricted to age 18 and above. Open to **Oncology specialty for Physician provider type.**
J9310	Rituximab 100mg	RituXan	Yes	ML	Anti-neoplastic	10 per day	X	X	X										
J9315	Injection, romidepsin, 1 mg.	Istodax	Yes	UN	Anti-neoplastic	None	X	X	X							X			New code effective 1/1/11. Restricted to **ICD-9** diagnosis 202.10 - 202.28. Restricted to age 18 and above. Open to **Oncology specialty for Physician provider type.**
J9320	Streptozocin 1g	Zanosar	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9328	Injection, temozolomide, 1 mg.	Temodar	Yes	UN	Anti-neoplastic	none	X	X	X							X			Effective 1/1/10. Restricted to ICD=9 diagnosis 191.0 - 191.9. restrict to age 18 and above.
J9330	Injection, temsirolimus, 1 mg.	Torisel	Yes	UN	Anti-neoplastic	limited to 18 years or older	X	X											New code effective 1/1/09. Restricted to **ICD-9** code 189.0 - 189.9, advanced renal cell carcinoma, with a maximum dose of 25 mg./mL. Covered to physicians effective 1/1/09.
J9340	Thiotepa 15mg	Thioplex	Yes	UN	Anti-neoplastic	10 per day	X	X	X										For Bone Marrow Transplants.
J9350	Topotecan 4mg	Hycamtin	Yes	UN	Anti-neoplastic	None	X	X	X										Closed 12/31/10. See J9351 after this date.
J9351	Injection, topotecan, 0.1 mg.	Hycamtin	Yes	UN	Anti-neoplastic	None	X	X	X							X			New code effective 1/1/11. Restricted to ICD-9 162.0 - 162.9, 180.0 - 180.9, 183.0 - 183.9, 198.6, 198.82. Restricted to ages 18 and above. **Open to Oncology specialty for Physician provider type.**
J9354	Injection, ado-trastuzumab emtansine, 1 mg	Kadcyla	Yes	UN	Anti-neoplastic	None	X	X	X										**Effective 1/1/14.** Restricted to ICD-9 diagnosis of 174.0 - 174.9 or 175.0 - 175.9. Minimum age restriction of 16 years.
J9355	Trastuzumab 10mg	Herceptin	Yes	UN	Anti-neoplastic	None	X	X	X										
J9357	Valrubicin intravesical 200mg	Valstar	Yes	ML	Anti-neoplastic	6 per day	X	X	X										
J9360	Vinblastine sulfate 1mg	Vinblastine Sulfate Velban	Yes	PWD=UN SOL=ML	Anti-neoplastic	46 per day	X	X	X										

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
J9370	Vincristine sulfate 1mg	Oncovin Vincasar Pfs	Yes	PWD=UN SOL=ML	Anti-neoplastic	7 per day	X	X	X										
J9371	Injection, vincristine sulfate liposome, 1 mg	Marqibo	Yes	UN	Anti-neoplastic	None	X	X	X										**Effective 1/1/14.** Restricted to ICD-9 diagnosis of 204.00 - 204.82. Minimum age restriction of 16 years.
J9375	Vincristine sulfate 2mg	Oncovin Vincasar Pfs	Yes	ML	Anti-neoplastic	4 per day	X	X	X										**Closed 12/31/10.**
J9380	Vincristine sulfate 5mg	Vincasar Pfs	Yes	ML	Anti-neoplastic	2 per day	X	X	X										
J9390	Vinorelbine tartrate 10mg	Navelbine	Yes	ML	Anti-neoplastic	10 per day	X	X	X										
J9395	Injection fulvestrant 25mg	Faslodex	Yes	ML	Anti-neoplastic	20 per day	X	X	X										**Update to service limit, effective 9/9/10.**
J9400	Injection, ziv-aflibercept, 1 mg	Zaltrap	Yes	ML	Anti-neoplastic	550 units bi-weekly	X	X	X										**Effective 1/1/14.** Restricted to ICD-9 diagnosis of 153.0 - 153.9, 154.0, 154.1, or 154.8. Minimum age restriction of 16 years.
