

MedStar Medicare Choice Pharmacy Services

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At a Glance

Welcome to Medicare Choice Pharmacy Services. Pharmacy services partners with the physician-led network of Medicare Choice providers to meet the medication and cost needs of members. The approach focuses on improving patient health through coordinated formulary and Care Advising programs that enhance the member and provider experience.

Medicare Choice develops a formulary of medications chosen based on clinical effectiveness, safety and value. The formulary's pricing strategy is designed to achieve the goal of better clinical outcomes at an affordable cost. The formulary is developed by physicians and clinical pharmacists.

Medicare Choice formulary includes the following features:

- Required generics
- Lists of preferred drugs (formulary medications)
- Prior authorization or step therapy requirements for selected medications
- Quantity limits (based on FDA guidelines and accepted standards of care)

Contact a Clinical Pharmacist

Medicare Choice encourages providers to contact the Pharmacy Services department at **855-266-0712** from Monday through Friday, 8 a.m. to 5 p.m., with comments or questions about a member's medication history, duplicate medications or compliance. A dedicated clinical pharmacy team is available to provide extra support, including

- Answering medication-related questions from providers and network pharmacies
- Developing and conducting prospective and retrospective drug utilization reviews
- Supporting providers, network pharmacies and members on pharmacy changes
- Serving as a clinical resource for the provider network
- Conducting a medication therapy management (MTM) program
- Providing physician and member education materials to network practices to support drug selection and use based on the best objective and clinical evidence

Coverage Reviews/Prior Authorizations

A limited number of medications require authorization before they are provided for patients. Authorizations may be needed for the following reasons:

- Prior authorization or a step therapy requirement as indicated on the formulary
- Prescriptions that exceed Medicare Choice quantity limits
- Non-formulary medications
- Early refills

In some cases, clinical documentation is necessary to review these medication requests. All requests will be reviewed promptly, and the decision will be communicated to the physician or patient.

How to Obtain Prior Authorization

To receive authorization for a medication requiring a prior authorization or quantity limits or for a non-formulary medication:

- Obtain a prior authorization form from the following website:
<http://medstarprovidernetwork.com/medicare-choice/pharmacy-prior-authorization-forms>
- Fax: **855-862-6517**

Medicare Choice will immediately communicate all coverage determinations/prior authorization decisions by fax to the physician's office once the review process is complete. If a fax number is not available, Medicare Choice Pharmacy Services will communicate decisions by phone and will mail a copy of any decision documentation to the provider's office. Patients will be notified of all pharmacy coverage determinations/prior authorization decisions determined by Medicare Choice.

Submitting a Request for a Coverage Determination or Appeal

A request may be made for a coverage decision for formulary exceptions which include: coverage of a drug not on the plan formulary; a request to waive restrictions on the plan's coverage of a drug such as quantity limits, the removal of prior authorization requirements, the requirement to use a generic version of the drug or the requirement to try a different drug first (often referred to as step therapy.) Coverage decisions may also be requested for a tiering exception to change the coverage of a drug to a lower cost-sharing tier. If the drug is in Tier 4 (non-preferred brand drugs), a request may be made to cover it at the cost-sharing amount that applies to drugs in Tier 3 (preferred brand drugs). Tiering exceptions may not be made for any drug in Tier 5 (specialty drugs).

If the health of the member requires a quick response, a provider may request an expedited coverage decision. A supporting statement outlining the medical reasons for the request must be submitted. A standard coverage decision means the plan will provide a response within 72 hours of receiving the request and supporting statement. For an expedited coverage decision, a response will be provided within 24 hours of receiving the request and supporting statement. A request for an expedited coverage decision will only be granted if using the standard deadlines could cause serious harm to the health of the member.

If a coverage decision that has been made for a formulary or tiering exception has been denied, a Level 1 appeal may be requested. The appeal must be submitted within 60 calendar days from the date of the denial. As with a coverage decision, if the health of the member requires it, the provider may request an expedited appeal. A decision on an expedited Level 1 appeal will be communicated within 72 hours of receiving the request and supporting documents. A response will be made sooner if the health of the member requires it. A decision will be made on standard Level 1 appeals within seven calendar days of receipt of the request and supporting documents. A decision will be made sooner if the member has not received the drug yet and their health condition requires it.

