MEDICAL PRIOR AUTHORIZATION AND EXCLUSION LISTS

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DR-07-2024-13837/HHW-HIPP0905 (7/24)

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

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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, A0431, A0435, A0436
Elective/emergent/urgent medical, surgical inpatient admissions, and skilled nursing facility services	Yes	POS 21, 51, 61, and 31; excluding maternity stays
Inpatient Rehabilitation	Yes	POS 21 or 61 and accommodation codes 024, 931, 932 POS 21 or POS 61. Revenue code 024
Subacute admission	Yes	POS 21
Transplants	Yes	POS 21 - Solid: Heart/lung 32851, 32852, 32853, 32854, 32855, 32856, 33927, 33930, 33933, 33935, 33940,33944, 33945 Liver - 47133, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147 Pancreas -48550, 48551, 48552, 48554, 48556 Bone Marrow: 38240, 38241, 38242 Cornea: 00144, 65710, 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: 38205, 38206, 38221, 38230, 38232 Pancreas: 48550, 48551, 48552, 48554, 48556 Intestine: 44132, 44133, 44135, 44136, 44137, 44715, 44720, 44721
Bariatric Surgery	Yes	Roux-en-Y- 43846, 43847 Gastroplasty - 43842, 43843 Gastric banding sleeve - 43770, 43771, 43772, 43773, 43774 Gastrectomy - 43644, 43847, 43848, 43886, 43888 Duodenal switch - 43845 43645, 43659, 43775, 43999

Type of Service	Requires PA	Coding
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, 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, 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,
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)	Yes	11920, 11921, 11922, 15730, 15731, 15733, 15734, 15736, 15780, 15781, 15782, 15783, 15820, 15821, 15822, 15823, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 17106, 17107, 17108, 19300, 19316, 19318, 19325, 19328, 19340,19350, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380, 21270, 21740, 21742, 21743, 30520, 30620, 36465, , 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, 69300, S2066, S2067, S2068, 19301, 19302

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, 99600, 99600 TE, 99600 TD, 99601, 99602, 92610, 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, E0439, E0441, E0442, E0443, E0444, E0455, 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.	B4034, B4035, B4036, B4081, B4082, B4083, B4087, B4088, B4100, B4105, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B4164, B4168, B4172, B4176, B4178, B4180 B4185, B4187, B4189, B4193, B4197, B4199, B4216, B4220, B4222, B4224, B5000, B5100, B5200, B9002, B9004, B9006, B9998
Outpatient ST/OT/PT (See BH PA list for ABA Therapy)	The initial evaluation does not require prior auth. No PA required for ST/OT/PT for the first 24 visits within a calendar year.	PT - Revenue codes - 420, 421, 422, 423, 429, and 97018, 97022, 97024, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, , 97164, 97168, 97530, 97533, 97535, 97537, 97542, 97750, 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, Prosthetics and Orthotics Rental/ Purchased	Yes, and any item billed for >$500 a month rented or for >$500 purchased.	E0251, E0250, E0255, E0256, E0260, E0261, E0265, E0266, E0277, E0290, E0292, E0293, E0294, E0301, E0302, E0303, E0304, E0316, E0328, E0329, E0372, E0373, E0465, E0466, E0471, E0472, E0483, E0636, E0652, E0783, E0786, E1006, E1008, E1035, E2402, E2510, K0606, K0826, K0828, K0829, K0839, K0840, K0850, K0851, K0852, K0853, K0854, K0855, K0857, K0858, K0859, K0860, K0862, K0863, K0864, K0868, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, L5856, L5857, L5858, L5961, L5987, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L7180, L7181, L7185, L7186, L7190, L7191, Q0480, Q0481, Q0483, Q0489 Please also refer to other categories for other items that may be considered DME that require prior authorization. Effective February 1, 2021, for capped rental items that are subject to the 21st Century Cures Act, the capped rental period will be 6 months or 10 months, depending on the type of item. For codes not subject to the Act, the capped rental period will remain 15 months.
Wheelchairs and accessories	Yes, and any item billed for >$500 a month rented or for >$500 purchased.	E0955, E0956, E0957, E0983, E0984, E0986, E1002, E1003, E1004, E1005, E1007, E1010, E1012, E1028, E1399, E2310, E2311, E2312, E2313, E2321, E2322, E2323, E2358, E2359, E2361, E2362, E2363, E2368, E2369, E2370, E2371, E2372, E2373, E2374, E2375, E2376, E2377, E2397, E2398, E2622, K0108, K0800, K0801, K0802, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0827, K0835, K0836, K0837, K0838, K0841, K0842, K0843, K0848, K0849, K0856, K0861, K0869, K0890, K0891, K0898
Continuous Glucose Monitors and Insulin Pumps	Yes, May also submit through pharmacy benefits: fax 858.790.7100 Please see Diabetic supply list: Indiana Health Coverage Programs - PBM (optum.com)	A4239, A4238, A9274, E0784, E2102, E2103