J9600	Porfimer sodium 75mg	Photofrin	Yes	UN	Anti-neoplastic	3 per day	X	X	X										
J9999	**Unclassified Antineoplastics. Use only if a more specific code is not available.**		Yes	KIT=UN SOL=ML PWD=UN			X	X	X										**Refer to the list of Approved Drugs from preceding page billed with HCPCS Code J3490. Cost invoice may be required with claim form.**
Q0090	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg.	Skyla	Yes	UN	Contraceptive	1 unit per 3 years	X	X	X	X	X								**Closed 12/31/13. See J7301.** Effective 7/1/13. Minimum age restriction of 16 years.
Q0112	All potassium hydroxide (KOH) preparations		N/A																Not covered
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg. (non-ESRD)	Feraheme	Yes	ML	Iron salt	none	X	X	X	X						X		X	Effective 1/1/10. Restricted to **ICD-9** diagnosis 280.0 - 280.9. Deny if billed with **ICD-9** diagnosis 585.6. Restrict to age 16 and above.
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg. (ESRD use)	Feraheme	Yes	ML	Iron salt	none	X	X	X	X						X		X	Effective 1/1/10. Restricted to **ICD-9** diagnosis 280.0 - 280.9 and 585.6. Restrict to age 16 and above.
Q0144	Azithromycin dehydrate, oral, capsules/powder, 1 gram	Zithromax Zithromax Z-pak	Yes	UN					X	X									New code effective 1/1/08.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q0162	Ondansetron 1 mg., oral, FDA-approved prescription anti-emetic, not to exceed a 48-hour dosage regimen	Zofran	N/A																Not covered.
Q0163	Diphenhydramine HCl 50 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen	Truxadryl	Yes	SOL=ML		None	X	X	X	X									Must be billed with chemo agent.
Q0164	Prochlorperazine maleate, 5mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitue for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Compa-zine	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0165	Prochlorperazine maleate, 10mg, oral, FDA approved antiemetic, for use as a complete therapeutic substitue for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Compazine	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q0166	Granisetron HCl, 1mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen	Kytril	Yes	SOL=ML		None	X	X	X	X									Must be billed with chemo agent.
Q0167	Dronabinol, 2.5mg, oral, FDA approved anti-emetic, for use as a complete therapeutic susbstitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Marinol	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0168	Dronabinol, 5mg, oral, FDA approved anti-emetic, for use as a complete therapeutic susbstitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Marinol	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0169	Promethazine HCl, 12.5mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Phenergan Amergan	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q0170	Promethazine HCl, 25mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Phenergan Amergan	Yes	SYR=ML		None	X	X	X	X									Must be billed with chemo agent.
Q0171	Chlorpromazine HCl, 10mg, oral, FDA approved antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48 hour regimen	Thorazine	Yes	SYR=ML		None	X	X	X	X									Must be billed with chemo agent.
Q0172	Chlorpromazine HCl, 25mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour regimen	Thorazine	Yes	SOL=ML		None	X	X	X	X									Must be billed with chemo agent.
Q0173	Trimethobenzamide HCl, 250mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Tebamide T-Gen Ticon Tigan Triban Thimazide	N/A																Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q0174	Thiethylperazine maleate, 10mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Torecan	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0175	Perphenzaine, 4mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Trilifon	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0176	Perphenzaine, 8mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Trilifon	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0177	Hydroxyzine pamoate, 25mg, oral, FDA approved antiemetic, for use as a complete therapeutic substitute for IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Vistaril	Yes	SUS=ML		None	X	X	X	X									Must be billed with chemo agent.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q0178	Hydroxyzine pamoate, 50mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Vistaril	Yes	PWD=UN		None	X	X	X	X									Must be billed with chemo agent.
Q0179	Ondansetron HCl, 8mg, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Zofran	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0180	Dolasetron mesylate, 100mg, oral, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen	Anzemet	Yes	UN		None	X	X	X	X									Must be billed with chemo agent.
Q0181	Unspecified oral dosage form, FDA approved anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen		N/A																Not covered
Q0511	Pharmacy supply fee for oral anticancer, oral antiemetic or immunosuppressive		N/A																Medicare X-over

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q0515	Injection, sermorelin acetate, 1 microgram	Geref - Diagnostic	N/A																Not covered
Q2004	Irrigation solution for treatment of bladder calculi, for example Renacidin, per 500 ml	Renacidin	N/A																Not covered
Q2009	Injection, fosphenytoin, 50 mg	Cerebryx	N/A																Not covered
Q2024	Injection, bevacizumab, 0.25 mg.						X	X	X						X				Closed 12/31/09. See J3490 for **Ophthalmology.**
Q2040	Injection, incobotulinim toxin A, 1 u.	Xeomin	Yes	UN	Neuromuscular blocker	120 u. per 90 days	X	X	X										**Closed 12/31/11. See J0588**. Effective 4/1/11. Restricted to ICD-9 diagnosis codes of 333.81 & 333.83. Minimum age restriction of 18 years.
