



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Injections, Vaccines and Other Physician- Administered Drugs

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Injections, Vaccines and Other Physician-Administered Drugs

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member’s managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Banner Pages](#) and [IHCP Bulletins](#) at in.gov/medicaid/providers.

Introduction

Physician-administered drugs include drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressives, inhalation solutions, and other miscellaneous drugs and solutions. These drugs may be administered by a physician or by another qualified medical practitioner. For information about pharmacist-administered drugs and vaccines, see the [Pharmacy Services](#) module.

The Indiana Health Coverage Programs (IHCP) generally provides coverage for physician-administered drugs for medically necessary conditions, when provided in accordance with applicable policies and procedures.

The IHCP also provides coverage for many immunizations and vaccines. In addition, various free vaccines are available for members 18 years of age and younger through the Vaccines for Children (VFC) program, administered through the Indiana Department of Health (IDOH).

National Drug Code Requirements

Medication listed under *Section 510* of the *U.S. Federal Food, Drug, and Cosmetic Act* is assigned a unique number known as the National Drug Code (NDC). The NDC contains three segments:

- The first segment, known as the *labeler code*, is assigned by the Food and Drug Administration (FDA). A labeler is any firm that manufactures, repacks or distributes a drug product.
- The second segment, known as the *product code*, identifies a specific drug, strength and dosage form of that drug.
- The third segment, known as the *package code*, identifies the package size.

In accordance with the *Federal Deficit Reduction Act of 2005*, providers must submit the NDC along with the Healthcare Common Procedure Coding System (HCPCS) procedure code when billing claims to the IHCP for most physician-administered drugs, excluding vaccines. Applicable HCPCS codes are listed in *Procedure Codes That Require National Drug Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. This list is reviewed and updated on an annual basis or as determined by the Family and Social Services Administration (FSSA).

In addition to the NDC number itself, providers must also submit the NDC unit of measure (UOM) and NDC quantity of units. To search for drug product information, access the [FDA National Drug Code Directory](#) at accessdata.fda.gov.

Note: Both procedure code billing units and NDC quantity are required. The procedure code billing units and NDC quantity do not always have a one-to-one relationship. The NDC quantity is based on the strength of the drug administered per unit and the designated strength of the procedure code. The NDC quantity billed must reflect the procedure code units billed on the claim.

This requirement applies to both professional claims and outpatient institutional claims. Because the IHCP may pay up to the 20% Medicare B copayment for dually eligible individuals, the NDC is also required on Medicare crossover claims for all applicable procedure codes.

Entering NDC Information on Claims

For billing purposes, the NDC must be configured as 11 digits, using what is referred to as a “5-4-2” format:

- The first segment must include five digits.
- The second segment must include four digits.
- The third segment must include two digits.

If the product label displays an NDC with fewer than 11 digits, a zero must be added at the beginning of the appropriate segment to achieve the 5-4-2 format. Hyphens and spaces are omitted when submitting the NDC number on a claim. For example, if a package displays an NDC as 12345-1234-1, a zero must be added to the beginning of the third segment to create an 11-digit NDC as follows: 12345123401.

The NDC information must be entered in the appropriate fields of the professional claim (*CMS-1500* claim form, IHCP Provider Healthcare Portal (IHCP Portal) professional claim or 837P electronic transaction) or the outpatient institutional claim (*UB-04* claim form, IHCP Portal institutional claim or 837I electronic transaction).

On the *CMS-1500* claim form, enter the NDC information in the shaded, top-half portion of each applicable detail line, beginning at field 24A. On the *UB-04* claim form, enter the NDC information in field 43 for each detail line with an applicable HCPCS code (in field 44).

Enter the information on the **paper** claim form as follows:

1. Enter the NDC qualifier of **N4**.
2. Enter the 11-digit numeric NDC (without spaces or hyphens).
3. Enter the drug description.
4. Enter the appropriate NDC unit-of-measure qualifier:
 - F2 – International Unit
 - GR – Gram
 - ME – Milligram
 - ML – Milliliter
 - UN – Unit
5. Enter the NDC quantity (administered amount) in the format 9999.999.

For professional and institutional outpatient claims submitted via the **IHCP Portal**, report NDC information in the *NDC for Service Detail* panel (see [Figure 1](#)) for the appropriate service detail, as follows:

1. Select “National Drug Code in 5-4-2 Format” from the Code Type drop-down list.
Selecting this option is equivalent to entering the NDC qualifier of **N4** on the paper claim form. No other options are available for this field.
2. Enter the 11-digit NDC (without hyphens or spaces) in the NDC field.
3. The portal autofills a drug description for the NDC entered.

4. Enter the NDC quantity, with up to three decimal places, in the Quantity field.
5. Select the appropriate option from the Unit of Measure drop-down list:
 - International Unit
 - Gram
 - Milligram
 - Milliliter
 - Unit

Figure 1 – Entering NDC information in the IHCP Portal

The screenshot shows a web form titled "NDC for Service Detail". At the top, there is a blue header bar. Below the header, a paragraph of instructions reads: "If applicable, only one NDC is allowed per service detail line. When adding an NDC, the Code Type, Quantity and Unit of Measure fields are required. Additionally, NDC information is required when adding or saving NDC with prescription information (Prescription Number, Prescription Type)." The form contains several input fields: "Code Type" is a dropdown menu set to "National Drug Code in 5-4-2 Format"; "NDC#" is a text box containing "58160082543-HAVRIX"; "Quantity" is a text box with "1.000"; "Unit of Measure" is a dropdown menu set to "Unit"; "Prescription Number" is an empty text box; "Prescription Type" is an empty dropdown menu; and "Prescription Date" is an empty date picker.

Billing Compounds With NDCs

When billing any compound drugs that require an NDC, providers must bill the appropriate NDC for each procedure code. Providers receive payment for all valid NDCs included in the compound drug.