Type of Service	Requires PA	Coding
Hearing Aids	Yes	Left and Right ear- V5030, V5040, V5050, V5060, , V5080, V5095, V5100, V5120, V5130, V5140, , V5246, V5247, V5252, V5253, V5256, V5257, V5260, V5261, V5267, Bilateral- V5100, V5120, V5130, V5140, V5252, V5253, V5260, V5261, V5299
TENS (see pain management)	Yes	A4556, A4557, A4558, A4595, A4630, E0720, E0730, E0731, A4290
Dialysis	Yes	Rev codes 082x,083x, 084x-, 085x 90935, 90937, 90940, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 90997, 90999
Genetic testing	Yes	81161, 81162, 81163, 81164, 81165, 81166, 81200, 81201, 81202, 81203, 81206, 81207, 81208, , 81220, 81212, 81215, 81216, 81217, 81218, 81219, 81228, 81229, 81230, 81231, 81232, 81235, 81238, , 81243, 81244, 81251, 81252, 81253, 81254, 81257, 81258, 81259, 81270, 81276, 81278, 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81302, 81303, 81304, 81310, 81311, 81317, 81318, 81319, 81321, 81322, 81323, 81330, 81346, 81361, 81364, 81403, 81404, 81405, 81407, 81420, 81479, 81507, 81519, 81522, 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, G0452
Genetic testing (biomarkers)	Yes, effective 7/1/2024	0029U, 0034U, 0037U, 0040U, 0045U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0094U, 0101U, 0102U, 0103U, 0111U, 0129U, 0130U, 0131U, 0132U, 0134U, 0135U, 0136U, 0137U, 0138U, 0158U, 0169U, 0209U, 0212U, 0213U, 0214U, 0215U, 0216U, 0217U, 0218U, 0231U, 0233U, 0235U, 0236U, 0237U, 0238U, 0242U, 0265U, 0267U, 0327U, 0335U, 0336U, 81170, 81185, 81191, 81192, 81193, 81194, 81222, 81223, 81225, 81226, 81227, 81248, 81249, 81272, 81274, 81285, 81286, 81314, 81324, 81325, 81336, 81340, 81342, 81349, 81351, 81352, 81353, 81362, 81363, 81406, 81408, 81410, 81411, 81412, 81413, 81414, 81415, 81416, 81417, 81425, 81426, 81427, 81430, 81431, 81432, 81433, 81434, 81435, 81436, 81437, 81438, 81441, 81442, 81443, 81445, 81448, 81449, 81451, 81456, 81460, 81465, 81518, 81520, 81521, 81523, 81539, 81546, 81595

Type of Service	Requires PA	Coding
Definitive Drug testing (less than 15 drug classes)	Yes after 16 cumulative units per calendar year.	G0480, G0481, G0659
Definitive Drug testing (15 or more drug classes)	Yes	G0482, G0483
Presumptive Drug testing	Yes, after the first 52 cumulative units per calendar year	80305, 80306, 80307
Hyperbaric oxygen	Yes	REV 41399183
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	A4556, A4557, A4558, A4595, A4630, E0720, E0730, E0731, A4290, 64490, 64491, 64492, 64493, 64494, 64495, 62320, 62321, 62322, 62323, 64454, 64455, 64479, 64480, 64483, 64484, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64590, 64595, 61850, 61860, 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, E0744, E0745, E0747, E0748, E0749, , E0766, L8679, L8680, L8681, L8682, L8683, L8684, L8685, L8686, L8687, L8688, L8689, L8691, L8692, L8693, L8694, L8695
Sacral nerve, Neuro or Spinal Cord stimulator	Yes	64553, 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, 92627, 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

Type of Service	Requires PA	Coding
Preparation of fecal microbiota for instillation, including assessment of donor specimen	Yes	44705
Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	Yes	0594T
Spinal Stenosis	Yes	22867, 22868, 22869, 22870

HCPCS Code List

MDwise Hoosier Healthwise and Healthy Indiana Plan

Effective 10/1/2024

Please be advised that the Indiana Health Coverage Programs (IHCP) transitioned to a Statewide Uniform Preferred Drug List (SUPDL) for the Fee-For-Service (FFS) and managed care entities (MCEs) on July 5, 2023. HCPCS Codes for agents on the SUPDL will be marked as such in the Coverage Status column in the table below, and prior authorization requests for these agents will be reviewed against SUPDL criteria.

Coverage Status:

- 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.
- Select physician-administered medications are not covered under the medical benefit. This means that providers may not "buy and bill" the medication to MDwise. These medications must be sourced from a MDwise network retail or specialty pharmacy. The MDwise specialty pharmacy network includes Walgreens Specialty Pharmacy, 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. These medications will be marked as 'Pharmacy Benefit Only' in the table below.
- A number of codes are available for coverage under either the pharmacy benefit or the medical benefit, up to the discretion of the ordering provider. These medications will be marked as 'Pharmacy or Medical' in the table below.
- Coverage of certain medications (e.g., antihemophilic factor, cystic fibrosis 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 BT202110. 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 (e.g., infertility, sexual dysfunction). These will be marked as 'IN Medicaid Excluded Category' in the table below.

Prior Authorization:

- Non-specific codes (e.g., J3490, J3590, J9999) require Prior Authorization only if the claim amount exceeds $500. These will be marked with an asterisk (*) in the table below.
- Medical benefit prior authorization requests should be faxed to MDwise using the IHCP Universal Prior Authorization Form as follows:
  - MDwise HIP at (866) 613-1642
  - MDwise Hoosier Healthwise at (888) 465-5581
- Pharmacy benefit prior authorization requests should be faxed to the MDwise Pharmacy Benefit Manager, MedImpact, at (858) 790-7100.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J0129	Injection, abatacept, 10 mg	Orencia	Pharmacy Benefit Only. PA required. SUPDL.
J0135	Injection, adalimumab, 20 mg	Humira	Pharmacy Benefit Only. PA required. SUPDL.
J0172	Injection, aducanumab-avwa, 2 mg	Aduhelm	Medical Benefit Only. PA Required. SUPDL (AAAX).