Q2042	Injection, hydroxyprogesterone caproate, 1 mg.	Makena	Yes	UN		250 u. weekly	X	X	X	X	X								**Closed 12/31/11. See J1725.** Effective 7/1/11. Cost invoice required with claim, with letter of justification for brand over compounded generic, billed with J3490. Restricted to ICD-9 diagnosis 644.0 - 644.2. Minimum age restriction of 16 years.
Q2043	Sipuleucel-T, minimum of 50 million autologous cells, including all preparatory procedures, per infusion	Provenge	Yes	UN	Anti-neoplastic	1 per 14 days	X	X	X										**Effective 7/1/11.** Restricted to ICD-9 diagnosis 185. Minimum age restriction of 18 years.
Q2046	Injection, aflibercept 1 mg.	Eylea	Yes	ML	neovascular-Age related Macular Degeneration	4 units weekly	X	X							X				**Ophthalmology physician specialty added 7/1/12.** New ICD-9 diagnosis restriction of 362.83 and 362.35 added, effective 9/21/12. Code opened 7/1/12. Restricted to ICD-9 diagnosis code of 362.52. Minimum age restriction of 16 years.
Q2047	Injection, peginesatide 0.1 mg.	Omontys	Yes	ML	Erythropoiesis stimulating agent													X	**Effective 7/1/12.** Restricted to ICD-9 diagnosis 285.21 and 585.6. Minimum age restriction of 16 years.
Q2049	Injection, doxorubicin HCl., liposomal, 10 mg.	Lipodox (imported)	Yes	ML	Anti-neoplastic	10 per day	X	X	X										**Effective 7/1/12.**
Q2050	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10mg	Doxil	Yes	ML	Anti-neoplastic	10 per day	X	X	X										**Effective 1/1/14.**
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Rebif Avonex	Yes	UN		4 daily	X	X	X	X									For IM only.
Q3026	Injection, interferon beta-1a, 11 mcg for subcutaneous use	Rebif Avonex	N/A																Closed 7/1/05

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q4074	Iloprost, inhalation solution, FDA-approved final product, non-compounded																		Not covered.
Q4079	Injection, Natalizumab 1 mg	Tysabri	Yes		Leukocyte Adhesion Inhibitor														Code closed 12/31/07. See J2323 effective 1/1/08.
Q4080	Iloprost inhalation solution administered thru DME up to 20 mcg	Ventavis	N/A																Not Covered. Closed 12/31/09. See Q4074
Q4081	Injection, Epoetin Alfa, 100 units (for ESRD on dialysis)	Epogen Procrit	Yes	ML		900 units 3 times weekly	X	X	X	X								X	New code 1/1/07. If more than 900 units needed, bill with J0886. **ICD-9** 585.6 needed on claim form.
Q4082	Drug or Biological, not otherwise classified, Part B drug		N/A																New code 1/1/07. Not covered.
Q4083	Hyaluronan or derative, Hyalgan or Supartz, for intra-articular injection per dose	Hyalgan Supartz	No		Osteoarthritic	10 injection (5 per knee) per 170 rolling days													Code closed 12/31/07. Claims will deny when billed with Q code with dates of service after 12/31/07. See J7321 effective 1/1/08.
Q4084	Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose	Synvisc	No		Osteoarthritic	6 injections (3 per knee) per 170 rolling days													Code closed 12/31/07. Claims will deny when billed with Q code with dates of service after 12/31/07. See J7322 effective 1/1/08.
Q4085	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	Euflexxa	No		Osteoarthritic	10 injection (5 per knee) per 170 rolling days													Code closed 12/31/07. Claims will deny when billed with Q code with dates of service after 12/31/07. See J7323 effective 1/1/08.
