



2020 Medical Prior Authorization and Exclusion Lists

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2020 Hoosier Healthwise and Healthy Indiana Plan Medical Services that Require Prior Authorization



Please note requests are considered urgent **ONLY** when a delay in care could jeopardize the life/health of the member; jeopardize the member's ability to regain maximum function, or may subject the member to severe pain that cannot be adequately managed without the requested service.

Medical services that require Prior Authorization

Type of Service	Requires PA	Coding
All Out of network services	Yes	With the exception of ER, Ambulance, Urgent Care Center services, Immunizations, Family planning services, chiropractic services, podiatry, and ologists, except if service is otherwise listed on PA list.
Air Ambulance	Yes	A0430, A043I, A0435, A0436
Elective/emergent/urgent medical, surgical inpatient admissions, and skilled nursing facility services	Yes	POS 2I, 5I, 6I, and 3I; excluding maternity stays
Inpatient Rehabilitation	Yes	POS 2I or 6I and accommodation codes 024, 93I, 932 POS 2I or POS 6I. Revenue code 024
Subacute admission	Yes	POS 2I
Transplants	Yes including the work up/ evaluation for transplant	POS 2I - Solid: Heart/lung 3285I, 32852, 32853, 32854, 32855, 32856, 33927, 33928, 33929, 33930, 33933, 33935, 33938, 33939, 33940,33944, 33945 Liver - 47I33, 47I35, 47I40, 47I4I, 47I42, 47I43, 47I44, 47I45, 47I46, 47I47, Pancreas -48550, 4855I, 48552, 48553, 48554, 48555, 48556 Bone Marrow: 38240, 3824I, 38242 Cornea: 00I44, 657I0, 65730, 65750, 65755, 65756 Heart valve tissue transplants: 33933, 33944 Kidney: 50300, 50320, 50323, 50325, 50327, 50328, 50329, 50340, 50360, 50365, 50370, 50380 Stem cell: 38204, 38205, 38206, 38207, 38208, 38209, 382I0, 382I I, 382I2, 382I3, 382I4, 382I5, 3822I, 38230,38232 Pancreas: 48550, 4855I, 48552, 48554, 48556 Intestine: 44I32, 44I33, 44I35, 44I36, 44I37, 447I5, 44720, 4472I

Type of Service	Requires PA	Coding
Bariatric Surgery	Yes	Roux-en-Y- 43846, 43847 Gastroplasty - 43842, 43843 Gastric banding sleeve - 43770, 43771, 43772, 43773, 43774 Gastrectomy - 43644, 43847, 43848, 43886, 46887, 43888 Duodenal switch - 43845 43645, 43659, 43775, 43844, 43999
Cochlear Implants surgery (See DME for device)	Yes	69930
Hysterectomy	Yes	51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58951, 58952, 58953, 58954, 58956
Gynecologic Procedures	Yes	58353, 58356
Male enhancement procedures	Yes	53445, 54406
Maxillofacial surgeries/ TMJ -including Arthroplasty, Arthroscopy, Reconstruction, Discectomy (with or without disc replacement), trigger point injections, Arthrocentesis, and mandibular orthopedic repositioning appliances (MORA)	Yes	21010, 21025, 21026, 21050, 21060, 21070, 21073, 21110, 21116, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21193, 21194, 21195, 21196, 21197, 21198, 21199, 21208, 21209, 21230, 21235, 21240, 21242, 21243, 21244, 21245, 21246, 21247, 21248, 21249, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21295, 21296, 21299, 21480, 21485, 21490, 21685, 29800, 29804, 30120, 40500, 40510, 40520, 40527, 40530, 41512, 41530, 41599, 42145, 42299,

Type of Service	Requires PA	Coding
<p>Potentially cosmetic procedures in addition to other procedures listed separately: blepharoplasty, septoplasty/rhinoplasty, port wine stain removal, otoplasty, breast reconstruction, breast enlargement, breast reduction/mammoplasty, mammoplasty for gynecomastia, breast implant removal, excision of excess skin due to weight loss including panniculectomy/abdominoplasty, lipectomy or excess fat removal, varicose vein treatment, cleft lip/palate surgery, congenital craniofacial anomaly surgery, surgical treatment of congenital chest wall deformity (pectus excavatum), breast congenital anomaly (i.e. polymastia)</p>	<p>Yes</p>	<p>11920, 11921, 11922, 11950, 11951, 11952, 11953, 11954, 15730, 15731, 15732, 15733, 15734, 15736, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15819, 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17106, 17107, 17108, 19300, 19316, 19318, 19324, 19325, 19328, 19340, 19343, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 20926, 21270, 21740, 21742, 21743, 30520, 30620, 36465, 36466, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37700, 37718, 37722, 37760, 37765, 37766, 37780, 37785, 40650, 40652, 40654, 40700, 40701, 40702, 40720, 40761, 42200, 42205, 42210, 42215, 42220, 42225, 42227, 42235, 42260, 42280, 42281, 54660, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67912, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67930, 67935, 67938, 67961, 67971, 67975, 69090, 69300, S2066, S2067, S2068, 19301, 19302</p>
<p>Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy</p>	<p>Yes</p>	<p>0051T</p>
<p>Replacement or repair of thoracic unit of a total replacement heart system (artificial heart)</p>	<p>Yes</p>	<p>0052T</p>
<p>Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit</p>	<p>Yes</p>	<p>0053T</p>