A Level 2 appeal may be requested through an independent review entity (IRE) if the Level 1 appeal upholds the initial coverage determination. Specific instructions on filing deadlines and how to submit the next level appeal are included in the written notification of the denial. When an appeal is made to the independent review organization, the plan will send the Level 1 appeal information to this organization. The independent review organization is an independent organization that is hired by Medicare. This organization is not connected with the plan, and it is not a government agency. This organization is a company chosen by Medicare to review plan decisions on Part D benefits. If the health of the member requires an expedited appeal, the IRE must provide a response to the Level 2 appeal within 72 hours of receipt. If the IRE approves all or part of the appeal, the drug will be supplied within 24 hours after the decision from the review organization is received. For a standard Level 2 Appeal, the IRE must respond within seven

calendar days of receipt. If the IRE approves all or part of the appeal, the drug will be supplied within 72 hours after the decision from the review organization is received.

If the IRE upholds the decision, there are three additional levels in the appeals process. However, in order to request a Level 3, 4, or 5 appeal, the dollar value of the drug coverage requested must meet a minimum amount. For most situations, the last three levels of appeals work in much the same way as the Level 1 and Level 2 appeals. Specific instructions on filing deadlines and how to submit the next level appeal are included in the written notification of the denial. A Level 3, 4, and 5 appeal is handled by an administrative law judge or the Appeals, Council, and Federal District Court, respectively. If the result of the appeal is overturned at any of these levels, the plan will authorize or provide the drug coverage that was approved within 72 hours. If a Level 3 or 4 appeal is upheld, the member may appeal to the next level. A Level 5 appeal is the last step of the appeals process.

Coverage decisions and appeals for Part D prescription drugs may be submitted to the following address:

**MedStar Medicare Choice
Attn: Pharmacy Services
950 N. Meridian St.
Suite 600
Indianapolis, IN 46204**

Pharmacy Policies

Prior Authorization Criteria

Prior authorizations are set on a specific drug-by-drug basis and require specific criteria for approval based upon FDA and manufacturer guidelines, medical literature, safety concerns and appropriate use. Drugs that require prior authorization may be

- Newer medications requiring monitoring by Medicare Choice
- Medications not used as a standard first option in treating a medical condition
- Medications with potential side effects that Medicare Choice would like to monitor to ensure safety

All prior authorization criteria are reviewed by the Pharmacy and Therapeutics (P&T) committee.

The physician should submit clinical information to the Medicare Choice Pharmacy Services department. Once that information has been received, a decision regarding the medical necessity of the requested medication will be made.

Step Therapy

Step therapy ensures patients are taking the most effective medication at the best cost. This means trying the least expensive medication that has been proven effective to treat a condition. The step therapy process for Medicare Choice includes

- Step 1: When your prescribed drug is impacted by step therapy, the patient will be asked to try preferred, often generic, drugs first. The generic drugs recommended will be approved by the Food and Drug Administration (FDA) as providing the same benefits at a much lower cost.
- Step 2: If the drug in Step 1 does not work, patients may need to try a drug in Step 2. Step therapy is coordinated with the patient's benefit plan. Some medications are automatically approved if there is a record that the patient has already tried a preferred medication.

If there is no record of a preferred medication in the patient's medication history, the physician must submit clinical information to the Medicare Choice Pharmacy Services team. Once that information is received, a decision regarding payment for the requested medication will be made.

Quantity Limits

A quantity limit or dose duration may be placed on certain medications to ensure patients are getting the most cost-effective drug/dose combination.

Medicare Choice follows the FDA and manufacturer's recommended dosing guidelines and limits how much of the medication the patient may receive in a certain time period. Providers are encouraged to incorporate these quantity limits into their prescribing patterns.

For the above pharmacy exceptions, please call Pharmacy Services at **855-266-0712** from Monday through Friday, 8 a.m. to 5 p.m.