Q4086	Hyaluronan or derivative, Orthovisc, for intra-articular injections, per dose	Orthovisc	No		Osteoarthritic	8 injections (4 per knee) per 170 rolling days													Code closed 12/31/07. Claims will deny when billed with Q code with dates of service after 12/31/07. See J7324 effective 1/1/08.
Q4087	Octagam injection - injection , immune globulin,(Octagam) IV, non-lyophilized (i.e., liquid), 500mg		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J1568 effective 1/1/08.
Q4088	Gammagard Liquid Injection - Injection,immune globulin (Gammagard Liquid), IV, non-lyophilized (e.e., liquid), 500mg.		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J1569 effective 1/1/08.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q4089	Rhophylac Injection - Injection, Rho(d) immune globulin (human), (Rhohylac), IM or IV, 100iu - Note that currently Rhophylac is the only product that should be billed using code Q0489. If other products under the Food and Drug Administration (FDA) approval for Rhophylac become available, Q4089 would be used to bill for such products.		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J2791 effective 1/1/08.
Q4090	HepaGam B Injection - Injection, hepatitis B immune globulin (HepaGam B, IM, 0.5 ml)		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J1571 effective 1/1/08.
Q4091	Fiebogamma Injection - Injection, immune globulin (Flebogamma), IV, non-lypohilized (e.g., liquid), 500mg.		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J1572 effective 1/1/08.
Q4092	Gamunex Injection - Injection, immune globulin (Gamunex), IV, non-lypohilized (e.g., liquid), 500mg		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J1561 effective 1/1/08.
Q4093	Albuterol, all formulations including separated isomers, inhaltion solution, FDA approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5mg (levalbuterol).		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J7602 effective 1/1/08.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q4094	Albuterol, all formulations including separated isomers, inhaltion solution, FDA approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5mg (levalbuterol).		N/A																New code effective 7/1/07. Not covered. Code closed effective 12/31/07. See J7603 effective 1/1/08.
Q4095	Zoledronic Acid/Mannitol/Water Reclast 5mg/100ml bottles	Reclast	Yes	ML	Bone Resorption Inhibitor														Code closed effective 12/31/07. See J3488 effective 1/1/08.
Q4096	Injection, Von Willebrand factor complex, human, Ristocetin cofactor, (NOS), per IU. VWF:RCO	Alphanate	N/A	IU	Anti-hemophilic														Not covered.
Q4098	Injection, iron dextrans, 50 mg.	Infed	Yes	ML	Iron salt	None	X	X	X	X									New code. Opened 7/1/08. Closed 12/31/08. See J1750 after 1/1/09.
Q4100	Skin substitute, NOS	N/A	No			None	X	X	X					X					Requires description of skin substitute on claim form, requires cost invoice with claim form, add to edit 162
Q4101	Skin substitute, Apligraf, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J73490. Required on claim form: For diabetes/surgeons ICD9 codes 250XX & 707XX. For podiatrists ICD9 codes 250XX & 707.13, 707.14, OR 707.15. For venous stasis ulcers/surgeon: ICD9 codes 454.0, 454.1, or 414.2 & 707XX. For podiatrists ICD9 codes 454.0, 454.1, or 454.2 & 707.13, 704.14, or 707.15.
Q4102	Skin substitute, Oasis Wound Matrix, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7341.
Q4103	Skin substitute, Oasis Burn Matrix, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7341.
Q4104	Skin substitute, Integra Bilayer Matrix Wound Dressing(BMWD), per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7343. Required on claim form: For surgeons ICD9 codes 941.30 - 949.4. For podiatrists ICD9 codes 945.X2 or 945.X3. Description required on claim.
Q4105	Skin substitute, Integra Dermal Regeneration Template(DRT), per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7343. Required on claim form: For surgeons ICD9 codes 941.30 - 949.4. For podiatrists ICD9 codes 945.X2 or 945.X3. Description required on claim.
Q4106	Skin substitute, Dermagraft, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7342. Required on claim form: For surgeons ICD9 codes 250XX & 707XX. For podiatrists ICD9 codes 250XX & 707.13, 707.14, or 707.15

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q4107	Skin substitute, Graft Jacket, per sq. cm.	N/A	No			None	X	X	X					X					
Q4108	Skin substitute, Integra Matrix, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7347.
Q4109	Skin substitute, Tissuemend, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7348.