Type of Service	Requires PA	Coding
Insertion or replacement of permanent subcutaneous defibrillator system/ Insertion of subcutaneous implantable defibrillator electrode/ Removal of subcutaneous defibrillator electrode/ Repositioning of previously implanted subcutaneous implantable defibrillator electrode/ Programming device evaluation (in person)/ Interrogation device evaluation (in person)/ Electrophysiologic evaluation of subcutaneous implantable defibrillator	Yes	33270, 33271, 33272, 93260, 93261, 93644
Home health services	Yes.	POS 12 or bill type 330 with the following codes, G0151, G0152, G0153, G0155, 99600, 99600 TE, 99600 TD, 99601, 99602, 92610, S9349, S9127, 92521, 92522, 92523, 92524 - Initial evaluation codes for PT, OT, ST in home and all subsequent therapy visits in home requires PA.
Home oxygen	Yes	E0424, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0445, E0446, E0449, E0450, E0455, E0461, E1352, E1353, E1355, E1356, E1357, E1358, E1390, E1391, E1392, E1405, E1406, K0738
Hospice (inpatient and outpatient)	Yes	All POS 34, For POS 12, the following should pend: 651, 652, 655 and 656
Nutritionals and Supplements, Enteral/Parenteral Nutrition and services	Yes, regardless of total claim cost	B4034 -B9998
Outpatient ST/OT/PT	The initial evaluation does not require prior auth. No PA required for ST for the first 12 visits or hours within a calendar year.	PT - Revenue codes - 420, 421, 422, 423, 429, and 97018, 97022, 97024, 97028, 97032, 97033, 97034, 97035, 97036, 97037, 97038, 97039, 97110, 97111, 97112, 97113, 97116, 97117, 97124, 97127, 97139, 97140, 97150, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 97159, 97160, 97164, 97168, 97169, 97170, 97171, 97172, 97530, 97531, 97532, 97533, 97535, 97537, 97542, 97546, 97750, 97755, 97760, 97761 OT - Revenue codes 430, 431, 432, 433, 439 ST - Revenue codes 440, 441, 442, 443, 444, 449, 92507, 92508, 92520, 92521, 92522, 92523, 92524, 92526
Cochlear Implants (device)	Yes	69930, L8614, L8615, L8616, L8617, L8618, L8619, L8627, L8690

Type of Service	Requires PA	Coding
Durable Medical Equipment Rental	Yes, billed per item, >\$500/month	E0193, E0194, E0277, E0302, E0304, E0373, E0450, E0460, E0461, E0463, E0464, E0465, E0466, E0471, E0472, E0483, E0636, E0764, E0783, E0786, E1006, E1007, E1008, E1035, E2402, E2510, K0606, K0826, K0828, K0829, K0839, K0840, K0850, K0851, K0852, K0853, K0854, K0855, K0857, K0858, K0859, K0860, K0862, K0863, K0864, K0686, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886 Please also refer to other categories for other items that may be considered DME that require prior authorization.
Durable Medical Equipment, Prosthetics and Orthotics Purchase	Yes, billed per item, >\$1500	E0193, E0302, E0304, E0460, E0471, E0472, E0483, E0652, E0764, E0783, E0786, E1006, E1007, E1008, E1035, E2510, K0606, K0826, K0828, K0829, K0839, K0840, K0850, K0852, K0853, K0854, K0855, K0858, K0859, K0860, K0862, K0863, K0864, K0868, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, L5856, L5857, L5858, L5961, L5973, L5987, L6025, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L7180, L7181, L7185, L7186, L7190, L7191, L7274, L8609, Q0480, Q0481, Q0483, Q0489
Continuous Glucose Monitors and Insulin Pumps	Yes	A9274, A9276, A9277, A9278, E0784, K0553, K0554
Hearing Aids	Yes	Left and Right ear- V5030, V5040, V5050, V5060, V5070, V5080, V5095, V5100, V5120, V5130, V5140, V5150, V5170, V5180, V5190, V5210, V5200, V5220, V5230, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5263, V5267, V5274 Bilateral- V5100, V5120, V5130, V5140, V5150, V5248, V5249, V5250, V5251, V5252, V5253, V5258, V5259, V5260, V5261, V5298, V5299
TENS (see pain management)	Yes	A4556, A4557, A4558, A4595, A4630, E0720, E0730, E0731, A4290
Dialysis	Yes	Rev codes 082x, 083x, 084x-, 085x