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J0174	Injection, lecanemab-irmb, 1 mg	Leqembi	Medical Benefit Only. PA Required. SUPDL (AAAX).
J0180	Injection, agalsidase beta, 1 mg	Fabrazyme	Medical Benefit Only. PA Required.
J0202	Injection, alemtuzumab, 1 mg	Lemtrada	Pharmacy Benefit Only. PA required. SUPDL.
J0218	Injection, olipudase alfa-rpcp, 1 mg	Xenpozyme	Medical Benefit Only. PA Required.
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	Nexviazyme	Medical Benefit Only. PA Required.
J0220	Injection, alglucosidase alfa, 10 mg not otherwise specified	alglucosidase alfa	Medical Benefit Only. PA Required.
J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg	Lumizyme	Medical Benefit Only. PA Required.
J0225	Injection, vutrisiran, 1 mg	Amvuttra	Medical Benefit Only. PA Required.
J0256	Injection, alpha 1 proteinase inhibitor, human, 10 mg, not otherwise specified	Aralast NP, Prolastin, Zemaira	Pharmacy Benefit Only. PA required.
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	Glassia	Pharmacy Benefit Only. PA required.
J0270	Injection, alprostadil, 1.25 mcg	Caverject, Edex	Not covered – IN Medicaid Excluded Category.
J0275	Alprostadil urethral suppository	Muse	Not covered – IN Medicaid Excluded Category.
J0349	Injection, rezafungin, 1 mg	Rezzayo	Medical Benefit Only. PA Required.
J0490	Injection, belimumab, 10 mg	Benlysta	Pharmacy Benefit Only. PA required.
J0491	Injection, anifrolumab-fnia, 1 mg	Saphnelo	Medical Benefit Only. PA Required.
J0517	Injection, benralizumab, 1 mg	Fasenra	Medical or Pharmacy. PA Required. SUPDL.
J0567	Injection, cerliponase alfa, 1 mg	Brineura	MMedical Benefit Only. PA Required.
J0570	Buprenorphine implant, 74.2 mg	Probuphine	Medical or Pharmacy. PA Required.
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only. SUPDL.
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only. SUPDL.