Mandatory Generics

Most formularies require the use of a generic version of a drug if one is available.

Medicare Choice Pharmacy Programs

Medicare Choice Pharmacy Benefit Coverage

Medicare Choice pharmacy plan includes a five tier formulary. Many medications, unless they are benefit exclusions, are covered under this benefit.

The formulary allows patients to access multiple medications, allowing patients and providers to determine the medication that is best for the individual patient.

- **First tier:** The first tier consists of preferred generic medications and has the lowest copay. These are therapeutically equivalent to the branded products and approved by the FDA. When a generic medication is available, providers are encouraged to prescribe the generic medication to patients.
- **Second tier:** The second tier has a slightly higher cost share and consists of non-preferred generic medications. These are therapeutically equivalent to the branded products and are approved by the FDA. When a generic medication is available, providers are encouraged to prescribe the generic medication to patients.
- **Third tier:** The third tier includes the brand-name drugs to be used when generics are not available. Medicare Choice has designated these medications as “preferred” based on clinical efficacy, safety profile and cost effectiveness.
- **Fourth tier:** The fourth tier includes brand-name medications that are not preferred but which the patient may purchase at a higher cost share.
- **Fifth tier:** The fifth tier includes specialty, high-cost and biological medication regardless of how the medication is administered (injectable, oral, transdermal or inhaled). These medications are often used to treat complex clinical conditions and usually require close management by a physician because of their potential side effects and the need for frequent dosage adjustments.

Additional Information about the Medicare Choice Pharmacy Benefit

The Medicare Choice pharmacy benefit is designed to provide patients with coverage for medications at an affordable cost.

Generics

To achieve this goal, prescribing a generic version of the drug is recommended if one is available. If members receive a brand-name drug when a generic is available, the member must pay the cost share amount in addition to the retail cost difference between the brand-name and generic forms of the drug.

Quantity Limits

Also, quantities are limited to a 30-day supply for controlled substances and for medications defined as specialty. A 90-day supply of most drugs is available from the mail order pharmacy, Express Scripts, Inc. (ESI). The ESI customer service center is available 24/7 at **877-787-6279**. TTY users may call toll free at **800-899-2114**.

Formulary

The drugs are listed in the 2017 formulary. This is a COMPLETE listing of the most commonly prescribed drugs and represents the drug formulary that is at the core of this pharmacy benefit plan. As drugs are released into the market, they are reviewed by the P&T Committee for formulary placement. Benefit exclusions may apply. Call Medicare Choice Pharmacy Services for more information at **855-266-0712**.

Where to Obtain Prescriptions

How to Fill Prescription Medications

Short-term Medications

These are drugs needed immediately and include medications used to treat short-term infections or to relieve pain temporarily. Providers can send these prescriptions:

- To a MedStar pharmacy: To locate a MedStar pharmacy, members should call Medicare Choice Member Services at **855-222-1041**.
- To a retail network pharmacy: Medicare Choice uses the Express Scripts national retail network for members to obtain prescription drugs. To locate the nearest retail network, pharmacy members should call Medicare Choice Member Services at **855-222-1041**.

Long-term Medications

These are drugs taken on a regular basis and can be picked up at a MedStar pharmacy or mailed to the members home for up to a 90-day supply. Members can fill these prescriptions:

- At a MedStar pharmacy: MedStar pharmacies can fill prescriptions for up to a 90-day supply. Often, the MedStar pharmacy may have a lower copay for the member's medication.
- Through home delivery from the Express Scripts pharmacy: Members may also receive home delivery for long-term medications from Express Scripts. These medications will be delivered directly to the member's home in a plain, weather-resistant pouch for privacy and protection. Standard shipping is free.

Specialty Medications

Specialty medications treat specific medical conditions such as cancer, hemophilia, hepatitis, multiple sclerosis, psoriasis, pulmonary arterial hypertension, respiratory syncytial virus, rheumatoid arthritis and more. Providers can send these prescriptions:

- To MedStar pharmacy: To locate a MedStar pharmacy, members should call MedStar Medicare Choice Member Services at **855-222-1041**.
- To Accredo (the Express Scripts specialty pharmacy): Members should call MedStar Medicare Choice Pharmacy Services at **855-266-0712** to learn more about specialty medications.