Type of Service	Requires PA	Coding
Genetic testing	Yes	81105, 81106, 81107, 81108, 81110, 81111, 81112, 81120, 81121, 81161, 81162, 81163, 81164, 81165, 81166, 81170, 81175, 81176, 81200, 81201, 81202, 81203, 81205, 81206, 81207, 81208, 81209, 81210, 81220, 81221, 81225, 81226, 81227, 81162, 81212, 81215, 81216, 81217, 81218, 81219, 81228, 81229, 81230, 81231, 81232, 81235, 81238, 81240, 81241, 81242, 81243, 81244, 81245, 81250, 81251, 81252, 81253, 81254, 81256, 81257, 81258, 81259, 81261, 81262, 81263, 81264, 81265, 81266, 81267, 81278, 81270, 81272, 81273, 81275, 81276, 81288, 81290, 81291, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81302, 81303, 81304, 81310, 81311, 81314, 81317, 81318, 81319, 81321, 81322, 81323, 81324, 81325, 81326, 81330, 81331, 81332, 81340, 81341, 81342, 81346, 81361, 81362, 81363, 81364, 81370, 81371, 81373, 81374, 81375, 81376, 81377, 81378, 81379, 81380, 81381, 81382, 81383, 81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81420, 81479, 81507, 81519, 81520, 81521, 81522, 81535, 81536, 81539, 83950, 83951, 84999, 86849, 88120, 88121, 88230, 88233, 88235, 88237, 88240, 88241, 88245, 88248, 88249, 88261, 88262, 88263, 88264, 88267, 88269, 88271, 88272, 88273, 88274, 88289, 88291, 88299, 88361, 88364, 88365, 88366, 88367, 88368, 88369, 88373, 88374, 88377, 88387, 89290, 89291, S0625
Drug testing	Yes	G0480, G0481, G0482, G0483
Hyperbaric oxygen	Yes	413 99183 C1300, A4575, E0446
Pulse generator	Yes	61885, 61886
Implantation of Auditory Brainstem implant	Yes	S2235
Vision training therapy	Yes	92065
Pain management- including trigger point injection, facet joint and/or facet joint nerve injection, Epidural steroid injection, transcutaneous electric nerve stimulator	Yes the following require prior authorization (TENS)	A4556, A4557, A4558, A4595, A4630, E0720, E0730, E0731, A4290, 64490, 64491, 64492, 64493, 64494, 64495, 62320, 62321, 62322, 62323, 64479, 64480, 64481, 64482, 64483, 64484, 72275, 64550, 64551, 64552, 64553, 64554, 64555, 64556, 64557, 64558, 64559, 64560, 64561, 64562, 64563, 64564, 64565, 64566, 64567, 64568, 64569, 64570, 64571, 64572, 64573, 64574, 64575, 64576, 64577, 64578, 64579, 64580, 64581, 64590, 64595, 61850, 61851, 61852, 61853, 61854, 61855, 61856, 61857, 61858, 61859, 61860, 61861, 61862, 61863, 61864, 61865, 61866, 61867, 61868, 61869, 61870, 61871, 61872, 61873, 61874, 61875, 61880, 61881, 61882, 61883, 61884, 61885, 61886, 61887, 61888, 64561, 64581, E0744, E0745, E0746, E0747, E0748, E0749, E0762, E0766, L8679, L8680, L8681, L8682, L8683, L8684, L8685, L8686, L8687, L8688, L8689, L8690, L8691, L8692, L8693, L8694, L8695

Type of Service	Requires PA	Coding
Sacral nerve, Neuro or Spinal Cord stimulator	Yes	64553, 64454, 64455, 64565, 43647, 43648, 43881, 43882, 63650, 63661, 63662, 63663, 63664, 63685,
Photochemotherapy	Yes	96573, 96574, 96910, 96912, 96913, 96920, 96921, 96922, E0691, E0692, E0693, E0694
Medical Rehabilitation	Yes	93668, 92626, 92626, 92630, 92633
Termination of Pregnancy	Yes	59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59870, 59897, 59898, 59899
Behavioral Health		See Behavioral Health Prior Authorization Lists
Radiology	Yes, effective 6/1/19	72125, 72126, 72127, 74150, 74160, 74170, 70450, 70460, 70470, , 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72128, 72129, 72130, 72192, 72193, 72194, 74174, 74175, 71550, 71551, 71552, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 73218 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 70336, 70540, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 70556, 70557, 70558, 70559, 71555, 72195, 72196, 72197, 74181, 74182, 74183, 78071, 78072, 76390

2020 Medications Requiring Prior Authorization Under the Medical Benefit for Hoosier Healthwise and Healthy Indiana Plan

Effective 5/1/2020

Therapeutic Category	Brand Name	Generic Name	Applicable Code(s)
Botulinum Toxins	Botox	onabotulinumtoxin A	J0585
	Dysport	abobotulinumtoxin A	J0586
	Myobloc	rimabotulinumtoxin B	J0587
	Xeomin	incobotulinumtoxin A	J0588
Enzyme Replacement Therapy	Aldurazyme	laronidase	J1931
	Brineura	cerliponase alfa	J0567
	Cerezyme	imiglucerase	J1786
	Elaprased	idurasulfase	J1743
	Elelyso	taliglucerase	J3060
	Fabrazyme	agalsidase beta	J0180
	Kanuma	sebelipase alfa	J2840
	Krystexxa	pegloticase	J2507
	Lumizyme	alglucosidase alfa	J0220, J0221
	Mepsevii	vestronidase alfa-vjvk	J3397
	Naglazyme	galsulfase	J1458
	Vimizim	elosulfase alfa	J1322
	VPRIV	velaglucerase	J3385
Hormonal Modifiers	Eligard, Lupron	leuprolide acetate	J9217, J9218, J1950
	Supprelin LA, Vantas	histrelin acetate	J9226
	Trelstar / Trelstar Depot / Trelstar LA	triptorelin pamoate	J3315, J3316
	Vantas	histrelin acetate	J9225
	Zoladex	goserelin acetate	J9202
Immune Globulins	Bivigam	immune globulin, human	J1556
	Carimune, Gammagard S/D	immune globulin, human	J1566
	Cuvitru	immune globulin, human	J1555
	Flebogamma / Flebogamma DIF	immune globulin, human	J1572
	Gammagard Liquid	immune globulin, human	J1569
	GamaSTAN S/D	immune globulin, human	J1460, J1560
	Gammaplex	immune globulin, human	J1557
	Gamunex-C, Gammaked	immune globulin, human	J1561
	Hizentra	immune globulin, human	J1559
	Hyqvia	immune globulin, human with recombinant hyaluronidase	J1575
	immune globulin, unspecified	immune globulin, human	J1599
	Octagam	immune globulin, human	J1568
	Privigen	immune globulin, human	J1459