Billing a Procedure Code With Multiple NDCs

When billing a single procedure code that involves multiple NDCs, providers bill the claim with each appropriate NDC for the drug they are dispensing or administering on a separate detail line, repeating the HCPCS code as needed for each unique NDC code.

For example, a 50 mg vial and a 100 mg vial of Synagis have different NDCs but the same procedure code. Therefore, if a provider administers 150 mg of Synagis using these two vials, the item would be billed with two detail lines for the same procedure code, and the appropriate NDC would be entered on each line.

NDC-Related Explanations of Benefits

The Remittance Advice (RA) does not display the NDC submitted on the claim. However, the following NDC-related explanations of benefits (EOBs) may be returned as a part of claim processing:

- EOB 0217 – *NDC number is missing or not on file – an NDC number can be up to eleven numeric characters. See the pharmacy chapter in your provider manual. Please provide and resubmit.*
- EOB 0810 – *NDC unit qualifier (unit of measure) is missing/invalid.*
- EOB 1016 – *This manufacturer does not participate in the drug rebate program.*

Note: The Centers for Medicare & Medicaid Services (CMS) maintains a Drug Manufacturer Contact Information list, which includes each drug company that participates in the Medicaid Drug Rebate Program. The list is available at the [Medicaid Drug Rebate Program](#) page at medicaid.gov. Providers can also contact their wholesaler or drug supplier to determine if products supplied are from CMS rebating labelers.

- EOB 4003 – *Less than effective drugs are not covered under Indiana Health Coverage Programs.*

Note: Less-than-effective drugs are drugs that the FDA approved before the Drug Amendments of 1962 (P.L. No. 87-781) and that FDA subsequently found to be less than effective.

- EOB 4007 – *Noncovered NDC due to CMS termination – Claims with an NDC that has been terminated by the CMS will not be reimbursable.*
- EOB 4300 – *Invalid NDC to procedure code combination.*

340B Program Requirements

Section 340B of the *Public Health Service Act* limits the cost of covered outpatient drugs to entities such as certain federal grantees, federally qualified health centers (FQHCs), FQHC look-alikes and qualified disproportionate share hospitals, enabling these entities to purchase drugs at discounted rates and stretch scarce federal resources.

This program applies to clinic-administered drugs within eligible facilities. Vaccines and inpatient drugs are not included.

If a covered entity will be submitting any claims for drugs purchased under the 340B program, then *all* drug claims submitted by the covered entity’s Medicaid provider number and/or NPI must be purchased under the 340B program (“carve in”). That covered entity’s Medicaid provider number/NPI must be listed in the Health Resources and Services Administration (HRSA) Medicaid Exclusion File (MEF). The entity can bill the Medicaid program for only the actual acquisition cost (AAC) for the drug, and a dispensing fee will not apply. If using different carve decisions for different states, please make sure that the proper state (Indiana) and associated NPI and/or Medicaid provider number (IHCP Provider ID) is listed on the MEF.

Providers enrolled in the 340B program should use one of the following modifiers when billing the IHCP for 340B drugs on professional claims (*CMS-1500* claim form, IHCP Portal professional claim or 837P electronic transaction) or institutional claims (*UB-04* claim form, IHCP Portal institutional claim or 837I electronic transaction):

- JG – *Drug or biological acquired with 340B drug pricing program discount*
- TB – *Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes*

The modifier requirement also applies to billing Medicaid for dually eligible patients (those enrolled in both Medicare and Medicaid). 340B providers using 340B products for Medicare beneficiaries must use the modifiers listed above for claims submitted to Medicaid to prevent duplicate discounts.

Reimbursement for Physician-Administered Drugs

With the exception of vaccines available through the VFC program and certain manually priced drugs, the IHCP calculates the maximum allowable amount for reimbursement for physician-administered drugs (billed using HCPCS drug codes) and vaccines (billed with Current Procedural Terminology [CPT^{®1}] vaccine codes) on the basis of the most cost-effective, current reimbursement for an appropriate NDC, identified as the *benchmark NDC*. The maximum allowable reimbursement is equal to wholesale acquisition cost (WAC) plus 5% (WAC+5%) of the benchmark NDC or, if no WAC data is available, average sales price (ASP) plus 6% (ASP+6%), or AAC for 340B-acquired drugs.

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The maximum allowable cost corresponds to the dose in the narrative description of the HCPCS or CPT code. When the procedure code specifies no dose in the narrative, the reimbursement rate is based on what corresponds to a typical dose for the particular code. The IHCP notifies providers through bulletins or banner pages about reimbursement rates for codes that have no dose or are dose-unspecified.

The IHCP reviews pricing for physician-administered drugs quarterly and updates pricing according to WAC data in the drug database file received from First DataBank. If no WAC data is available, currently ASP+6%, is used.

*Note: For outpatient facility billing under the fee-for-service reimbursement methodology, **treatment room services** are reimbursed at a flat rate that includes most drugs, injections and supplies. See the Treatment Room Visits section of the [Outpatient Facility Services](#) module for details.*

For inpatient hospital stays, all drugs, injections and supplies are included in the diagnosis-related group (DRG) payment, with the exception of specific drugs as described in the [Hospital Reimbursement for Physician-Administered Drugs](#) section.

Nonspecific CPT or HCPCS Drug Codes

When a provider cannot use an existing CPT or HCPCS code to bill for new drugs that the IHCP covers because the IHCP has not assigned a specific code, the provider should bill using an appropriate nonspecific CPT or HCPCS code, such as the following:

- J3490 – *Unclassified drugs*
- J3590 – *Unclassified biologics*
- 90749 – *Unlisted vaccine/toxoid*

Providers can use a nonspecific CPT or HCPCS code only when no code is available. Providers must include a narrative that accurately describes the drug being administered or the drug's route of administration.