Q4110	Skin substitute, Primatrix, per sq. cm.	N/A	No			None	X	X	X					X					Replaces J7349.
Q4111	Skin substitute, GammaGraft, per sq. cm.	N/A	No			None	X	X	X					X					
Q4112	Allograft, Cmyetra, injectable, 1 cc.	N/A	No			None	X	X	X					X					Replaces J7346.
Q4113	Allograft, GRAFTJACKET express, injectable, 1 cc.	N/A	No			None	X	X	X					X					Replaces J7346.
Q4114	Integra flowable wound matrix, injectable, 1 cc.	N/A	No			None	X	X	X					X					
Q9951	Low osmolar contrast material, 400 mg/.ml or greater,iodine concentration per ml		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9952	Injection Gadolinim-based magnetic resonance contrast agent , per ml	Magnevist 46.9% Prohance Multihance Omniscan Omnimark	No		Diagnostic agent Radio-pharmaceutical		X	X									X		**Closed.** Paper Claim. Send copy of the invoice which includes the NDC billed
Q9953	Injection iron-based magnetic resonance contrast agent, per ml	Feridex IV	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9954	Oral magnetic resonance contrast agent, per 100ml	Gastromark	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q9955	Injection, perflexane lipid microsphere, per ml		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9956	Injection octafluoropropane microspheres, per ml	Optison	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9957	Injection , perfluitren lipid microspheres, per ml	Definity	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed. Cardiology specialty added as covered provider, effective 1/1/09.
Q9958	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml	Cystografin Reno-30 Cystografin Hypaque Cysto-Conray Conray -30	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9959	High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9960	High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml	Conray 43	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9961	High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml	Cholografin Reno-60 Renografin-60 Hypaque Conray	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
Q9962	High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9963	High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml	Gastrografin Sinografin Renocal-76 Hypaque Md-76R Md Gastroview	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9964	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml	Conray 400	No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9965	Low osmolar contrast material, 100-199 MG/ML IODINE CONCENTRATION, PER ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9966	Low osmolar contrast material, 200-299 MG/ML Iodine Concentration, Per ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9967	Low osmolar contrast material, 300-399 MG/ML Iodine Concentration, Per ML		No		Diagnostic agent Radio-pharmaceutical		X	X	X								X		Paper Claim. Send copy of the invoice which includes the NDC billed
Q9968	Injection, non-radioactive, non-contrast, visualization adjunct																		Not covered.
Q9970	Injection, ferric carboxymaltose, 750 mg./15 ml.	Injectafer	Yes	ML	Iron therapy	None	X	X	X										**Closed 12/31/14. See J1439 after this date.** Effective 7/1/14. Cost invoice with NDC required with claim. Restricted to ICD-9 diagnosis of 280.1 - 280.9. Minimum age restriciton of 16 years.
Q9974	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg	Duramorph	yes	ML	Analgesic narcotic	None	X	X	X										**Closed 12/31/14. See J2274 after this date.** Effective 7/1/14. Cannot be billed with J2271 or J2275 for same DOS.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
S0012	Butorphanol tartrate, nasal spray, 25 mg.		N/A																Not covered.
S0014	Tacrine HCl, 10 mg.		N/A																Not covered.