Therapeutic Category	Brand Name	Generic Name	Applicable Code(s)
Miscellaneous	Crysvita	burosumab-twza	J0584
	Radicava	edaravone	J1301
	Xiaflex	collagenase, clostridium histolyticum	J0775
Oncology Agents	Abraxane	paclitaxel, protein bound	J9264
	Adcetris	brentuximab	J9042
	Aliqopa	copanlisib	J9057
	Aldurazyme	laronidase	J1931
	Arzerra	ofatumumab	J9302
	Beleodaq	belinostat	J9032
	Besponsa	inotuzumab ozogamicin	J9229
	Blinicyto	blinatumomab	J9039
	Cyramza	ramucirumab	J9308
	Darzalex	daratumumab	J9145
	Elspar	asparaginase	J9020
	Empliciti	elotuzumab	J9176
	Erbix	erbituxin	J9055
	Faslodex	fulvestrant	J9395
	Folotylin	pralatrexate	J9307
	Gazyva	obinutuzumab	J9301
	Halaven	eribulin mesylate	J9179
	Herceptin	trastuzumab	J9355
	Herceptin Hylecta	trastuzumab 10mg and hyaluronidase-oysk	J9356
	Imfinzi	durvalumab	J9173
	Imlygic	talimogene laherparepvec	J9325
	Istodax	romidepsin	J9315
	Ixempra	ixabepilone	J9207
	Kadcyla	ado-trastuzumab emtansine	J9354
	Keytruda	pembrolizumab	J9271
	Kyprolis	carfilzomib	J9047
	Lartruvo	olaratumab	J9285
Marqibo	vincristine sulfate liposome	J9371	
Mytolarg	gemtuzumab ozogamicin	J9203	

Oncology Agents (Continued)	Novantrone	mitoxantrone hydrochloride	J9293
	Oncaspar	pegaspargase	J9266
	Onyvive	irinotecan liposome	J9205
	Opdivo	nivolumab	J9299
	Perjeta	pertuzumab	J9306
	Photofrin	porfimer sodium	J9600
	Portrazza	necitumab	J9295
	Rituxan/Rituxan Hyclea	rituximab	J9311, J9312
	Synribo	omacetaxine	J9262
	Tecentriq	atezolizumab	J9022
	Torisel	temsirolmus	J9330
	Triluron	sodium hyaluronate	J7332
	Velcade	bortezomib	J9041, J9044
	Yervoy	ipilimumab	J9228
	Yondelis	trabectedin	J9352
Zaltrap	ziv-aflibercept	J9400	
Ophthalmic Injections	Eylea	afibercept	J0178
	Lucentis	ranibizumab	J2778
	Macugen	pegaptinib	J2503
Osteoarthritis	Durolane	sodium hyaluronate	J7318
	Euflexxa	sodium hyaluronate	J7323
	Gel-One	sodium hyaluronate	J7326
	Gelsyn-3	sodium hyaluronate	J7328
	GenVisc 850	sodium hyaluronate	J7320, Q9980
	Hyalgan, Supartz, VISCO-3	sodium hyaluronate	J7321
	Hymovis	sodium hyaluronate	J7322
	Monovisc	sodium hyaluronate	J7327
	Orthovisc	sodium hyaluronate	J7324
	Synvisc / Synvisc-One	sodium hyaluronate	J7325
	Triluron	sodium hyaluronate	J7332
	Trivisc	sodium hyaluronate	J7329
Unclassified	<various>	Unclassified drugs	J3490
	<various>	Unclassified biologics	J3590
	<various>	Unclassified drug or biological used for esrd on dialysis	J3591
	<various>	Immunosuppressive drug, NOC	J7599
	<various>	NOC drugs, other than inhalation drugs, administered through DME	J7799
	<various>	Compounded drug, NOC	J7999, Q9977
	<various>	NOC, antineoplastic drugs	J9999

HHW-HIP0498 (6/17)

2020 Medical Code Exclusion List for Hoosier Healthwise and Healthy Indiana Plan

Background and Instructions for Use:

- MDwise only covers the certain medications under the pharmacy benefit. These medications must be sourced from a MDwise network retail or specialty pharmacy. The MDwise specialty pharmacy network includes AllianceRx Walgreens Prime, IU Health Pharmacies, or Eskenazi Pharmacies. The provider should generate a prescription for the desired medication, and the dispensing pharmacy will submit a claim through the point-of-sale system. To determine whether these medications require prior authorization under the pharmacy benefit, visit **MDwise HIP and HHW Drug List**. Pharmacy prior authorization requests should be faxed to the MDwise Pharmacy Benefit Manager, MedImpact, at (858) 790-7100.
 - Some codes are associated with medications that can be self-administered by the patient or a caregiver (e.g., oral or SC route). These will be marked as 'Pharmacy Benefit Only' in the table below.
 - Some physician-administered medications are not covered under the medical benefit. This means that providers may not "buy and bill" the medication to MDwise. These will be marked as 'Pharmacy Benefit Only' in the table below.
- Some medications are not covered by MDwise under either the medical benefit or the pharmacy benefit.
 - Coverage of certain medications (e.g., antihemophilic drugs, cystic fibrosis drugs, muscular dystrophy drugs, gene therapy agents) has been carved out from MDwise. Coverage requests and claims should be submitted to the Medicaid fee-for-service delivery system according to IHCP Bulletins BT201810 and BT201812. These will be marked as 'Carved out of Managed Care Coverage' in the table below.
 - Some medications are categorized within Indiana Medicaid excluded therapeutic classes (i.e., infertility and cosmetic use). These will be marked as 'IN Medicaid Excluded Category' in the table below.