For Medicare Choice members who require specialty medications to be administered by a healthcare professional, such as Remicade, Orencia, etc., please follow the defined protocol to assist with prior authorization requests.

Obtaining Prior Authorization for Specialty Medications

For Medications Covered under the Pharmacy Benefit:

- To request prior authorization for medications covered under the pharmacy benefit, please visit the following website: <http://medstarprovidernetwork.com/medicare-choice/pharmacy-prior-authorization-forms>
- From the website, complete, print and fax prior authorization forms for specific drugs and non-formulary exceptions. Fax completed prior authorization forms for Pharmacy Services along with supporting documentation to **855-862-6517**.
- Please contact the Medicare Choice Pharmacy Services team at **855-266-0712** for assistance with steps 1 and 2 mentioned above.

For Medications Covered under the Medical Benefit:

To request prior authorization for medications covered under the medical benefit, please contact the Medicare Choice Medical Management/Prior Authorization team for assistance at **855-242-4875**.

Fax Instructions for Prior Authorization Forms:

Completed forms should be faxed, along with supporting documentation, to Pharmacy Services at **855-862-6517**.

- Please indicate on the form that the request is going to be paid through the “buy and bill” method.
- To avoid delays in responses, please provide all relevant information. Examples follow:
 - Patient diagnosis
 - Previously medications attempts (including the trial period)
 - Supporting lab reports
 - Notes from the member’s most recent office visit
 - Contact information for attending physician or office manager on the fax document
- For additional support regarding J-Code selection for specialty medications provided under the medical benefit, please refer to the table provided below.

Prior Authorization for Medical Necessity Pharmacy Review Process

If the request is approved under the medical benefit (e.g., buy and bill), you will be provided with an authorization number to provide on your claim submittal via a faxed approval letter.

If the request is approved under the pharmacy benefit, no additional authorization numbers are needed and the medication can be obtained at any network pharmacy.

If coverage is denied, you will be notified of the denial reason and the appeals process via a fax to your office and a letter to the member.

The services listed below require a Prior Authorization when covered under the medical benefit. The list is subject to change. Please contact Pharmacy Services for confirmation prior to administration of services. This list was last updated on **May 4, 2017. **

Jcode	Brand Name	Description	Prior Authorization for Medical PA's apply at all places of service except 21 (inpatient) unless otherwise specified		J-code Block J-code blocks are effective at place of service 11 (physician office) unless otherwise specified	
			PA	Exceptions/Notes	Block	Exceptions/Notes
90378 (CPT)	Synagis	PALIVIZUMAB	X			
A9606	Xofigo	Radium RA-223 dichloride, therapeutic, per microcurie	X			
J7322	Hymovis	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	X			
J2181	Nucala	Injection, mepolizumab, 1 mg	X			
J2840	Kanuma	Injection, sebelipase alfa , 1 mg	X			
J2786	Cinqair	Injection, reslizumab 1mg	X			
J0129	Orencia	INJECTION, ABATACEPT, 10 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF-ADMINISTERED)	X			
J0135	Humira	INJECTION, ADALIMUMAB, 20 MG	X			
J0178	Eylea	Injection, aflibercept, 1 mg	X			
J0180	Fabrazyme	INJECTION, AGALSIDASE BETA, 1 MG	X			
J0202	Lemtrada	INJECTION ALEMTUZUMAB 1 MG	X			
J0220	Myozyme	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	X			
J0221	Lumizyme	Injection, alglucosidase alfa, (Lumizyme), 10 mg	X			
J0256	Aralast NP, Prolastin, Prolastin C, Zemaira	INJECTION, ALPHA 1-PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG	X			
J0257	Glassia	Injection, alpha 1 proteinase inhibitor (human), (GLASSIA), 10 mg	X			
J0364	Apokyn	INJECTION, APOMORPHINE HYDROCHLORIDE 1 MG			X	
J0485	Nulojix	Injection, belatacept, 1 mg	X			
J0490	Benlysta	Injection, belimumab, 10 mg	X			
J0571	Subutex	Buprenorphine, oral, 1 mg	X		X	
J0572	Suboxone	Buprenorphine/naloxone, oral, less than or equal to 3 mg	X		X	
J0573	Suboxone	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	X		X	