S0017	Injection, aminocaproic acid		N/A		Hemorrhage														Not Covered
S0020	Injection, bupivicaine hydro		N/A		Anesthetic														Not Covered
S0021	Injection, cefoperazone sod		N/A		Antibiotic														Not Covered
S0023	Injection, cimetidine hydroc		N/A		Anti-Ulcer Preparation														Not Covered
S0028	Injection, famotidine, 20 mg		N/A		Anti-Ulcer Preparation														Not Covered
S0030	Injection, metronidazole		N/A		Anti-protoxoal														Not Covered
S0032	Injection, nafcillin sodium		N/A		Penicillin-Antibiotic														Not Covered
S0034	Injection, ofloxacin, 400 mg		N/A		Quinolone-Antibiotic														Not Covered
S0039	Injection, sulfamethoxazole		N/A		Sulfa - Antibiotic														Not Covered
S0040	Injection, ticarcillin disod		N/A		Penicillin-Antibiotic														Not Covered
S0073	Injection, aztreonam, 500 mg		N/A		Betalactam-Antibiotic														Not Covered
S0074	Injection, cefotetan disodiu		N/A		Cephalosporin-Antibiotic														Not Covered
S0077	Injection, clindamycin phosp		N/A		Lincosamide-Antibiotic														Not Covered
S0078	Injection, fosphenytoin sodi		N/A		Anticonvulsant														Not Covered
S0080	Injection, pentamidine iseth		N/A		Antiprotozoal														Not Covered
S0081	Injection, piperacillin sodi		N/A		Penicillin-Antibiotic														Not Covered
S0088	Imatinib 100 mg		N/A		Leukemia														Not Covered
S0090	Sildenafil citrate, 25 mg		N/A		Impotency														Not Covered
S0091	Granisetron 1mg		N/A		Antiemetic/ Antivertigo Agents														Not Covered
S0092	Hydromorphone 250 mg		N/A		Narcotic														Not Covered
S0093	Morphine 500 mg		N/A		Narcotic														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
S0104	Zidovudine, oral, 100 mg		N/A		HIV- Antiviral														Not Covered
S0106	Bupropion HCL SR 60 tablets		N/A		Anti-Smoking														Not Covered
S0108	Mercaptopurine 50 mg		N/A		Leukemia														Not Covered
S0109	Methadone oral 5mg		N/A		Narcotic														Not Covered
S0117	Tretinoin topical 5 g		N/A		Acne														Not Covered
S0122	Inj menotropins 75 iu		N/A		Follicle Stim /Lutenizing Homones														Not Covered. Code closed effective 12/31/07.
S0126	Inj follitropin alfa 75 iu		N/A		Follicle Stim /Lutenizing Homones														Not Covered. Code closed effective 12/31/07.
S0128	Inj follitropin beta 75 iu		N/A		Follicle Stim /Lutenizing Homones														Not Covered. Code closed effective 12/31/07.
S0132	Inj ganirelix acetat 250 mcg		N/A		LHRH (GNRH) Antagonist, Pituitary														Not Covered. Code closed effective 12/31/07.
S0136	Clozapine, 25 mg		N/A		Atypical Antipsychotic														Not Covered
S0137	Didanosine, 25 mg		N/A		HIV- Antiviral														Not Covered
S0138	Finasteride, 5 mg		N/A		Prostatic Hypertrophy														Not Covered
S0139	Minoxidil, 10 mg		N/A		Anti hypertensive														Not Covered
S0140	Saquinavir, 200 mg		N/A		HIV Antiviral														Not Covered
S0141	Zalcitabine, 0.375 mg ,		N/A		HIV- Antiviral														Not Covered
S0142	Colistimethate inh sol mg		N/A		Polymyxin-Antibiotic														Not Covered
S0143	Aztreonam, inh sol gram		N/A		Betalactam-Antibiotic														Not Covered
S0145	Peg interferon alfa-2A/180		N/A		Hepatitis C														Not Covered
S0146	Peg interferon alfa-2b/10		N/A		Hepatitis C														Not Covered
S0147	Alglucosidase alfa 20 mg		N/A		Enzyme Replacement														Not Covered. Code closed effective 12/31/07.
S0155	Sterile dilutant for epoprostenol, 50 ml		N/A		Diluent Solutions														Not Covered. Code closed effective 12/31/07.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
S0156	Exemestane, 25 mg		N/A		Antineoplastic														Not Covered. Code closed effective 12/31/07.
S0157	Becaplermin gel 1%, 0.5 gm		N/A		Diabetic Ulcer Preparations														Not Covered. Code closed effective 12/31/07.
S0160	Dextroamphetamine		N/A		ADHD, Narcolepsy														Not Covered
S0161	Calcitrol		N/A		Vitamin D														Not Covered
S0162	Injection efalizumab		N/A		Psoriasis														Not Covered
S0164	Injection pantroprazole		N/A		Gastric Reflux, Esophogitis														Not Covered
S0166	Inj olanzapine 2.5mg		N/A		Atypical Antipsychotic														Not Covered
S0170	Anastrozole 1 mg		N/A		Antineoplastic														Not Covered
S0171	Bumetanide 0.5 mg		N/A		Loop Diuretics														Not Covered
S0172	Chlorambucil 2 mg		N/A		Alkylating Agents														Not Covered. Code closed effective 12/31/07.
S0174	Dolasetron 50 mg		N/A		Antiemetic/ Antivertigo Agents														Not Covered. Code closed effective 12/31/07.