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
C9015	Injection, C-I esterase inhibitor (human), Haegarda, 10 units	Haegarda	Pharmacy Benefit Only
J0129	Injection, abatacept, 10 mg	Orencia	Pharmacy Benefit Only
J0135	Injection, adalimumab, 20 mg	Humira	Pharmacy Benefit Only
J0202	Injection, alemtuzumab, 1 mg	Lemtrada	Pharmacy Benefit Only
J0256	Injection, alpha I-proteinase inhibitor, human, 10 mg, not otherwise specified	Aralast NP, Prolastin, Zemaira	Pharmacy Benefit Only
J0257	Injection, alpha I proteinase inhibitor (human), (Glassia), 10 mg	Glassia	Pharmacy Benefit Only
J0517	Injection, benralizumab, 1 mg	Fasenra	Pharmacy Benefit Only
J0270	Injection, alprostadil, 1.25 mcg	Caverject, Edex	IN Medicaid Excluded Category
J0275	Alprostadil urethral suppository	Muse	IN Medicaid Excluded Category
J0490	Injection, belimumab, 10 mg	Benlysta	Pharmacy Benefit Only
J0570	Buprenorphine implant, 74.2 mg	Probuphine	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
J0571	Buprenorphine, oral, 1 mg	Subutex	Pharmacy Benefit Only
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only
J0575	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only
J0596	Injection, C-I esterase inhibitor (recombinant), Ruconest, 10 units	Ruconest	Pharmacy Benefit Only
J0597	Injection, C-I esterase inhibitor (human), Berinert, 10 units	Berinert	Pharmacy Benefit Only
J0598	Injection, C-I esterase inhibitor (human), Cinryze, 10 units	Cinryze	Pharmacy Benefit Only
J0599	Injection, C-I esterase inhibitor (human), (haegarda), 10 units	Haegarda	Pharmacy Benefit Only
J0604	Cinacalcet, oral, 1 mg, (for ESRD on dialysis)	Sensipar	Pharmacy Benefit Only
J0630	Injection, calcitonin salmon, up to 400 units	Calcimar; Miacalcin	Pharmacy Benefit Only
J0638	Injection, canakinumab, 1 mg	Ilaris	Pharmacy Benefit Only
J0717	Injection, certolizumab pegol, 1 mg	Cimzia	Pharmacy Benefit Only
J0800	Injection, corticotropin, up to 40 units	H.P.Acthar	Pharmacy Benefit Only
J0897	Injection, denosumab, 1 mg	Prolia, Xgeva	Pharmacy Benefit Only
J1290	Injection, ecallantide, 1 mg	Kalbitor	Pharmacy Benefit Only
J1300	Injection, eculizumab, 10 mg	Soliris	Pharmacy Benefit Only
J1324	Injection, enfuvirtide, 1 mg	Fuzeon	Pharmacy Benefit Only
J1325	Injection, epoprostenol, 0.5 mg	Flolan, Veletri	Pharmacy Benefit Only
J1428	Injection, eteplirsen, 10 mg	Exondys-51	Carved out of Managed Care Coverage
J1438	Injection, etanercept, 25 mg	Enbrel	Pharmacy Benefit Only
J1595	Injection, glatiramer acetate, 20 mg	Copaxone	Pharmacy Benefit Only
J1602	Injection, golimumab, 1 mg, for intravenous use	Simponi Aria	Pharmacy Benefit Only
J1628	Injection, guselkumab, 1 mg	Tremfya	Pharmacy Benefit Only
J1740	Injection, ibandronate sodium, 1 mg	Boniva	Pharmacy Benefit Only
J1744	Injection, icatibant, 1 mg	Firazyr	Pharmacy Benefit Only
J1745	Injection, infliximab, excludes biosimilar; 10 mg	Remicade	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
J1815	Injection, insulin, per 5 units	Admelog, Apidra, Basaglar, Humalog, Humulin, Lantus, Levemir, Novolin, NovoLog	Pharmacy Benefit Only
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units	Admelog, Apidra, Humalog, Humulin, Novolin, Novolog	Pharmacy Benefit Only
J1826	Injection, interferon beta-1a, 11 mcg for intramuscular use	Avonex, Rebif	Pharmacy Benefit Only
J1830	Injection, interferon beta-1b, 0.25 mg	Betaseron, Extavia	Pharmacy Benefit Only
J1930	Injection, lanreotide, 1 mg	Somatuline	Pharmacy Benefit Only
J2170	Injection, mecasermin, 1 mg	Iplex, Increlex	Pharmacy Benefit Only
J2182	Injection, mepolizumab, 1 mg	Nucala	Pharmacy Benefit Only
J2315	Injection, naltrexone, depot form, 1 mg	Vivitrol	Pharmacy Benefit Only
J2323	Injection, natalizumab, 1 mg	Tysabri	Pharmacy Benefit Only
J2326	Injection, nusinersen, 0.1 mg	Spinraza	Carved out of Managed Care Coverage
J2350	Injection, ocrelizumab, 1 mg	Ocrevus	Pharmacy Benefit Only
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	Sandostatin LAR	Pharmacy Benefit Only
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	Sandostatin	Pharmacy Benefit Only
J2357	Injection, omalizumab, 5 mg	Xolair	Pharmacy Benefit Only
J2430	Injection, pamidronate disodium, per 30 mg	Aredia	Pharmacy Benefit Only
J2786	Injection, reslizumab, 1 mg	Cinqair	Pharmacy Benefit Only
J2793	Injection, rilonacept, 1 mg	Arcalyst	Pharmacy Benefit Only
J2860	Injection, siltuximab, 10 mg	Sylvant	Pharmacy Benefit Only
J2940	Injection, somatrem, 1 mg	Protropin	Pharmacy Benefit Only
J2941	Injection, somatropin, 1 mg	Genotropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-Tropin, Zorbtive	Pharmacy Benefit Only
J3030	Injection, sumatriptan succinate, 6 mg	Imitrex	Pharmacy Benefit Only
J3110	Injection, teriparatide, 10 mcg	Forteo	Pharmacy Benefit Only
J3245	Injection, tildrakizumab, 1 mg	Ilumya	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
J3262	Injection, tocilizumab, 1 mg	Actemra	Pharmacy Benefit Only
J3285	Injection, treprostinil, 1 mg	Remodulin	Pharmacy Benefit Only
J3355	Injection, urofollitropin, 75 IU	Bravelle	IN Medicaid Excluded Category
J3357	Ustekinumab, for subcutaneous injection, 1 mg	Stelara (SC only)	Pharmacy Benefit Only
J3358	Ustekinumab, for intravenous injection, 1 mg	Stelara IV	Pharmacy Benefit Only
J3380	Injection, vedolizumab, 1 mg	Entyvio	Pharmacy Benefit Only
J3489	Injection, zoledronic acid, 1 mg	Reclast, Zometa	Pharmacy Benefit Only
J7170	Injection, emicizumab-kxwh, 0.5 mg	Hemlibra	Carved Out of Managed Care Coverage
J7175	Injection, factor x, (human), 1 IU	Coagadex	Carved out of Managed Care Coverage
J7177	Injection, human fibrinogen concentrate (fibryga), 1 mg	Fibryga	Carved out of Managed Care Coverage
J7178	Injection, human fibrinogen concentrate, not otherwise specified, 1 mg	RiaSTAP	Carved out of Managed Care Coverage
J7179	Injection, von willebrand factor (recombinant), (Vonvendi), 1 IU vwf:rco	Vonvedi	Carved out of Managed Care Coverage
J7180	Injection, factor xiii (antihemophilic factor; human), 1 IU	Corifact	Carved out of Managed Care Coverage
J7181	Injection, factor xiii a-subunit, (recombinant), per IU	Tretten	Carved out of Managed Care Coverage
J7182	Injection, factor viii, (antihemophilic factor; recombinant), (Novoeight), per IU	Novoeight	Carved out of Managed Care Coverage
J7183	Injection, von willebrand factor complex (human), Wilate, 1 IU vwf:rco	Wilate	Carved out of Managed Care Coverage
J7185	Injection, factor viii (antihemophilic factor; recombinant) (Xyntha), per IU	Xyntha	Carved out of Managed Care Coverage
J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii IU	Alphanate (VWF Complex)	Carved out of Managed Care Coverage
J7187	Injection, von willebrand factor complex (Humate-P), per IU vwf:rco	Humate-P	Carved out of Managed Care Coverage
J7188	Injection, factor viii (antihemophilic factor; recombinant), (Obizur), per IU	Obizur	Carved out of Managed Care Coverage
J7189	Factor viia (antihemophilic factor; recombinant), per 1 microgram	NovoSeven RT	Carved out of Managed Care Coverage
J7190	Factor viii (antihemophilic factor; human) per IU	Hemofil M	Carved out of Managed Care Coverage