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			PA	Exceptions/Notes	Block	Exceptions/Notes
J0574	Suboxone	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	X		X	
J0575	Suboxone	Buprenorphine/naloxone, oral, greater than 10 mg	X		X	
J0585	Botox	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	X			
J0586	Dysport	AbobotulinumtoxinA	X			
J0587	Myobloc	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS	X			
J0588	Xeomin	Injection, incobotulinumtoxinA, 1 unit	X			
J0596	Ruconest	INJ C1 ESTERASE INHIB RUCONEST 10 U	X	PA applies to POS 12 (home) only		
J0597	Berinerit	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS	X	PA applies to POS 12 (home) only		
J0598	Cinryze	INJECTION, C-1 ESTERASE, 10 UNITS	X			
J0638	Ilaris	Canakinumab injection	X			
J0717	Cimzia	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	X			
J0718	Cimzia	INJECTION, CERTOLIZUMAB PEGOL, 1 MG	X			
J0775	Xiaflex	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	*	*Med Mgmt has Xiaflex policy. Provider should contact provider services for questions on coverage.		
J0800	Acthar Gel	Corticotropin injection	X			
J0897	Prolia/Xgeva	Injection, denosumab, 1 mg	X			
J1070	Depo-Testosterone	INJECTION, TESTOSTERONE CYPIONATE, UP TO 100 MG	X			
J1071	Depo-Testosterone	Injection, testosterone cypionate, 1 mg	X			
J1080	Depo-Testosterone	INJECTION, TESTOSTERONE CYPIONATE, 1 CC, 200 MG	X			
J1290	Kalbitor	Ecallantide injection	X	PA applies to POS 12 (home) only		

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J1300	Soliris	INJECTION, ECULIZUMAB, 10 MG	X			
J1322	Vimizim	Injection, elosulfase alfa, 1 mg	X			
J1325	Flolan	Epoprostenol injection	X			
J1438	Enbrel	INJECTION, ETANERCEPT, 25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF-ADMINISTERED)	X		X	
J1458	Naglazyme	Galsulfase injection	X			
J1459	Privigen	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NONLYOPHILIZED (E.G., LIQUID), 500 MG	X			
J1460	Gamastan	INJECTION, GAMMA GLOBULIN, 1CC	X			
J1556	Bivigam	Injection, immune globulin (bivigam), 500 mg	X			
J1557	Gammaplex	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	X			
J1559	Hizentra	Hizentra injection	X			
J1560	Gamastan	INJECTION, GAMMA GLOBULIN, 10CC	X			
J1561	Gamunex, Gammunex-C, Gammaked	INJECTION, IMMUNE GLOBULIN, (GAMUNEX/GAMUNEX-C/GAMMAKED), NONLYOPHILIZED (E.G., LIQUID), 500 MG	X			
J1562	Vivaglobin	IVIG	X			
J1566	Gammagard S/D / Carimune Nf	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), NOT OTHERWISE SPECIFIED, 500 MG	X			
J1568	Octagam	INJECTION, OCTAGAM, 500MG	X			
J1569	Gammagard Liquid	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NONLYOPHILIZED, (E.G., LIQUID), 500 MG	X			
J1572	Flebogamma	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS, NONLYOPHILIZED (E.G., LIQUID), 500 MG	X			
J1573	Hepagam B	INJECTION, HEPAGAM B INTRAVENOUS, 0.5ML				