The IHCP manually prices drugs billed with nonspecific, nonvaccine HCPCS codes (such as J3490 and J3590) based on the NDC billed. All professional and institutional claims billed with a nonspecific, nonvaccine drug code must include the following information:

- NDC qualifier
- NDC
- Drug description
- NDC unit of measure
- Number of units (quantity) administered

If the required information is not included on the claim, the IHCP will deny the claim.

The IHCP reimburses for nonspecific, nonvaccine drug codes at the WAC+5% (or ASP+6% if no WAC data is available) of the NDC indicated on the claim, multiplied by the number of units administered.

Hospital Reimbursement for Physician-Administered Drugs

The IHCP allows separate reimbursement, outside the diagnosis-related group (DRG) payment, for certain drugs administered during an inpatient hospital stay. To receive separate reimbursement, the drugs must be billed as **professional** claims (using the CMS-1500 claim form or electronic equivalent). For applicable codes, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Managed Care Carve-Outs

Certain physician-administered drugs are carved out from the managed care delivery system. The IHCP processes prior authorization (PA) requests and claims for these designated physician-administered drugs through the fee-for-service (FFS) delivery system for *all* IHCP members, including members enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise managed care programs.

For a list of applicable drugs, see *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

PA requests and claims for these carved-out physician-administered drugs must be submitted as follows for all IHCP members:

- Any required prior authorization requests must be submitted to the IHCP fee-for-service prior authorization and utilization review (PA-UM) contractor.
- All claims must be submitted to Gainwell Technologies. The claims must be billed using the professional claim (*CMS-1500* claim form or electronic equivalent).

To clarify, only the drug procedure codes indicated on the table are carved out of managed care. All services associated with the drug (for example, laboratory testing, administration of the drug, inpatient stay during which the drug is administered) are the responsibility of the managed care entity (MCE) with which the member is enrolled.

Exception: For coronavirus disease 2019 (COVID-19) vaccination, both the drug and its administration are carved out of managed care. Both codes should be submitted to Gainwell for all IHCP members, including those in managed care programs. COVID-19 vaccines are to be supplied free of charge, without copay, to all IHCP members, including members in limited-benefit categories.

Physician-administered drugs that are not carved out of managed care per IHCP policy remain the responsibility of the MCE with which the managed care member is enrolled.

Drug Administration Fees

The IHCP may provide separate reimbursement for the *administration* (for example, injection) of a drug (including vaccines) when billed with the appropriate procedure code.

However, if an evaluation and management (E/M) code is billed with the same date of service as a physician-administered drug, the provider should **not** bill a drug administration procedure code separately. Reimbursement for administration is included in the E/M code allowed amount. **Separate reimbursement for drug administration is allowed when the administration is the only service billed by the practitioner on that date of service.** If more than one injection is given on the same date of service and no E/M code is billed, providers may bill a separate administration fee for each injection using the appropriate codes.

*Note: For VFC vaccines, the IHCP reimburses **only** for the administration of the vaccine, not for the vaccine itself. The administration of a VFC vaccine is separately reimbursable in addition to an E/M service. For details, including specific billing instructions, see the [Vaccines for Children Program](#) section.*

For drugs administered in an outpatient facility setting, the IHCP will not reimburse for both an administration procedure code and a treatment room revenue code on the same date of service and by the same billing provider. If a treatment room revenue code has already paid, the IHCP will not reimburse the same provider for an administration procedure code billed for the same member on the same date of service. The reverse also applies; the IHCP will not reimburse a treatment room revenue code billed by the same provider for the same date of service as an administration procedure code that was already paid. This limit includes codes billed on the same or different claims for the same member, on the same date of service and by the same billing provider.

For drugs administered during an inpatient stay, there is no separate reimbursement for the administration of the drug – including in cases where the drug itself is eligible for separate reimbursement, as described in the [Hospital Reimbursement for Physician-Administered Drugs](#) section.

Vaccines

Providers should bill vaccination services according to the source of the vaccine stock – privately purchased or obtained through the Vaccines for Children (VFC) program or the COVID-19 Vaccination Program – as described in the following sections.

For children under the age of 19, if a vaccine is available through the VFC program, the IHCP will not provide reimbursement for a non-VFC vaccine (referred to as private stock vaccine). To guarantee that all IHCP children receive immunizations as needed, providers are encouraged to enroll in the VFC program if they are not currently enrolled.

Providers must continue to submit claims to the appropriate claim-processing unit (to the member's MCE for managed care claims, or to Gainwell for fee-for-service, nonpharmacy claims, including claims for services that are carved out of the managed care delivery system), regardless of the source of the vaccine stock. See the [Pharmacy Services](#) module for information regarding reimbursement to pharmacy providers for pharmacist-administered vaccines.

Note: With the exception of COVID-19 vaccinations, FQHC- and rural health clinic (RHC)-specific encounter rates already include payment for vaccines and their administration. See the [Federally Qualified Health Centers and Rural Health Clinics](#) module for details and billing instructions.

Billing for Privately Purchased Vaccines

For IHCP-covered vaccines that are **not** part of the COVID-19 Vaccination Program or (for members under the age of 19) the VFC program, providers may receive reimbursement for the vaccine itself as well as for its administration, as described in the [Drug Administration Fees](#) section.

Note: See the [Third-Party Liability](#) section for information about the option to bill the IHCP as a secondary insurer for the administration of a privately purchased vaccine for a VFC member.

The IHCP maximum fee information is on the Professional Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers. Be aware of the member's primary medical provider assignment, managed care delivery system assignment and third-party liability resources. Claims are eligible for postpayment review, and providers must maintain documentation and invoices related to private stock.

COVID-19 Vaccination Program

Note: The information in this section is subject to change. Be sure to check [IHCP bulletins](#) for updates to policies and procedure related to the COVID-19 public health emergency.