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
J7191	Factor viii (antihemophilic factor (porcine), per IU	N/A	Carved out of Managed Care Coverage
J7192	Factor viii (antihemophilic factor; recombinant) per IU, not otherwise specified	Advate	Carved out of Managed Care Coverage
J7193	Factor ix (antihemophilic factor; purified, non-recombinant) per IU	Alphanine SD	Carved out of Managed Care Coverage
J7194	Factor ix, complex, per IU	Bebulin	Carved out of Managed Care Coverage
J7195	Injection, factor ix (antihemophilic factor; recombinant) per IU, not otherwise specified	BeneFIX	Carved out of Managed Care Coverage
J7196	Injection, antithrombin recombinant, 50 IU	Atryn	Carved out of Managed Care Coverage
J7197	Antithrombin iii (human), per IU	Thrombate III	Carved out of Managed Care Coverage
J7198	Anti-inhibitor; per IU	Feiba	Carved out of Managed Care Coverage
J7199	Hemophilia clotting factor; not otherwise classified	<various>	Carved out of Managed Care Coverage
J7200	Injection, factor ix, (antihemophilic factor; recombinant), Rixubis, per IU	RIXUBIS	Carved out of Managed Care Coverage
J7201	Injection, factor ix, fc fusion protein, (recombinant), Alprolix, 1 IU	Alprolix	Carved out of Managed Care Coverage
J7202	Injection, factor ix, albumin fusion protein, (recombinant), Idelvion, 1 IU	Idelvion	Carved out of Managed Care Coverage
J7203	Injection factor ix, (antihemophilic factor; recombinant), glycopegylated, (rebinyn), 1 iu	Rebinyn	Carved out of Managed Care Coverage
J7205	Injection, factor viii fc fusion protein (recombinant), per IU	Eloctate	Carved out of Managed Care Coverage
J7207	Injection, factor viii, (antihemophilic factor; recombinant), pegylated, 1 IU	Adynovate	Carved out of Managed Care Coverage
J7209	Injection, factor viii, (antihemophilic factor; recombinant), (Nuwiq), 1 IU	Nuwiq	Carved out of Managed Care Coverage
J7210	Injection, factor VIII, (antihemophilic factor; recombinant), (Afstyla), 1 IU	Afstyla	Carved out of Managed Care Coverage
J7211	Injection, factor VIII, (antihemophilic factor; recombinant), (Kovaltry), 1 IU	Kovaltry	Carved out of Managed Care Coverage
J7303	Contraceptive supply, hormone containing vaginal ring, each	NuvaRing	Pharmacy Benefit Only
J7304	Contraceptive supply, hormone containing patch, each	OrthoEvra, Xulane	Pharmacy Benefit Only
J7342	Installation, ciprofloxacin otic suspension, 6 mg	Cipro Otic	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
J7500	Azathioprine, oral, 50 mg	Azasan, Imuran	Pharmacy Benefit Only
J7502	Cyclosporine, oral, 100 mg	Gengraf, Neoral, Sandimmune	Pharmacy Benefit Only
J7503	Tacrolimus, extended release, (Envarsus XR), oral, 0.25 mg	Envarsus XR	Pharmacy Benefit Only
J7506	Prednisone, oral, per 5mg	prednisone	Pharmacy Benefit Only
J7507	Tacrolimus, immediate release, oral, 1 mg	Hecoria, Prograf	Pharmacy Benefit Only
J7508	Tacrolimus, extended release, oral, 0.1 mg	Astagraf XL	Pharmacy Benefit Only
J7509	Methylprednisolone oral, per 4 mg	Medrol	Pharmacy Benefit Only
J7510	Prednisolone oral, per 5 mg	Millipred, Orapred, PEDIAPRED, Veripred	Pharmacy Benefit Only
J7512	Prednisone, immediate release or delayed release, oral, 1 mg	Deltasone, Rayos	Pharmacy Benefit Only
J7515	Cyclosporine, oral, 25 mg	Gengraf, Neoral, Sandimmune	Pharmacy Benefit Only
J7517	Mycophenolate mofetil, oral, 250 mg	Cellcept	Pharmacy Benefit Only
J7518	Mycophenolic acid, oral, 180 mg	Myfortic	Pharmacy Benefit Only
J7520	Sirolimus, oral, 1 mg	Rapamune	Pharmacy Benefit Only
J7527	Everolimus, oral, 0.25 mg	Zortress	Pharmacy Benefit Only
J8498	Antiemetic drug, rectal/suppository, NOS	<various>	Pharmacy Benefit Only
J8499	Prescription drug, oral, non-chemotherapeutic, NOS	<various>	Pharmacy Benefit Only
J8501	Aprepitant, oral, 5 mg	Emend	Pharmacy Benefit Only
J8510	Busulfan, oral, 2 mg	Myleran	Pharmacy Benefit Only
J8515	Cabergoline, oral, 0.25 mg	cabergoline	Pharmacy Benefit Only
J8520	Capecitabine, oral, 150 mg	Xeloda	Pharmacy Benefit Only
J8521	Capecitabine, oral, 500 mg	Xeloda	Pharmacy Benefit Only
J8530	Cyclophosphamide, oral, 25 mg	cyclophosphamide	Pharmacy Benefit Only
J8540	Dexamethasone, oral, 0.25 mg	dexamethasone	Pharmacy Benefit Only
J8560	Etoposide; oral, 50 mg	etoposide	Pharmacy Benefit Only
J8562	Fludarabine phosphate, oral, 10 mg	fludarabine phosphate	Pharmacy Benefit Only
J8565	Gefitinib, oral, 250 mg	Iressa	Pharmacy Benefit Only
J8597	Antiemetic drug, oral, NOS	<various>	Pharmacy Benefit Only
J8600	Melphalan, oral, 2 mg	Alkeran	Pharmacy Benefit Only
J8610	Methotrexate, oral, 2.5 mg	Rheumatrex, Trexall	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
J8650	Nabilone, oral, 1 mg	Cesamet	Pharmacy Benefit Only
J8655	Netupitant 300 mg and palonosetron 0.5 mg , oral	Akynzeo	Pharmacy Benefit Only
J8670	Rolapitant, oral, 1 mg	Varubi	Pharmacy Benefit Only
J8700	Temozolomide, oral, 5 mg	Temodar	Pharmacy Benefit Only
J8705	Topotecan, oral, 0.25 mg	Hycamtin	Pharmacy Benefit Only
J8999	Prescription drug, oral, chemotherapeutic, NOS	<various>	Pharmacy Benefit Only
J9212	Injection, interferon alfacon-1, recombinant, 1 microgram	Infergen	Pharmacy Benefit Only
J9213	Injection, interferon, alfa-2a, recombinant, 3 million units	Roferon A	Pharmacy Benefit Only
J9214	Injection, interferon, alfa-2b, recombinant, 1 million units	Intron-A	Pharmacy Benefit Only
J9216	Injection, interferon, gamma-1b, 3 million units	Actimmune	Pharmacy Benefit Only