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HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only. SUPDL.
J0575	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine	Bunavail, Suboxone, Zubsolv	Pharmacy Benefit Only. SUPDL.
J0577	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	Brixadi	Medical or Pharmacy. PA Required. SUPDL.
J0578	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	Brixadi	Medical or Pharmacy. PA Required. SUPDL.
J0584	Injection, burosumab-twza 1 mg	Crysvita	Medical Benefit Only. PA Required.
J0585	Injection, onabotulinumtoxina, 1 unit	Botox	Medical or Pharmacy. PA Required.
J0586	Injection, abobotulinumtoxina, 5 units	Dysport	Medical or Pharmacy. PA Required.
J0587	Injection, rimabotulinumtoxinb, 100 units	Myobloc	Medical or Pharmacy. PA Required.
J0588	Injection, incobotulinumtoxin a, 1 unit	Xeomin	Medical or Pharmacy. PA Required.
J0591	Injection, deoxycholic acid, 1 mg	Kybella	IN Medicaid Excluded Category.
J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	Ruconest	Pharmacy Benefit Only. PA Required.
J0597	Injection, c-1 esterase inhibitor (human), berinert, 10 units	Berinert	Pharmacy Benefit Only. PA Required.
J0598	Injection, c-1 esterase inhibitor (human), cinryze, 10 units	Cinryze	Pharmacy Benefit Only. PA Required.
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	Haegarda	Pharmacy Benefit Only. PA Required.
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. SUPDL.
J0638	Injection, canakinumab, 1 mg	Ilaris	Pharmacy Benefit Only. PA Required. SUPDL.
J0717	Injection, certolizumab pegol, 1 mg	Cimzia	Pharmacy Benefit Only. PA Required. SUPDL.
J0791	Injection, crizanlizumab-tmca, 5 mg	Adakveo	Carved out of Managed Care Coverage.
J0801	Injection, corticotropin (acthar gel), up to 40 units	Acthar gel	Pharmacy Benefit Only. PA Required.
J0802	Injection, corticotropin (ani), up to 40 units	Purified corticotropin gel	Pharmacy Benefit Only. PA Required.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J0897	Injection, denosumab, 1 mg	Prolia, Xgeva	Pharmacy Benefit Only. PA Required.
J1202	Miglustat, oral, 65 mg	Opfolda	Pharmacy Benefit Only. PA Required.
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	Pombiliti	Medical Benefit Only. PA Required.
J1290	Injection, ecallantide, 1 mg	Kalbitor	Pharmacy Benefit Only. PA Required.
J1300	Injection, eculizumab, 10 mg	Soliris	Pharmacy Benefit Only. PA Required.
J1301	Injection, edaravone, 1 mg	Radicava	Medical Benefit Only. PA Required.
J1302	Injection, sutimlimab-jome, 10 mg	Enjaymo	Medical Benefit Only. PA Required.
J1303	Injection, ravulizumab-cwvz, 10 mg	Ultomiris	Medical Benefit Only. PA Required.
J1304	Injection, tofersen, 1 mg	Qalsody	Medical Benefit Only. PA Required.
J1306	Injection, inclisiran, 1 mg	Leqvio	Medical Benefit Only. PA Required. SUPDL.
J1322	Injection, elosulfase alfa, 1 mg	Vimizim	Medical Benefit Only. PA Required.
J1323	Injection, elranatamab-bcmm, 1 mg	Elrexfio	Medical Benefit Only. PA Required.
J1324	Injection, enfuvirtide, 1 mg	Fuzeon	Pharmacy Benefit Only.
J1325	Injection, epoprostenol, 0.5 mg	Flolan, Veletri	Pharmacy Benefit Only. PA Required.
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Hemgenix	Carved out of Managed Care Coverage.
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	Roctavian	Carved out of Managed Care Coverage.
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Elevidys	Carved out of Managed Care Coverage.
J1426	Injection, casimersen, 10 mg	Amondys-45	Carved out of Managed Care Coverage.
J1427	Injection, viltolarsen, 10 mg	Viltepso	Carved out of Managed Care Coverage.
J1428	Injection, eteplirsen, 10 mg	Exondys-51	Carved out of Managed Care Coverage.
J1429	Injection, golodirsen, 10 mg	Vyondys-53	Carved out of Managed Care Coverage.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J1438	Injection, etanercept, 25 mg	Enbrel	Pharmacy Benefit Only. PA Required. SUPDL..
J1449	Injection, eflapegrastim-xnst, 0.1 mg	Rolvedon	Pharmacy Benefit Only. PA Required. SUPDL.
J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	Privigen	Medical or Pharmacy. PA Required.
J1460	Injection, gamma globulin, intramuscular, 1 cc	GamaSTAN S/D	Medical or Pharmacy. PA Required.
J1551	Injection, immune globulin (cutaquig), 100 mg	Cutaquig	Medical or Pharmacy. PA Required.
J1554	Injection, immune globulin (asceniv), 500 mg	Asceniv	Medical or Pharmacy. PA Required.
J1555	Injection, immune globulin (cuvitru), 100 mg	Cuvitru	Medical or Pharmacy. PA Required.
J1556	Injection, immune globulin (bivigam), 500 mg	Bivigam	Medical or Pharmacy. PA Required.
J1557	Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg	Gammaplex	Medical or Pharmacy. PA Required.
J1558	Injection, immune globulin (xembify), 100 mg	Xembify	Medical or Pharmacy. PA Required.
J1559	Injection, immune globulin (hizentra), 100 mg	Hizentra	Medical or Pharmacy. PA Required.
J1560	Injection, gamma globulin, intramuscular, over 10 cc	GamaSTAN S/D	Medical or Pharmacy. PA Required.
J1561	Injection, immune globulin, (gamunex-c/ gammaked), non-lyophilized (e.g., liquid), 500 mg	Gamunex-C, Gammaked	Medical or Pharmacy. PA Required.
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	Carimune, Gammagard S/D	Medical or Pharmacy. PA Required.
J1568	Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg	Octagam	Medical or Pharmacy. PA Required.
J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg	Gammagard	Medical or Pharmacy. PA Required
J1572	Injection, immune globulin, (flebogamma/ flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg	Flebogamma, Flebogamma DIF	Medical or Pharmacy. PA Required.
J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin	Hyqvia	Medical or Pharmacy. PA Required
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Panzyga	Medical or Pharmacy. PA Required
J1595	Injection, glatiramer acetate, 20 mg	Copaxone, Glatopa	Pharmacy Benefit Only. PA Required. SUPDL.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg	immune globulin	Medical or Pharmacy. PA Required.
J1602	Injection, golimumab, 1 mg, for intravenous use	Simponi Aria	Pharmacy Benefit Only. PA Required. SUPDL.
J1628	Injection, guselkumab, 1 mg	Tremfya	Pharmacy Benefit Only. PA Required. SUPDL.
J1740	Injection, ibandronate sodium, 1 mg	Boniva	Pharmacy Benefit Only. SUPDL.
J1744	Injection, icatibant, 1 mg	Firazyr	Pharmacy Benefit Only. PA Required.
J1745	Injection, infliximab, excludes biosimilar, 10 mg	Remicade	Medical or Pharmacy. PA Required. SUPDL.
J1747	Injection, spesolimab-sbzo, 1 mg	Spevigo	Medical or Pharmacy. PA Required. SUPDL.
J1786	Injection, imiglucerase, 10 units	Cerezyme	Medical Benefit Only. PA Required.
J1811	Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units	Fiasp	Pharmacy Benefit Only. SUPDL.
J1812	Insulin (fiasp), per 5 units	Fiasp	Pharmacy Benefit Only. SUPDL.
J1813	Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units	Lyumjev	Pharmacy Benefit Only. SUPDL.
J1814	Insulin (lyumjev), per 5 units	Lyumjev	Pharmacy Benefit Only. SUPDL.
J1815	Injection, insulin, per 5 units	e.g., Admelog, Apidra, Basaglar, Humalog, Lantus, Levemir, Novolin	Pharmacy Benefit Only. SUPDL.
J1817	Insulin for administration through dme (i.e., insulin pump) per 50 units	e.g., Admelog, Apidra, Basaglar, Humalog, Lantus, Levemir, Novolin	Pharmacy Benefit Only. SUPDL.
J1826	Injection, interferon beta-1a, 30 mcg	Avonex, Rebif	Pharmacy Benefit Only. PA Required. SUPDL.
J1830	Injection, interferon beta-1b, 0.25 mg	Betaseron, Extavia	Pharmacy Benefit Only. PA Required. SUPDL.
J1930	Injection, lanreotide, 1 mg	Somatuline	Pharmacy Benefit Only. PA Required.
J1932	Injection, lanreotide, (cipla), 1 mg	lanreotide	Pharmacy Benefit Only. PA Required.
J2182	Injection, mepolizumab, 1 mg	Nucala	Medical or Pharmacy. PA Required. SUPDL.
J2267	Injection, mirikizumab-mrkz, 1 mg	Omvoh	Medical or Pharmacy. PA Required. SUPDL.