Coronavirus disease 2019 (COVID-19) vaccine codes for products obtained through the Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Program at no charge to the provider, will pay at zero. The IHCP will reimburse for applicable COVID-19 vaccine administration codes. For a complete list of IHCP-covered vaccine codes and associated administration codes, see *COVID-19 Vaccination Procedure Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. For information related to IHCP-covered COVID-19 vaccine products through the pharmacy benefit, see the *COVID-19 Vaccination Information* page under the Preferred Products tab on the [Optum Rx Indiana Medicaid website](#), accessible from the [Pharmacy Services](#) page at in.gov/medicaid/providers.

COVID19 vaccinations can be administered to all eligible IHCP members meeting vaccine Emergency Use Authorization (EUA) criteria and CDC Advisory Committee on Immunization Practices (ACIP) age and dosing interval recommendations. Any additional requirements or limitations specified by the IDOH, CDC, or *Health and Human Services (HHS) Public Readiness and Emergency Preparedness (PREP) Act* must also be met.

COVID-19 vaccines are to be supplied free of charge, without copay, to all IHCP members, including members in limited benefit categories, such as Emergency Services Only (ESO). COVID-19 vaccination claims for IHCP members who are dually eligible for both Medicare and Medicaid must be billed to the member's Medicare plan provider.

Emergency Medical Services (EMS) providers, pharmacy providers, and federally qualified health center (FQHC) and rural health clinic (RHC) providers are allowed to bill for COVID-19 vaccine administration. In addition, Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver providers are allowed to bill COVID-19 vaccine and administration codes, with modifier U7 appended.

FQHC and RHC reimbursement for COVID-19 vaccine administration is provided separately from the prospective payment system (PPS) rate. FQHC and RHC providers must bill the vaccine administration on a separate claim form, without the encounter code. See the [Federally Qualified Health Centers and Rural Health Clinics](#) module for more information.

COVID-19 vaccination reimbursement is carved out of managed care benefits. Professional claims for managed care and fee-for-service (FFS) members should be submitted to the FFS claim-processing vendor, Gainwell.

Vaccines for Children Program

Vaccines for Children (VFC) is a federally funded program that provides vaccines at no cost to providers for children under 19 years of age who might not otherwise be vaccinated because of inability to pay. Children who are eligible for VFC are entitled to receive all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). See the [CDC Vaccine Price List](#) at cdc.gov for information on what vaccines are covered under the VFC program. In addition, providers can refer to the [Vaccines for Children: Information for Providers](#) page at in.gov/health for information regarding vaccine availability, provider obligations and general program information.

Note: For information regarding the VFC program through the pharmacy benefit, see the [Pharmacy Services](#) module.

The IDOH administers the VFC program in Indiana. All VFC vaccine ordering, distribution and accountability processes are administered through the IDOH Immunization Division. Providers can direct questions concerning VFC provider enrollment, patient eligibility for VFC, and vaccine orders and distribution to the IDOH at:

**Indiana Department of Health
Immunization Division
2 N. Meridian St.
Indianapolis, IN 46204**
Telephone: 800-701-0704
Email: immunize@isdh.in.gov

Provider Enrollment in the VFC Program

The federal VFC program includes private and public practitioners across Indiana. The IDOH Immunization Division handles VFC provider enrollment and education as well as VFC vaccine orders and distribution. To enroll in the VFC program, providers should complete the following steps:

1. Review the IDOH VFC program eligibility statements to ensure that your practice is able to meet all program requirements:
 - [Provider Eligibility for Publicly Funded Vaccine Programs](#)
 - [Childhood Vaccine Eligibility Statement](#)
2. Download the Immunization Provider Contact Request Form, accessible from the [Document Center – VFC Providers](#) at in.gov/health.
3. Complete the form and submit it to the IDOH in one of the following ways:
 - Email to enrollments@isdh.in.gov
 - Fax to 317-233-3719

A representative from the IDOH Immunization Division will contact the provider within five business days after receiving the form to help complete the necessary enrollment paperwork and schedule a time to visit the provider's location.

VFC Eligibility and Tracking

The goal of the VFC program is to help raise childhood immunization levels in the United States by supplying healthcare providers with free vaccines to administer to children 18 years old and younger who meet one or more of the following criteria:

- Enrolled in Medicaid (including children enrolled in Hoosier Healthwise Package C)
- Without health insurance
- Identified by parent or guardian as American Indian or Alaskan native
- Underinsured – for example, children with health insurance that does not cover immunizations

Note: The FSSA, the Children's Health Insurance Program (CHIP) and IDOH worked together to open the VFC program to children in all the IHCP Medicaid, Hoosier Care Connect and Hoosier Healthwise benefit packages.

To screen patients for VFC eligibility, providers may use the *Patient Eligibility Screening Record* form. This form includes a box to indicate whether children are eligible for any form of Medicaid. Providers may use this form or may incorporate it into existing clinical forms.

IHCP Reimbursement for VFC Vaccine Administration

IHCP reimbursement for vaccines supplied through the VFC program is limited to the VFC vaccine administration fee. The VFC vaccine administration fee is a maximum of \$15 (payment is made at whichever is lower – \$15 or the submitted charge).

Providers using VFC-provided vaccines should bill the IHCP for the VFC vaccine administration fee by submitting the claim as follows:

- Appropriate **diagnosis code** in the primary position (and indicated with the diagnosis pointer for the vaccine and administration procedure codes)
 - Z00.121 – *Encounter for routine child health examination with abnormal findings*
 - Z00.129 – *Encounter for routine child health examination without abnormal findings*
- Procedure code of the specific vaccine administered with a billed amount of \$0.00
- Appropriate vaccine **administration procedure code** with the **SL modifier**:
 - 90471 SL – *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
 - 90472 SL – *Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
 - 90473 SL – *Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
 - 90474 SL – *Each additional vaccine by intranasal or oral route (single or combination vaccine/toxoid); VFC vaccine administration*

Note: For a VFC vaccine administered during the course of an office visit, providers may bill the VFC vaccine administration procedure code/modifier combination in addition to the evaluation and management (E/M) procedure code.