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gram	azithromycin dihydrate	Pharmacy Benefit Only
Q0161	Chlorpromazine hydrochloride, 5 mg, oral, FDA approved prescription 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	chlorpromazine hydrochloride	Pharmacy Benefit Only
Q0162	Ondansetron 1 mg, oral, FDA approved prescription 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	ondansetron	Pharmacy Benefit Only
Q0163	Diphenhydramine hydrochloride, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen	diphenhydramine hydrochloride	Pharmacy Benefit Only
Q0164	Prochlorperazine maleate, 5 mg, oral, FDA approved prescription 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	prochlorperazine maleate	Pharmacy Benefit Only
Q0165	Prochlorperazine maleate, 10 mg, oral, fda approved prescription 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	prochlorperazine maleate	Pharmacy Benefit Only
Q0166	Granisetron hydrochloride, 1 mg, oral, FDA approved prescription 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	granisetron hydrochloride	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
Q0167	Dronabinol, 2.5 mg, oral, FDA approved prescription 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	dronabinol	Pharmacy Benefit Only
Q0168	Dronabinol, 5 mg, oral, FDA approved prescription 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	dronabinol	Pharmacy Benefit Only
Q0169	Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription 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	promethazine hydrochloride	Pharmacy Benefit Only
Q0170	Promethazine hydrochloride, 25 mg, oral, fda approved prescription 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	promethazine hydrochloride	Pharmacy Benefit Only
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, fda approved prescription 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	chlorpromazine hydrochloride	Pharmacy Benefit Only
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, fda approved prescription 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	chlorpromazine hydrochloride	Pharmacy Benefit Only
Q0173	Trimethobenzamide hydrochloride, 250 mg, oral, FDA approved prescription 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	trimethobenzamide hydrochloride	Pharmacy Benefit Only
Q0174	Thiethylperazine maleate, 10 mg, oral, FDA approved prescription 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	thiethylperazine maleate	Pharmacy Benefit Only
Q0175	Perphenazine, 4 mg, oral, FDA approved prescription 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	perphenazine	Pharmacy Benefit Only
Q0176	Perphenazine, 8 mg, oral, FDA approved prescription 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	perphenazine	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
Q0177	Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription 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	hydroxyzine pamoate	Pharmacy Benefit Only
Q0178	Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription 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	hydroxyzine pamoate	Pharmacy Benefit Only
Q0180	Dolasetron mesylate, 100 mg, oral, FDA approved prescription 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	dolasetron mesylate	Pharmacy Benefit Only
Q0181	Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	<various>	Pharmacy Benefit Only
Q0510	Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant	N/A	Pharmacy Benefit Only
Q0511	Pharmacy supply fee for oral anti-cancer; oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30-day period	N/A	Pharmacy Benefit Only
Q0512	Pharmacy supply fee for oral anti-cancer; oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	N/A	Pharmacy Benefit Only
Q0513	Pharmacy dispensing fee for inhalation drug(s); per 30 days	N/A	Pharmacy Benefit Only
Q0514	Pharmacy dispensing fee for inhalation drug(s); per 90 days	N/A	Pharmacy Benefit Only
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CART cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Yescarta	Carved Out of Managed Care Coverage
Q2042	Tisagenlecleucel, up to 600 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Kymriah	Carved Out of Managed Care Coverage
Q2026	Injection, Radiesse, 0.1 ml	Radiesse	IN Medicaid Excluded Category
Q2027	Injection, Sculptra, 0.1 ml	Sculptra	IN Medicaid Excluded Category
Q2028	Injection, Sculptra, 0.5 mg	Sculptra	IN Medicaid Excluded Category
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Avonex, Rebif	Pharmacy Benefit Only
Q3026	Injection, interferon beta-1a, 11 mcg for subcutaneous use	Avonex, Rebif	Pharmacy Benefit Only

Code	Descriptor, Generic Name, J code unit	Brand Name	Reason for Medical Exclusion
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	Avonex, Rebif	Pharmacy Benefit Only
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	Avonex, Rebif	Pharmacy Benefit Only
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg	Inflectra	Pharmacy Benefit Only
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg	Renflexis	Pharmacy Benefit Only
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	Ixifi	Pharmacy Benefit Only
Q9981	Rolapitant, oral, 1 mg	Varubi	Pharmacy Benefit Only
Q9991	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg	Sublocade	Pharmacy Benefit Only