S0175	Flutamide 125 mg		N/A		Antiandrogenic Agent														Not Covered. Code closed effective 12/31/07.
S0176	Hydroxyurea 500 mg		N/A		Alkylating Agents														Not Covered. Code closed effective 12/31/07.
S0177	Levamisole 50 mg		N/A																Not Covered. Code closed effective 12/31/07.
S0178	Lomustine 10 mg		N/A		Alkylating Agents														Not Covered. Code closed effective 12/31/07.
S0179	Megestrol 20 mg		N/A		Appetite Stim. For Anorexia														Not Covered. Code closed effective 12/31/07.
S0180	Etonogestrel implant system		N/A		Contraceptive, Implantable														Code closed effective 12/31/07. Claims will deny when S code billed after dates of service 12/31/07. See J7307 effective 1/1/08.
S0181	Ondansetron 4 mg		N/A		Antiemetic/ Antivertigo Agents														Not Covered. Code closed effective 12/31/07.
S0182	Procarbazine 5 mg		N/A		Antineoplastic														Not Covered. Code closed effective 12/31/07.

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
S0183	Prochlorperazine 5 mg		N/A		Antiemetic/ Antivertigo Agents														Not Covered. Code closed effective 12/31/07.
S0187	Tamoxifen 10 mg		N/A		Selective Estrogen Receptor Modulators														Not Covered. Code closed effective 12/31/07.
S0189	Testosterone pellet 75 mg		N/A		Androgenic Agent														Not Covered. Code closed effective 12/31/07.
S0190	Mifepristone, oral, 200 mg	Mifeprex	Yes		Abortifacient, Progesterone Receptor Antagonist				X										
S0191	Misoprostol, oral, 200 mcg	Cytotec	Yes		Anti-Ulcer Prep/Abortifacient				X										
S0196	Poly-l-lactic acid 1ml face		N/A																Not Covered
S4989	Contracept IUD		N/A		IUD Contraceptive														Not Covered
S4990	Nicotine patches, legend		N/A																Not Covered
S4991	Nicotine patches, nonlegend		N/A		Anti-Smoking														Not Covered
S4993	Contraceptive pills for bc		N/A		Oral Contraceptive														Not Covered
S4995	Smoking cessation gum		N/A		Anti-Smoking														Not Covered
S5000	Prescription drug, generic		N/A		IV Fluid														Not Covered
S5001	Prescription drug,brand name		N/A		IV Fluid														Not Covered
S5010	5% dextrose and 45% normal saline, 1000 ml		N/A		IV Fluid														Not Covered
S5011	5% dextrose in lactated ringer's, 1000 ml		N/A		IV Fluid														Not Covered
S5012	5% dextrose with potassium chloride, 1000 ml		N/A		IV Fluid														Not Covered
S5013	5% dextrose/45% normal saline with potassium chloride and magnesium sulfate, 1000 ml		N/A		IV Fluid														Not Covered

Code	Description	Brand Name	NDC Required	NDC unit of measure	Category	Service Limits	AC OP	CAH OP	P	NP	MW	MH	HS	PO	OPH	HI	ID TF	DC	Special Instructions
S5014	5% dextrose/45% normal saline with potassium chloride and magnesium sulfate, 1500 ml		N/A		IV Fluid														Not Covered
S5550	Insulin rapid 5 u		N/A		Diabetes														Not Covered
S5551	Insulin most rapid 5 u		N/A		Diabetes														Not Covered
S5552	Insulin intermed 5 u		N/A		Diabetes														Not Covered
S5553	Insulin long acting 5 u		N/A		Diabetes														Not Covered
S5565	Insulin cartridge 150 u		N/A		Diabetes														Not Covered
S5566	Insulin cartridge 300 u		N/A		Diabetes														Not Covered

***ACOP - Acute Care Outpatient Hospital**
***CAHOP - Critical Access Outpatient Hospital**
***P - Physician**
***NP - Nurse Practitioner**
***MW - Midwife**
***MH - Mental Health/Rehabilitation**
***HS - Hemophilia Services**
***PO - Podiatry**
***OPH- Ophthalmologist**
***HI - Home IV Infusion**
***IDTF - Independent Diagnostic Treatment Facility**
***D - Dialysis Center**