When a VFC vaccine is administered by a nurse practitioner employed by physicians in a physician-directed group or clinic, the administration procedure codes should be billed followed by the SA modifier (for example, 90471 SL SA) to identify the service is performed by a nurse practitioner.

For combined vaccines, bill the correct code for the combined vaccine and charge only one vaccine administration fee. The allowed amount for each administration of a VFC vaccine is \$15.

Providers are reminded that reimbursement for a VFC vaccine itself is not appropriate, because providers receive VFC vaccines at no charge. However, to ensure that the vaccine is appropriately included in CHIRP, the provider must bill the appropriate CPT code for the vaccine and a billed amount of \$0.00.

Contact IHCP Customer Assistance toll-free at 800-457-4584 with questions about IHCP fee-for-service billing and reimbursement for VFC vaccine administration. Contact the patient's MCE with questions about VFC vaccine administration and reimbursement under the managed care network.

Third-Party Liability

When VFC vaccine is administered to a child enrolled in Medicaid, and the primary diagnosis is Z00.121 or Z00.129, providers can bill directly to the appropriate IHCP claim-processing unit (Gainwell for fee-for-service claims or the member's MCE for managed care claims) for reimbursement of the administration fee. Providers need not bill the administration fee to the primary insurance company before billing the IHCP. However, after a claim is submitted, the IHCP may seek reimbursement for the administration fee from the primary insurer.

Note: Providers should not experience third-party liability (TPL) claim denials for children enrolled in Hoosier Healthwise Package C. If providers obtain information that identifies a primary insurance for children enrolled in Hoosier Healthwise Package C, they should contact the IHCP TPL Unit at 800-457-4584.

Children and Hoosier Immunization Registry Program

The Children and Hoosier Immunization Registry Program (CHIRP) is a secure, web-based application administered by the IDOH. An immunization registry program is designed to permanently store a person's immunization records in an electronic format. Healthcare providers can use the registry to both review vaccination records for their patients and record all newly administered vaccinations. The state of Indiana mandates use of the registry for certain providers.

Indiana Code IC 16-38-5-2 mandates that all medical providers in the state of Indiana submit complete vaccination records to the state CHIRP registry system within seven business days. This legislation covers all vaccines that are administered to individuals under 19 years of age. For more information about CHIRP, contact the CHIRP helpdesk at 888-227-4439 or chirp@isdh.in.gov.

Reporting Individual Cases of Vaccine Preventable Diseases

Suspected and confirmed cases of most vaccine preventable diseases are reportable to the IDOH using the *Confidential Report of Communicable Diseases* form (State Form 43823) available on the IDOH [Forms](#) page at in.gov/health. The form includes a complete list of reportable diseases and conditions.

The complete revised [Communicable Disease Control Rule](#) is available at in.gov.

Stand-Alone Vaccine Counseling

Stand-alone vaccine counseling refers to when a patient and/or caregiver receives counseling about a vaccine from a healthcare practitioner, but the patient does *not* receive the vaccine dose at the same time as the counseling (for example, because a patient does not consent to receiving the vaccine). If the vaccine *is* delivered during the same visit as the counseling, the provider would bill for the vaccine instead of the counseling.

For members under 21 years of age, vaccine counseling is covered as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service, and must be billed with diagnosis code Z00.121 or Z00.129, and in accordance with all other EPSDT billing guidance. See the [EPSDT Services](#) module for more information.

Coverage and Limitations for Specific Physician-Administered Drugs

The IHCP generally provides coverage for all physician-administered drugs for medically necessary conditions. However, reimbursement is not available to a practitioner for injecting medications that can be self-administered, unless justified by the patient's condition. Possible noncompliance by a recipient to oral medications is insufficient justification to administer injections.

It is the provider's responsibility to ensure the treatment is appropriate based on FDA-approved indications, peer-reviewed journals and standards of practice. The IHCP reserves the right to place diagnosis restrictions on physician-administered drugs when deemed appropriate.

The following sections provide coverage and limitations for certain types of physician-administered drugs and injections. Other modules may include information about physician-administered drugs or injections related to particular types of services or providers, such as the following:

- For information about specific physician-administered ophthalmological drugs, see the [Vision Services](#) module.
- For information about physician-administered oncology drugs, see the [Oncology Services](#) module.
- For information about injections to prevent preterm delivery, see the [Obstetrical and Gynecological Services](#) module.

For information about *pharmacist*-administered injections, see the [Pharmacy Services](#) module.

Aducanumab-avwa (Aduhelm)

Aducanumab-avwa (Aduhelm) is the only FDA-approved monoclonal antibody drug directed against amyloid for the treatment of Alzheimer's disease. For dates of service on or after Jan. 1, 2022, the IHCP covers Aduhelm, billed with HCPCS code J0172 – *Injection, aducanumab-avwa, 2 mg*. Prior authorization is required.

For dates of service on or after April 7, 2022, the IHCP will not reimburse claims for procedure code J0172 for Medicare-eligible members with full Medicaid benefits. Aduhelm reimbursement policy pertains to IHCP-enrolled members with physician-administered drug coverage, but who are not eligible for Medicare.

For IHCP reimbursement, the practitioner performing the injection must be a physician enrolled in the IHCP under one of the following specialties:

- Geriatric Practitioner (provider specialty 320)
- Neurological Surgeon (provider specialty 325)
- Neurologist (provider specialty 326)
- Psychiatrist (provider specialty 339)

Aduhelm prior authorization requests and claims can only be processed through the member's medical benefit, not through the member's pharmacy benefit.