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J2277	Injection, motixafortide, 0.25 mg	Aphexda	Medical Benefit Only. PA Required.
J2323	Injection, natalizumab, 1 mg	Tysabri	Pharmacy Benefit Only. PA Required. SUPDL.
J2326	Injection, nusinersen, 0.1 mg	Spinraza	Carved out of Managed Care Coverage.
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	Skyrizi	Medical or Pharmacy. PA Required. SUPDL.
J2329	Injection, ublituximab-xiiy, 1mg	Briumvi	Medical or Pharmacy. PA Required. SUPDL.
J2350	Injection, ocrelizumab, 1 mg	Ocrevus	Medical or Pharmacy. PA Required. SUPDL.
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	Sandostatin LAR	Pharmacy Benefit Only. PA Required.
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	Bynfezia, Sandostatin	Pharmacy Benefit Only. PA Required.
J2356	Injection, tezepelumab-ekko, 1 mg	Tezspire	Medical or Pharmacy. PA Required. SUPDL.
J2357	Injection, omalizumab, 5 mg	Xolair	Medical or Pharmacy. PA Required. SUPDL.
J2430	Injection, pamidronate disodium, per 30 mg	Aredia	Pharmacy Benefit Only. PA Required.
J2502	Injection, pasireotide long acting, 1 mg	Signifor LAR	Pharmacy Benefit Only. PA Required.
J2507	Injection, pegloticase, 1 mg	Krystexxa	Medical Benefit Only. PA Required.
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	Elfabrio	Medical Benefit Only. PA Required.
J2786	Injection, reslizumab, 1 mg	Cinqair	Medical or Pharmacy. PA Required. SUPDL.
J2793	Injection, rilonacept, 1 mg	Arcalyst	Pharmacy Benefit Only. PA Required. SUPDL.
J2840	Injection, sebelipase alfa, 1 mg	Kanuma	Medical Benefit Only. PA Required.
J2860	Injection, siltuximab, 10 mg	Sylvant	Pharmacy Benefit Only. PA Required.
J2940	Injection, somatrem, 1 mg	Protropin	Pharmacy Benefit Only.
J2941	Injection, somatropin, 1 mg	e.g., Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope	Pharmacy Benefit Only. PA Required. SUPDL.