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			PA	Exceptions/Notes	Block	Exceptions/Notes
J1575	HyQyvia	INJ IG/HYALURONIDASE 100 MG IG	X			
J1595	Copaxone	INJECTION, GLATIRAMER ACETATE, 20 MG			X	
J1599		IVIG, NON-LYOPHILIZED, LIQUID, NOS	X			
J1602	Simponi Aria	Injection, golimumab, 1 mg, for intravenous use	X			
J1725	Makena	Injection, hydroxyprogesterone caproate, 1 mg	X			
J1740	Boniva	INJECTION, IBANDRONATE SODIUM, 1 MG	X			
J1743	Elaprase	Idursulfase injection	X			
J1744	Firazyr	Injection, icatibant, 1 mg	X	PA applies at POS 12 (home) only		
J1745	Remicade	INJECTION INFLIXIMAB, excludes biosimilar, 10 MG	X			
J1786	Cerezyme	INJECTION, IMIGLUCERASE, 10 UNITS	X			
J1830	Betaseron/ Extavia	INJECTION INTERFERON BETA-1B, 0.25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF-ADMINISTERED)			X	
J1930	Somatuline Depot	Lanreotide injection	X			
J1931	Aldurazyme	Laronidase injection	X			
J1950	Lupron	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG	X	PA applies at POS 11 only; hem/onc exempt from PA		
J2212	Relistor	Injection, methylnaltrexone, 0.1 mg	X		X	
J2323	Tysabri	INJECTION, NATALIZUMAB, 1 MG	X			
J2353	Sandostatin LAR	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	X			
J2357	Xolair	INJECTION, OMALIZUMAB, 5 MG	X			
J2502	Signifor LAR	INJ PASIREOTIDE LONG ACTING 1 MG	X			
J2504	Adagen	Pegademase bovine, 25 iu	X			
J2507	Krystexxa	Injection, pegloticase, 1 mg	X			

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J2547	Rapivab	INJECTION PERAMIVIR 1 MG	*	*Not covered on either medical or pharmacy benefit		
J2562	Mozobil	PLERIXAFOR	X			
J2778	Lucentis	INJECTION, RANIBIZUMAB, 0.1 MG	X			
J2793	Arcalyst	RILONACEPT	X		X	
J2796	Nplate	INJECTION, ROMIPLOSTIM, 10 MCG	X			
J2860	Sylvant	INJECTION SILTUXIMAB 10 MG	X			
J2941	Genotropin	SOMATROPIN	X		X	
J3060	Elelyso	Injection, taliglucerase alfa, 10 units	X			
J3120	Delatestryl	INJECTION, TESTOSTERONE ENANTHATE, UP TO 100 MG	X			
J3121	Delatestryl	Injection, testosterone enanthate, 1 mg	X			
J3130	Delatestryl	INJECTION, TESTOSTERONE ENANTHATE, UP TO 200 MG	X			
J3145	Aveed	Injection, testosterone undecanoate, 1 mg	X			
J3262	Actemra	INJECTION, TOCILIZUMAB, 1 MG	X			
J3285	Remodulin	Treprostinil injection	X			
J3315	Trelstar	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG	X			
J3357	Stelara	Ustekinumab injection	X			
J3380	Entyvio	INJECTION VEDOLIZUMAB 1 MG	X			
J3385	Vpriv	Velaglucerase alfa	X			
J3490		UNCLASSIFIED DRUGS	*	Requests for drugs with unclassified codes are reviewed for medical necessity and appropriate indication.		

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			PA	Exceptions/ Notes	Block	Exceptions/ Notes
J3590		UNCLASSIFIED BIOLOGICS	*	Requests for drugs with unclassified codes are reviewed for medical necessity and appropriate indication.		
J7312	Ozurdex	INJECTION, DEXAMETHASONE, INTRAVITREAL IMPLANT, 0.1 MG	X			
J7313	Iluvien	INJ FA INTRAVITREAL IMPL 0.01 MG	X			
J7315	Mitosol	Mitomycin, ophthalmic, 0.2 mg				
J7316	Jetrea	Injection, ocriplasmin, 0.125 mg	X			
J7321	Supartz/ Hyalgan	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE	X			
J7323	Euflexxa	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	X			
J7324	Orthovisc	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	X			
J7325	Synvisc/ Synvisc-One	HYALURONAN OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG	X			
J7326	Hyaluronan "Gel-One"	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	X			
J7327	Monovisc	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	X			
J7328	Gel-Syn	HYAL/DERIVATV GEL-SYN IA INJ 0.1 MG	X			
J7330	Carticel	IMPLANT, CULTURED CHONDROCYTES, 1 EA				
J7336	Qutenza	Capsaicin 8% patch, per sq cm	X			
J7508	Astagraf XL	Tacrolimus, extended release, oral, 0.1 mg			X	Blocked at POS 11, 12, and 99