For **initial authorization**, all the following medical necessity criteria must be met:

- Member must be age 50 through 85 years.
- Member must have a diagnosis of Alzheimer's disease as determined by both of the following:
 - One of the following:
 - Presence of amyloid beta plaque levels confirmed by an amyloid-positron emission tomography (PET) scan (CPT code 78814) (documentation required)
 - Presence of amyloid proteins in Cerebral Spinal Fluid (CSF) obtained from a lumbar puncture (documentation required)
 - Mild cognitive impairment or mild dementia, consistent with stages 3 or 4 of Alzheimer's disease, assessed using at least one of the following:
 - A Clinical Dementia Rating (CDR) global score of 0.5
 - A Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score of less than or equal to 85
 - A Mini-Mental State Examination (MMSE) score of greater than or equal to 24
- Baseline magnetic resonance imaging (MRI) of the brain has been obtained within the past year that confirms the following amyloid-related imaging abnormalities (ARIA) parameters (documentation required):
 - No focal areas of superficial siderosis
 - Less than 10 microhemorrhages
 - No brain hemorrhage greater than 1 cm
- Drug is prescribed by, or in consultation with, a neurologist, geriatric psychiatrist or a geriatrician.
- Quantity limit is based upon documented weight relative to the dose schedule.

Exclusion criteria include the following:

- Diagnosed concurrently with another potentially contributory medical, neurological or psychiatric condition
- Stroke or transient ischemic attack (TIA) within the past 12 months or any relevant:
 - Brain hemorrhage
 - Cerebrovascular abnormalities
- Cardiovascular disease
- Bleeding disorders
- Clinically significant hepatic disease
- Clinically significant renal disease
- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection
- Concurrent utilization of an antithrombotic agent other than low-dose aspirin

Prior authorization for continuation of therapy may be requested if subsequent clinical evaluation and brain MRI results demonstrate stabilization. For **reauthorization**, all the following medical necessity criteria must be met:

- Member has a history of requested agent within the past 60 days.
- Prescriber has provided updated documentation of clinical improvement or stabilization when compared to previous CDR global score, RBANS delayed memory index score, or MMSE score.
- Prescriber provides updated brain MRI results (performed prior to seventh and twelfth doses) that demonstrates the following ARIA parameters (documentation required):
 - Less than 10 microhemorrhages
 - Less than or equal to two focal areas of superficial siderosis
- Quantity limit is based upon documented weight.
- For continuation of therapy beyond the first 12 months, provide documentation of decreases (or at a minimum, no increases) in amyloid beta plaque levels, confirmed by an amyloid-PET scan performed after the seventh dose.

Botulinum Toxin

Treatment with botulinum toxin injections provides temporary relief of symptoms and is indicated for use when conventional treatment has failed or in conjunction with physical therapy or other therapeutic techniques. The IHCP provides reimbursement for chemodenervation using botulinum toxins for treating certain neuromuscular conditions, including cervical dystonia, cerebral palsy, multiple sclerosis and other muscular and neurological conditions that cause excessive muscle contractions. The IHCP does not provide reimbursement for botulinum toxins for cosmetic purposes.

Currently, the FDA has approved four types of botulinum toxin injections. Providers should be aware that the potency units of these products are not interchangeable with each other; therefore, units of biological activity of one product cannot be compared to or converted into units of other botulinum toxin products.

Due to the short life of the botulinum toxin products, providers may bill the units injected in a single treatment **and** the units discarded and not used for another patient. The amount of the agent actually administered and the amount discarded should be documented in the patient's medical chart. If a vial is split between two or more members, the provider must bill the amount used for each member and then bill the unused amount as wastage on the claim for the last member injected.

For IHCP reimbursement, providers should bill botulinum toxin injections using the appropriate HCPCS code and must include one of the CPT codes available for billing chemodenervation. In addition, to ensure that the injections are medically necessary, IHCP reimbursement for botulinum toxin injections is limited to specific International Classification of Diseases (ICD) diagnosis codes. Appropriate HCPCS, CPT and ICD codes for botulinum toxin injections are listed in *Injections, Vaccines and Other Physician-Administered Drugs Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

The IHCP limits reimbursement of these injections to one injection every three months, per member, unless an additional injection is medically necessary. The medical record must contain documentation of the medical necessity for additional treatment sessions provided within a three-month period.

Brexanolone (Zulresso)

The IHCP covers brexanolone (Zulresso), billed with HCPCS code J1632 – *Injection, brexanolone, 1 mg*. Prior authorization is required. All the following medical necessity criteria must be met:

- Member must have diagnosis of postpartum depression.
- Request must include confirmation that the member, pharmacy and facility are enrolled in the Zulresso REMS program.
- Request must include name and NPI of the qualified facility and healthcare providers providing and monitoring infusion.

Buprenorphine

The buprenorphine *drug* is covered by the IHCP, but there is no separate code for *administering* the drug.

Reimbursement for buprenorphine procedure codes is limited to certain IHCP provider specialties. The list of eligible specialties is being added to the [Behavioral Health Services](#) module.

Buprenorphine Extended-Release (Sublocade)

IHCP coverage of buprenorphine extended-release (Sublocade) requires prior authorization.

For dates of service on or after Dec. 9, 2022, this agent may be considered medically necessary when all the following criteria are met:

- Member is 18 years of age or older.
- One of the following has occurred:
 - Member has tried and failed each of the preferred agents listed on the pharmacy benefit Preferred Drug List (PDL) (submit chart notes that document failures).
 - Prescriber has provided documentation of member-specific medically justifiable reason(s) that all the pharmacy benefit preferred agents are not suitable for use for this member.
- Initial dose of Sublocade is less than or equal to 300 mg/month.
- Subsequent doses are less than or equal to 100 mg/month.

Sublocade is billed using the following procedure codes:

- Q9991 – *Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg*
- Q9992 – *Injection, buprenorphine extended-release (Sublocade), greater than 100 mg*

Casimersen (Amondys 45)

The IHCP covers casimersen (Amondys 45), billed with HCPCS code J1426 – *Injection, casimersen, 10 mg*. Prior authorization is required.

All the following medical necessity criteria must be met:

- Member must have a documented diagnosis of Duchenne muscular dystrophy (DMD), with confirmed mutation of the DMD gene that is amenable to exon 45 skipping.
- Dosage is 30 mg/kg once weekly; patient weight must be provided to confirm dose.
- Prescriber must provide documentation of current clinical status (for example, Brooke Score, six-minute walk test, and so on) to compare upon reevaluations of therapy.