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J2998	Injection, plasminogen, human-tvmh, 1 mg	Ryplazim	Medical Benefit Only. PA Required.
J3030	Injection, sumatriptan succinate, 6 mg	Imitrex	Pharmacy Benefit Only. SUPDL.
J3032	Injection, eptinezumab-jjmr, 1 mg	Vyepti	Medical Benefit Only. PA Required. SUPDL.
J3055	Injection, talquetamab-tgvs, 0.25 mg	Talvey	Medical Benefit Only. PA Required.
J3060	Injection, taliglucerase alfa, 10 units	Elelyso	Medical Benefit Only. PA Required.
J3110	Injection, teriparatide, 10 mcg	Forteo	Pharmacy Benefit Only. PA Required. SUPDL.
J3111	Injection, romosozumab-aqqg, 1 mg	Evenity	Medical or Pharmacy. PA Required. SUPDL.
J3245	Injection, tildrakizumab, 1 mg	Ilumya	Pharmacy Benefit Only. PA Required. SUPDL.
J3247	Injection, secukinumab, intravenous, 1 mg	Cosentyx	Medical or Pharmacy. PA Required. SUPDL.
J3262	Injection, tocilizumab, 1 mg	Actemra	Pharmacy Benefit Only. PA Required. SUPDL.
J3263	Injection, toripalimab-tpzi, 1 mg	Loqtorzi	Medical Benefit Only. PA Required.
J3285	Injection, treprostinil, 1 mg	Remodulin	Pharmacy Benefit Only. PA Required.
J3355	Injection, urofollitropin, 75 iu	Bravelle	IN Medicaid Excluded Category.
J3357	Ustekinumab, for subcutaneous injection, 1 mg	Stelara SC	Pharmacy Benefit Only. PA Required. SUPDL.
J3358	Ustekinumab, for intravenous injection, 1 mg	Stelara IV	Medical or Pharmacy. PA Required. SUPDL.
J3380	Injection, vedolizumab, 1 mg	Entyvio	Pharmacy Benefit Only. PA Required. SUPDL.
J3385	Injection, velaglucerase alfa, 100 units	VPRIV	Medical Benefit Only. PA Required.
J3397	Injection, vestronidase alfa-vjbk, 1 mg	Mepsevii	Medical Benefit Only. PA Required.
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	Luxturna	Carved out of Managed Care Coverage.
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	Zolgensma	Carved out of Managed Care Coverage.
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	Vyjuvek	Carved out of Managed Care Coverage.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J3489	Injection, zoledronic acid, 1 mg	Reclast, Zometa	Medical or Pharmacy. PA Required.
J3490	Unclassified drugs	<various>	Medical Benefit Only. *PA Required.
J3590	Unclassified biologics	<various>	Medical Benefit Only. *PA Required.
J3591	Unclassified drug or biological used for esrd on dialysis	<various>	Medical Benefit Only. *PA Required.
J7165	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	Balfaxar	Carved out of Managed Care Coverage.
J7168	Prothrombin complex concentrate (human), kcentra, per i.u. of factor ix activity	Kcentra	Carved out of Managed Care Coverage.
J7170	Injection, emicizumab-kxwh, 0.5 mg	Hemlibra	Carved out of Managed Care Coverage.
J7175	Injection, factor x, (human), 1 i.u.	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 i.u. vwf:rco	Vonvendi	Carved out of Managed Care Coverage.
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	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 i.u. vwf:rco	Wilate	Carved out of Managed Care Coverage.
J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	Xyntha	Carved out of Managed Care Coverage.
J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.	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 i.u.	Obizur	Carved out of Managed Care Coverage.
J7189	Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram	NovoSeven RT	Carved out of Managed Care Coverage.
J7190	Factor viii (antihemophilic factor, human) per i.u.	Hemofil M	Carved out of Managed Care Coverage.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J7191	Factor viii ((antihemophilic factor (porcine)), per i.u.	Hyate:C	Carved out of Managed Care Coverage.
J7192	Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified	Advate	Carved out of Managed Care Coverage.
J7193	Factor ix (antihemophilic factor, purified, non-recombinant) per i.u.	Alphanine SD	Carved out of Managed Care Coverage.
J7194	Factor ix, complex, per i.u.	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.
J7198	Anti-inhibitor, per i.u.	Feiba	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 i.u.	Alprolix	Carved out of Managed Care Coverage.
J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.	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.
J7204	Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu	Esperoct	Carved out of Managed Care Coverage.
J7205	Injection, factor viii fc fusion protein (recombinant), per iu	Eloctate	Carved out of Managed Care Coverage.
J7207	NInjection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.	Adynovate	Carved out of Managed Care Coverage.
J7208	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	JIVI	Carved out of Managed Care Coverage.
J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.	Nuwiq	Carved out of Managed Care Coverage.
J7210	Injection, factor VIII, (antihemophilic factor, recombinant), (afstyla), 1 i.u.	Afstyla	Carved out of Managed Care Coverage.
J7211	Injection, factor VIII, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	Kovaltry	Carved out of Managed Care Coverage.
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	SEVENFACT	Carved out of Managed Care Coverage.
J7214	Injection, factor viii/von willebrand factor complex, recombinant (altuviiio), per factor viii i.u.	Altuviiio	Carved out of Managed Care Coverage.
J7294	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each	Annovera	Pharmacy Benefit Only. SUPDL.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	NuvaRing	Pharmacy Benefit Only. SUPDL.
J7303	Contraceptive supply, hormone containing vaginal ring, each	e.g., NuvaRing, Annovera	Pharmacy Benefit Only. SUPDL.
J7304	Contraceptive supply, hormone containing patch, each	e.g., OrthoEvra, Xulane	Pharmacy Benefit Only. SUPDL.
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	Durolane	Pharmacy Benefit Only. PA Required.
J7320	Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg	GenVisc 850	Pharmacy Benefit Only. PA Required.
J7321	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose	Hyalgan Supartz VISCO-3	Pharmacy Benefit Only. PA Required.
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	Hymovis	Pharmacy Benefit Only. PA Required.
J7323	Hyaluronan or derivative, euflexxa, for intra-articular injection, per dose	Euflexxa	Pharmacy Benefit Only. PA Required.
J7324	Hyaluronan or derivative, orthovisc, for intra-articular injection, per dose	Orthovisc	Pharmacy Benefit Only. PA Required.
J7325	Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg	Synvisc Synvisc-One	Pharmacy Benefit Only. PA Required.
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	Gel-One	Pharmacy Benefit Only. PA Required.
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	Monovisc	Pharmacy Benefit Only. PA Required.
J7328	Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg	Gelsyn-3	Pharmacy Benefit Only. PA Required.
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	TriVisc	Pharmacy Benefit Only. PA Required.
J7332	Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg	Triluron	Pharmacy Benefit Only. PA Required.
J7342	Instillation, ciprofloxacin otic suspension, 6 mg	Cipro Otic	Pharmacy Benefit Only. SUPDL.
J7354	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	Ycanth	Medical Benefit Only. PA Required.
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.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J7507	Tacrolimus, immediate release, oral, 1 mg	Hecoria, Prograf	Pharmacy Benefit Only.
J7508	Tacrolimus, extended release, (astagraf xl) oral, 0.1 mg	Astagraf	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.
J7599	Immunosuppressive drug, not otherwise classified	<various>	Medical Benefit Only. *PA Required.
J7799	Noc drugs, other than inhalation drugs, administered through dme	<various>	Medical Benefit Only. *PA Required.
J7999	Compounded drug, not otherwise classified	<various>	Medical Benefit Only. *PA Required.
J8498	Antiemetic drug, rectal/suppository, not otherwise specified	<various>	Medical Benefit Only. *PA Required.
J8499	Prescription drug, oral, non chemotherapeutic, nos	<various>	Pharmacy Benefit Only.
J8501	Aprepitant, oral, 5 mg	Emend	Pharmacy Benefit Only. SUPDL.
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.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J8565	Gefitinib, oral, 250 mg	Iressa	Pharmacy Benefit Only.
J8597	Antiemetic drug, oral, not otherwise specified	<various>	Pharmacy Benefit Only.
