

MDwise Self-Administered Codes for Medical

The following codes are associated with medications that can be self-administered by the patient or a caregiver. As a result, MDwise will transfer coverage of these self-administered medications exclusively to the pharmacy benefit **effective 4/1/2018**. At that time, medication should only be sourced from a contracted retail or specialty pharmacy. To do so, the provider should generate a prescription for the desired medication, and the dispensing pharmacy will submit a claim through the point-of-sale system. Please note that UM criteria may apply for pharmacy claims processing. Prior authorization requests may be faxed to the MDwise Pharmacy Benefit Manager, MedImpact, at **(858) 790-7100**.

Code	Descriptor, Generic Name, J code unit	Brand Name
J0135	Injection, adalimumab, 20 mg	Humira
J0270	Injection, alprostadil, 1.25 mcg	Caverject, Edex
J0275	Alprostadil urethral suppository	Muse
J0571	Buprenorphine, oral, 1 mg	Subutex
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Bunavail, Suboxone, Zubsolv
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Bunavail, Suboxone, Zubsolv
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Bunavail, Suboxone, Zubsolv
J0575	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine	Bunavail, Suboxone, Zubsolv
J0604	Cinacalcet, oral, 1 mg, (for ESRD on dialysis)	Sensipar
J0630	Injection, calcitonin salmon, up to 400 units	Calcimar, Miacalcin
J0717	Injection, certolizumab pegol, 1 mg	Cimzia
J1324	Injection, enfuvirtide, 1 mg	Fuzeon
J1438	Injection, etanercept, 25 mg	Enbrel
J1595	Injection, glatiramer acetate, 20 mg	Copaxone
J1815	Injection, insulin, per 5 units	Ademlog, Apidra, Basaglar, Humalog, Humulin, Lantus, Levemir, Novolin, NovoLog
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units	Apidra, Humalog, Humulin, Novolin, Novolog
J1826	Injection, interferon beta-1a, 11 mcg for intramuscular use	Avonex, Rebif
J1830	Injection, interferon beta-1b, 0.25 mg	Betaseron, Extavia
J2170	Injection, mecasemin, 1 mg	Iplex, Increlex

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J2940	Injection, somatrem, 1 mg	Protropin
J2941	Injection, somatropin, 1 mg	Genotropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-Tropin, Zorbtive
J3030	Injection, sumatriptan succinate, 6 mg	Imitrex
J3110	Injection, teriparatide, 10 mcg	Forteo
J3357	Ustekinumab, for subcutaneous injection, 1 mg	Stelara (SC only)
J7303	Contraceptive supply, hormone containing vaginal ring, each	NuvaRing
J7304	Contraceptive supply, hormone containing patch, each	OrthoEvra, Xulane
J7342	Installation, ciprofloxacin otic suspension, 6 mg	Cipro Otic
J7500	Azathioprine, oral, 50 mg	Azasan, Imuran
J7502	Cyclosporine, oral, 100 mg	Gengraf, Neoral, Sandimmune
J7503	Tacrolimus, extended release, (Envarsus XR), oral, 0.25 mg	Envarsus XR
J7506	Prednisone, oral, per 5mg	prednisone
J7507	Tacrolimus, immediate release, oral, 1 mg	Hecoria, Prograf
J7508	Tacrolimus, extended release, oral, 0.1 mg	Astagraf XL
J7509	Methylprednisolone oral, per 4 mg	Medrol
J7510	Prednisolone oral, per 5 mg	Millipred, Orapred, Pediapred, Veripred
J7512	Prednisone, immediate release or delayed release, oral, 1 mg	Deltasone, Rayos
J7515	Cyclosporine, oral, 25 mg	Gengraf, Neoral, Sandimmune
J7517	Mycophenolate mofetil, oral, 250 mg	Cellcept
J7518	Mycophenolic acid, oral, 180 mg	Myfortic
J7520	Sirolimus, oral, 1 mg	Rapamune
J7527	Everolimus, oral, 0.25 mg	Zortress
J8498	Antiemetic drug, rectal/suppository, NOS	<various>
J8499	Prescription drug, oral, non-chemotherapeutic, NOS	<various>
J8501	Aprepitant, oral, 5 mg	Emend
J8510	Busulfan, oral, 2 mg	Myleran
J8515	Cabergoline, oral, 0.25 mg	cabergoline
J8520	Capecitabine, oral, 150 mg	Xeloda
J8521	Capecitabine, oral, 500 mg	Xeloda
J8530	Cyclophosphamide, oral, 25 mg	cyclophosphamide

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J8540	Dexamethasone, oral, 0.25 mg	dexamethasone
J8560	Etoposide; oral, 50 mg	etoposide
J8562	Fludarabine phosphate, oral, 10 mg	fludarabine phosphate
J8565	Gefitinib, oral, 250 mg	Iressa
J8597	Antiemetic drug, oral, NOS	<various>
J8600	Melphalan, oral, 2 mg	Alkeran
J8610	Methotrexate, oral, 2.5 mg	Rheumatrex, Trexall
J8650	Nabilone, oral, 1 mg	Cesamet
J8655	Netupitant 300 mg and palonosetron 0.5 mg	Akynzeo
J8670	Rolapitant, oral, 1 mg	Varubi
J8700	Temozolomide, oral, 5 mg	Temodar
J8705	Topotecan, oral, 0.25 mg	Hycamtin
J8999	Prescription drug, oral, chemotherapeutic, NOS	<various>
J9212	Injection, interferon alfacon-1, recombinant, 1 microgram	Infergen
J9213	Injection, interferon, alfa-2a, recombinant, 3 million units	Roferon A
J9214	Injection, interferon, alfa-2b, recombinant, 1 million units	Intron-A
J9216	Injection, interferon, gamma-1b, 3 million units	Actimmune
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gram	azithromycin dihydrate
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
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
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
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

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Code	Descriptor, Generic Name, J code unit	Brand Name
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
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
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
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
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
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
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
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
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

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Code	Descriptor, Generic Name, J code unit	Brand Name
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
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
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
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
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
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
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>
Q0510	Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant	N/A
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
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

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Code	Descriptor, Generic Name, J code unit	Brand Name
Q0513	Pharmacy dispensing fee for inhalation drug(s); per 30 days	N/A
Q0514	Pharmacy dispensing fee for inhalation drug(s); per 90 days	N/A
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Avonex, Rebif
Q3026	Injection, interferon beta-1a, 11 mcg for subcutaneous use	Avonex, Rebif
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	Avonex, Rebif
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	Avonex, Rebif
Q9981	Rolapitant, oral, 1 mg	Varubi