For dates of service on or after Dec. 9, 2022, for **reauthorization**, documentation must demonstrate improvement (including stabilization) in current clinical status.

Amondys 45 is not used concomitantly with other exon-skipping therapies for DMD.

Crizanlizumab-tmca (Adakveo)

The IHCP covers crizanlizumab-tmca (Adakveo), billed with HCPCS code J0791 – *Injection, crizanlizumab-tmca, 5 mg*. Prior authorization is required.

For dates of service on or after Dec. 9, 2022, all the following medical necessity criteria must be met:

- Member meets the following:
 - Is 16 years or older.
 - Has a diagnosis of a sickle cell disease, including but not limited to homozygous hemoglobin S, sickle hemoglobin C disease, sickle beta 0 thalassemia and sickle beta + thalassemia.
 - Is currently receiving hydroxyurea therapy; or has a history of intolerance or contraindication to hydroxyurea therapy.
 - Has experienced one of the following:
 - At least two sickle cell-related vaso-occlusive crises within the previous 12 months while concurrently receiving hydroxyurea therapy.
 - At least two sickle cell-related vaso-occlusive crises within the previous 12 months and has an intolerance or contraindication to hydroxyurea therapy.
- Adakveo is prescribed by, or in consultation with, a hematologist or other prescriber specialized in the treatment of sickle cell disease.
- Dose is 5 mg/kg IV at week 0, week 2 and every four weeks thereafter; patient weight must be provided to confirm dose.

Eptinezumab-jjmr (Vyepiti)

The IHCP covers eptinezumab-jjmr (Vyepiti), billed with HCPCS code J3032 – *Injection, eptinezumab-jjmr, 1 mg*. Prior authorization is required.

For dates of service on or after Dec. 9, 2022, all the following medical necessity criteria must be met:

- Member meets the following:
 - Is 18 years of age or older.
 - Has a diagnosis of migraine with or without aura requiring prophylaxis.

- All the following have either been tried and failed, or there is documented intolerance or contradiction for their use:
 - Divalproex, valproate, topiramate, metoprolol, propranolol, timolol and tricyclic antidepressant
 - Aimovig
 - Emgality
- Quantity does not exceed 3 mL/90 days.

Eteplirsen (Exondys 51)

Eteplirsen (Exondys 51) is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD). The IHCP covers Exondys 51, billed with HCPCS code J1428 – *Injection, eteplirsen, 10 mg*. Prior authorization is required.

All the following medical necessity criteria must be met:

- Member must have a documented diagnosis of DMD, with confirmed mutation of the DMD gene that is amenable to exon 51 skipping.
- Dosage is 30 mg/kg once weekly; patient weight must be provided to confirm dose.
- Prescriber must provide documentation of current clinical status (for example, Brooke Score, six-minute walk test and so on) to compare upon reevaluations of therapy.

For dates of service on or after Dec. 9, 2022, for **reauthorization**, documentation must demonstrate improvement (including stabilization) in current clinical status.

Evinacumab-dgnb (Evkeeza)

For dates of service on or after Oct. 1, 2021, the IHCP covers evinacumab-dgnb (Evkeeza), billed with HCPCS code J1305 – *Injection, evinacumab-dgnb, 5 mg*. Prior authorization is required.

For **initial authorization**, all the following medical necessity criteria must be met:

- Member has a diagnosis of homozygous familial hypercholesterolemia (HoFH).
- Member is 12 years of age or older.
- Evkeeza is prescribed by, or in consultation with, a cardiologist or endocrinologist.
- One of the following must apply:
 - Trial and failure of alirocumab (Praluent) for patients 18 years of age and older or evolocumab (Repatha) for patients 10 years of age or older
 - Medical rationale for use of Evkeeza over Praluent or Repatha
- There is concurrent use of at least one additional lipid-lowering therapy.
- Dose does not exceed 15 mg/kg every four weeks.

For **reauthorization**, all the following medical necessity criteria must be met:

- Member has history of Evkeeza within the past 90 days.
- Dose does not exceed 15 mg/kg every four weeks.
- Reduction in LDL-C from baseline **or** maintenance of goal LDL-C is made.

Golodirsen (Vyondys 53)

The IHCP covers golodirsen (Vyondys 53), billed with HCPCS code J1429 – *Injection, golodirsen, 10 mg*. Prior authorization is required.

For dates of service on or after Dec. 9, 2022, all the following medical necessity criteria must be met:

- Member must have a documented diagnosis of DMD with confirmed mutation of the DMD gene that is amenable to exon 53 skipping.
- Dosage is 30mg/kg once weekly; patient weight must be provided to confirm dose.
- Prescriber has validated that member is not currently experiencing renal toxicity.
- Prescriber must provide documentation of current clinical status (for example, Brooke Score, six-minute walk test and so on) to compare upon reevaluations of therapy.

For **reauthorization**, documentation must demonstrate improvement (including stabilization) in current clinical status.

Histrelin Implant (Supprelin LA)

Supprelin LA implant is approved by the FDA for the treatment of central precocious puberty (CPP). Children with CPP have an early onset of secondary sexual characteristics before age 8 in females and age 9 in males. They also show significantly advanced bone age that can result in diminished adult height attainment.

The IHCP covers Supprelin LA, billed with HCPCS code J9226 – *Histrelin implant (Supprelin LA), 50 mg*. For dates of service on or after Dec. 9, 2022, the IHCP does not restrict reimbursement for this drug to a specific diagnosis code. For prior dates of service, reimbursement for Supprelin LA was available only when billed in conjunction with ICD-10 diagnosis code E30.1 – *Precocious puberty*.