J8600	Melphalan; oral, 2 mg	Alkeran	Pharmacy Benefit Only.
J8610	Methotrexate; oral, 2.5 mg	Rheumatrex, Trexall	Pharmacy Benefit Only.
J8650	Nabilone, oral, 1 mg	Cesamet	Medical Benefit Only. PA Required.
J8655	Netupitant 300 mg and palonosetron 0.5 mg, oral	Akynzeo	Pharmacy Benefit Only. SUPDL.
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.
J9019	Injection, asparaginase (erwinaze), 1,000 iu	Erwinaze	Medical Benefit Only. PA Required.
J9022	Injection, atezolizumab, 10 mg	Tecentriq	Medical Benefit Only. PA Required.
J9032	Injection, belinostat, 10 mg	Beleodaq	Medical Benefit Only. PA Required.
J9037	Injection, belantamab mafodotin-blmf, 0.5 mg	Blenrep	Medical Benefit Only. PA Required.
J9039	Injection, blinatumomab, 1 microgram	Blincyto	Medical Benefit Only. PA Required.
J9041	Injection, bortezomib, 0.1 mg	Velcade	Medical Benefit Only. PA Required.
J9042	Injection, brentuximab vedotin, 1 mg	Adcetris	Medical Benefit Only. PA Required.
J9046	Injection, bortezomib, (dr. reddy's), not therapeutically equivalent to j9041, 0.1 mg	bortezomib	Medical Benefit Only. PA Required.
J9047	Injection, carfilzomib, 1 mg	Kyprolis	Medical Benefit Only. PA Required.
J9048	Injection, bortezomib (fresenius kabi), not therapeutically equivalent to j9041, 0.1 mg	bortezomib	Medical Benefit Only. PA Required.
J9049	Injection, bortezomib (hospira), not therapeutically equivalent to j9041, 0.1 mg	bortezomib	Medical Benefit Only. PA Required.
J9051	Injection, bortezomib (maia), not therapeutically equivalent to J9041, 0.1 mg	bortezomib	IN Medicaid Excluded.
J9055	Injection, cetuximab, 10 mg	Erbitux	Medical Benefit Only. PA Required.
J9057	Injection, copanlisib, 1 mg	Aliqopa	Medical Benefit Only. PA Required.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J9061	Injection, amivantamab-vmjw, 2 mg	Rybrevant	Medical Benefit Only. PA Required.
J9063	Injection, mirvetuximab soravtansine-gynx, 1 mg	Elahere	Medical Benefit Only. PA Required.
J9145	Injection, daratumumab, 10 mg	Darzalex	Medical Benefit Only. PA Required.
J9173	Injection, durvalumab, 10 mg	Imfinzi	Medical Benefit Only. PA Required.
J9176	Injection, elotuzumab, 1 mg	Empliciti	Medical Benefit Only. PA Required.
J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg	Padcev	Medical Benefit Only. PA Required.
J9179	Injection, eribulin mesylate, 0.1 mg	Halaven	Medical Benefit Only. PA Required.
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	Mylotarg	Medical Benefit Only. PA Required.
J9204	Injection, mogamulizumab-kpkc, 1 mg	Poteligeo	Medical Benefit Only. PA Required.
J9205	Injection, irinotecan liposome, 1 mg	Onivyde	Medical Benefit Only. PA Required.
J9207	Injection, ixabepilone, 1 mg	Ixempra	Medical Benefit Only. PA Required.
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.
J9227	Injection, isatuximab-irfc, 10 mg	Sarclisa	Medical Benefit Only. PA Required.
J9228	Injection, ipilimumab, 1 mg	Yervoy	Medical Benefit Only. PA Required.
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	Besponsa	Medical Benefit Only. PA Required.
J9259	Injection, paclitaxel protein-bound particles (american regent) not therapeutically equivalent to J9264, 1 mg	paclitaxel	Medical Benefit Only. PA Required.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J9264	Injection, paclitaxel protein-bound particles, 1 mg	Abraxane	Medical Benefit Only. PA Required.
J9266	Injection, pegaspargase, per single dose vial	Oncaspar	Medical Benefit Only. PA Required.
J9271	Injection, pembrolizumab, 1 mg	Keytruda	Medical Benefit Only. PA Required.
J9272	Injection, dostarlimab-gxly, 10 mg	Jemperli	Medical Benefit Only. PA Required.
J9273		Tivdak	Medical Benefit Only. PA Required.
J9274	Injection, tisotumab vedotin-tftv, 1 mg	Kimmtrak	Medical Benefit Only. PA Required.
J9285	Injection, tebentafusp-tebn, 1 microgram	Lartruvo	Medical Benefit Only. PA Required.
J9286	Injection, olaratumab, 10 mg	Columvi	Medical Benefit Only. PA Required.
J9293	Injection, mitoxantrone hydrochloride, per 5 mg	Novantrone	Medical Benefit Only. PA Required.
J9295	Injection, necitumumab, 1 mg	Portrazza	Medical Benefit Only. PA Required.
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	Opdualag	Medical Benefit Only. PA Required.
J9299	Injection, nivolumab, 1 mg	Opdivo	Medical Benefit Only. PA Required.
J9301	Injection, obinutuzumab, 10 mg	Gazyva	Medical Benefit Only. PA Required.
J9302	Injection, ofatumumab, 10 mg	Arzerra	Medical Benefit Only. PA Required.
J9306	Injection, pertuzumab, 1 mg	Perjeta	Medical Benefit Only. PA Required.
J9307	Injection, pralatrexate, 1 mg	Folotyn	Medical Benefit Only. PA Required.
J9308	Injection, ramucirumab, 5 mg	Cyramza	Medical Benefit Only. PA Required.
J9309	Injection, polatuzumab vedotin-piiq, 1 mg	Polivy	Medical Benefit Only. PA Required.
J9311	Injection, rituximab 10 mg and hyaluronidase	Rituxan Hycela	Medical Benefit Only. PA Required.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J9312	Injection, rituximab, 10 mg	Rituxan	Medical Benefit Only. PA Required.
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg	Trodelvy	Medical Benefit Only. PA Required.
J9319	Injection, romidepsin, lyophilized, 0.1 mg	Istodax	Medical Benefit Only. PA Required.
J9321	Injection, epcoritamab-bysp, 0.16 mg	Epkinly	Medical Benefit Only. PA Required.
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	Imlygic	Medical Benefit Only. PA Required.
J9330	Injection, temsirolimus, 1 mg	Torisel	Medical Benefit Only. PA Required.
J9331	Injection, sirolimus protein-bound particles, 1 mg	Fyarro	Medical Benefit Only. PA Required.
J9332	Injection, efgartigimod alfa-fcab, 2mg	Vyvgart	Medical Benefit Only. PA Required.
J9333	Injection, rozanolixizumab-noli, 1 mg	Rystiggo	Medical Benefit Only. PA Required.
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Vyvgart Hytrulo	Medical Benefit Only. PA Required.
J9345	Injection, retifanlimab-dlwr, 1 mg	Zynyz	Medical Benefit Only. PA Required.
J9347	Injection, tremelimumab-actl, 1 mg	Imjudo	Medical Benefit Only. PA Required.
J9350	Injection, mosunetuzumab-axgb, 1 mg	Lunsumio	Medical Benefit Only. PA Required.
J9352	Injection, trabectedin, 0.1 mg	Yondelis	Medical Benefit Only. PA Required.
J9353	Injection, margetuximab-cmkb, 5 mg	Margenza	Medical Benefit Only. PA Required.
J9354	Injection, ado-trastuzumab emtansine, 1 mg	Kadcyla	Medical Benefit Only. PA Required.
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg	Herceptin	Medical Benefit Only. PA Required.
J9356	Injection, trastuzumab 10 mg and hyaluronidase-oysk	Herceptin Hylecta	Medical Benefit Only. PA Required.
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Enhertu	Medical Benefit Only. PA Required.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg	Zynlonta	Medical Benefit Only. PA Required.
J9371	Injection, vincristine sulfate liposome, 1 mg	Marqibo	Medical Benefit Only. PA Required.
J9376	Injection, pozelimab-bbfg, 1 mg	Veopoz	Medical Benefit Only. PA Required.
J9380	Injection, teclistamab-cqyv, 0.5 mg	Tecvayli	Medical Benefit Only. PA Required.
J9381	Injection, teplizumab-mzwv, 5 mcg	Tzield	Medical Benefit Only. PA Required.
J9393	Injection, fulvestrant (teva) not therapeutically equivalent to j9395, 25 mg	fulvestrant	Medical Benefit Only. PA Required.
J9394	Injection, fulvestrant (fresenius kabi) not therapeutically equivalent to j9395, 25 mg	fulvestrant	Medical Benefit Only. PA Required.
J9395	Injection, fulvestrant, 25 mg	Faslodex	Medical Benefit Only. PA Required.
J9400	Injection, ziv-aflibercept, 1 mg	Zaltrap	Medical Benefit Only. PA Required.
J9600	Injection, porfimer sodium, 75 mg	Photofrin	Medical Benefit Only. PA Required.
J9999	Not otherwise classified, antineoplastic drugs	<various>	Medical Benefit Only. *PA Required.
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gram	azithromycin dihydrate	Pharmacy Benefit Only. SUPDL.
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. SUPDL (AAAX).
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. SUPDL.
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.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
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.
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. SUPDL.
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. SUPDL.
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.
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. SUPDL (AAAX).
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. SUPDL (AAAX).