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			PA	Exceptions/Notes	Block	Exceptions/Notes
J7527	Zortress	Everolimus, oral, 0.25 mg			X	Blocked at POS 11, 12, and 99
J7639	Pulmozyme	DORNASE ALFA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MG	X			
J7682	Tobi	TOBRAMYCIN, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED, UNIT DOSE FORM, ADMINISTERED THROUGH DME, PER 300 MG			X	
J7686	Tyvaso	Treprostinil, non-comp unit	X			
J8510	Myleran	Oral busulfan			X	
J8520	Xeloda	Capecitabine, oral, 150 mg			X	
J8521	Xeloda	Capecitabine, oral, 500 mg			X	
J8560	Etoposide	Etoposide oral 50 MG			X	
J8562	Oforta	Oral fludarabine phosphate	X		X	CS and Chartwell
J8600	Alkeran	Melphalan oral 2 MG			X	
J8700	Temodar	Temozolomide			X	
J8705	Hycamtin	Topotecan oral			X	
J8999		PRESCRIPTION DRUG, ORAL, CHEMOTHERAPEUTIC, NOS	*	Requests for drugs with unclassified codes are reviewed for medical necessity and appropriate indication.		
J9155	Firmagon	INJECTION, DEGARELIX, 1 MG	X	PA at POS 11 only; hem/onc exempt from PA		
J9202	Zoladex	GOSERELIN ACETATE IMPLANT, PER 3.6 MG	X	PA at POS 11 only; hem/onc exempt from PA		
J9216	Actimmune	Interferon gamma 1-b	X	*Not payable on medical benefit		
J9217	Eligard	LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	X	PA at POS 11 only; hem/onc exempt from PA		
J9218	Lupron	LEUPROLIDE ACETATE, PER 1 MG	X	PA at POS 11 only; hem/onc exempt from PA		

Jcode	Brand Name	Description	Prior Authorization for Medical PA's apply at all places of service except 21 (inpatient) unless otherwise specified		J-code Block J-code blocks are effective at place of service 11 (physician office) unless otherwise specified	
			PA	Exceptions/Notes	Block	Exceptions/Notes
J9225	Vantas	HISTRELIN IMPLANT (VANTAS), 50 MG	X	PA at POS 11 only; hem/onc exempt from PA		
J9226	Supprelin LA	HISTRELIN IMPLANT	X			
J9310	Rituxan	INJECTION, RITUXIMAB, 100 MG	X	Hem/onc exempt from PA		
J9999		NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS	*	Requests for drugs with unclassified codes are reviewed for medical necessity and appropriate indication.		
Q2043	Provenge	Sipuleucel-T auto CD54+	X			
Q3027	Avonex	Injection, interferon beta-1a, 1 mcg for intramuscular use			X	
Q3028	Rebif	Injection, interferon beta-1a, 1 mcg for subcutaneous use	X		X	
Q4074	Ventavis	Iloprost non-comp unit dose	X			
Q5102	Inflectra	Injection, infliximab, biosimilar 10 mg	X			
J7320	Genvisc 850	HYLAN/DER GENVISC 850 FOR IA INJ	X			
J8670	Varubi	rolapitant, oral 1 mg			X	
S0088	Gleevec	IMATINIB			X	Jcode blocked at POS 11, 12, and 99
S0189	Testopel	Implant, testosterone pellet	X			