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
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 CAR T 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.
Q2028	Injection, sculptra, 0.5 mg	Sculptra	IN Medicaid Excluded Category.
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Carvykti	Carved out of Managed Care Coverage.
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	Avonex, Rebif	Pharmacy Benefit Only. PA Required. SUPDL.
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	Avonex, Rebif	Pharmacy Benefit Only. PA Required. SUPDL.

HCPCS Code	Code Description	Drug Name	Coverage Status / Prior Authorization (PA)
Q5102	Injection, infliximab, biosimilar, 10 mg	infliximab (biosimilar)	Medical or Pharmacy. PA Required. SUPDL.
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	Inflectra	Medical or Pharmacy. PA Required. SUPDL.
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	Renflexis	Medical or Pharmacy. PA Required. SUPDL.
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	Ixifi	Medical or Pharmacy. PA Required. SUPDL.
Q5112	Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg	Ontruzant	Medical Benefit Only. PA Required.
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	Ogivri	Medical Benefit Only. PA Required.
Q5115	Injection, rituximab-abbs, biosimilar, (truxima), 10 mg	Truxima	Medical Benefit Only. PA Required.
Q5116	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg	Trazimera	Medical Benefit Only. PA Required.
Q5117	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	Kanjinti	Medical Benefit Only. PA Required.
Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	Ruxience	Medical Benefit Only. PA Required.
Q5121	Injection, infliximab-axxq, biosimilar, (avsola), 10 mg	Avsola	Medical or Pharmacy. PA Required. SUPDL.
Q5123	Injection, rituximab-arrx, biosimilar, (riabrni), 10 mg	Riabni	Medical Benefit Only. PA Required.
Q5125	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	Releuko	Medical or Pharmacy. PA Required. SUPDL.
Q5130	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	Fylnetra	Medical or Pharmacy. SUPDL.
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg	Idacio	Pharmacy Benefit Only. PA Required. SUPDL.
Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg	Abrilada	Pharmacy Benefit Only. PA Required. SUPDL.
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg	Sublocade	Medical or Pharmacy. PA Required. SUPDL.
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg	Sublocade	Medical or Pharmacy. PA Required. SUPDL.
S0013	Esketamine, nasal spray, 1 mg	Spravato	Pharmacy or Medical. PA Required. SUPDL (AAAX).