Supprelin LA implant is designed to deliver approximately 65 mcg of histrelin per day over 12 months. The recommended dose of histrelin is one 50 mg implant inserted subcutaneously for 12 months. The implant must be removed 12 months after insertion. At the time the implant is removed, another implant may be inserted to continue therapy.

Histrelin Implant (Vantas)

Vantas is a subcutaneous drug-delivery system that contains the medicine histrelin. After it is placed under the skin, Vantas delivers histrelin continuously for 12 months. Vantas is a sterile, nonbiodegradable, diffusion-controlled Hydron polymer reservoir containing histrelin acetate, a synthetic nonapeptide analog of the naturally occurring gonadotropin-releasing hormone (GnRH), also known as luteinizing hormone-releasing hormone (LHRH), possessing a greater potency than the natural sequence hormone. Vantas is used to help relieve the symptoms of advanced prostate cancer; it is not a cure.

The IHCP covers Vantas, billed with HCPCS code J9225 – *Histrelin implant (Vantas), 50 mg*.

For dates of service on or after Dec. 9, 2022, prior authorization is required for J9225. The IHCP considers this agent medically necessary when all the following criteria are met:

- Member meets the following:
 - Is 18 years of age or older.
 - Has a medical need for the implant (such as mobility or compliance issues, or inability to receive daily injections).
 - Has not had a bilateral orchiectomy.
- Submitted documentation shows a diagnosis of cancer of the prostate.

For **reauthorization**, a demonstrated response to luteinizing hormone-releasing hormone (LHRH) agonists has been confirmed by periodic measurement of testosterone and prostate-specific antigen (PSA) levels.

Note: For dates of service prior to Dec. 9, 2022, the IHCP covered J9225 only when billed in conjunction with one of the following ICD-10 diagnosis codes:

- *C61 – Malignant neoplasm of prostate*
- *Z85.46 – Personal history of malignant neoplasm of prostate*
- *R97.21 – Rising PSA following treatment for malignant neoplasm of prostate*

Vantas is designed to deliver approximately 50 mcg histrelin per day over 12 months. The recommended dose of histrelin is one 50 mg implant inserted subcutaneously for 12 months. The implant must be removed 12 months after insertion. At the time the implant is removed, another implant may be inserted to continue therapy. J9225 is limited to one unit per member per 12 months.

Joint Injections

The IHCP limits joint injections to four injections per joint site, per provider, per month. Claims submitted for more than three injections per joint site in a one-month period must have supporting documentation attached to indicate the medical necessity of the fourth injection per joint site. Additionally, providers billing for more than four joint injections per provider in a one-month period must have supporting documentation to indicate that the injections involve different joint sites and that no more than four injections were administered to a single joint.

Leuprolide Acetate (Fensolvi)

The IHCP covers leuprolide acetate (Fensolvi), billed with HCPCS code J1951 – *Injection, leuprolide acetate for depot suspension (Fensolvi), 0.25 mg*. For dates of service on or after Dec. 9, 2022, the IHCP does not restrict reimbursement for this drug to a specific diagnosis code. For prior dates of service, reimbursement for Fensolvi was available only when billed in conjunction with diagnosis code E30.1 – *Precocious puberty*.

Nusinersen (Spinraza)

Nusinersen (Spinraza) is an intrathecal medication for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.

The IHCP covers Spinraza, billed with HCPCS code J2326 – *Injection, nusinersen, 0.1 mg*. Prior authorization is required.

For dates of service on or after Dec. 9, 2022, this agent may be considered medically necessary for the treatment of SMA in members who meet both criteria A and B:

- *Criteria A: Documentation of a confirmatory SMA diagnosis by one of the following:*
 - SMA diagnostic test results confirming zero copies of the SMN1 gene
 - Molecular genetic testing of 5q SMA for any of the following:
 - Homozygous gene deletion
 - Homozygous conversion mutation
 - Compound heterozygote

- *Criteria B:* Documentation of one of the following:
 - Genetic testing confirming no more than three copies of the SMN2 gene

Note: If the member has more than three copies of SMN2, but has point mutations on SMN2 exon 7, treatment would be considered medically necessary.

- SMA-associated symptoms before 6 months of age

Continuation of treatment with Spinraza beyond six months after the initiation of therapy, and every four months thereafter, is considered medically necessary for the treatment of SMA both of the following criteria are met:

- Initial therapy was determined to meet the preceding criteria (A and B).
- Submitted documentation shows clinically significant improvement in SMA-associated symptoms (for example, progression, stabilization or decrease in the rate of decline in motor function) compared to the predicted natural history trajectory of the disease.

Spinraza is not considered medically necessary when used under the following treatment scenarios:

- Post onasemnogene abeparvovec-xioi treatment
- Concurrently with risdiplam

Onasemnogene Abeparvovec-xioi (Zolgensma)

Onasemnogene abeparvovec-xioi (Zolgensma), is a U.S. FDA-approved drug treatment for spinal muscular atrophy (SMA). The IHCP covers physician-administered Zolgensma, billed with HCPCS code J3399 – *Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10¹⁵ vector genomes*. Prior authorization is required.

Zolgensma prior authorization requests and claims can only be processed through the member's medical benefit, not through the member's pharmacy benefit.

Effective March 3, 2022, providers need to follow the standard PA submission process when requesting prior authorization for J3399. PA documents should no longer be submitted to the FSSA via email as previously required.

For dates of service on or after Aug. 1, 2022, all the following medical necessity criteria must be met:

- Have documentation of genetic testing confirming SMA resulting from bi-allelic mutations in the survival motor neuron 1 (SMN1) gene
- Have no more than three copies of SMN2 or displaying clinical symptoms of SMA
- Have documentation demonstrating negative presence of anti-AAV9 antibodies
- Have a gestational age of at least 37 weeks
- Be less than 2 years of age
- Have been prescribed Zolgensma treatment by, or in consultation with, a pediatric neurologist or child neurologist
- Have had no previous Zolgensma treatment
- Have a life expectancy of at least 12 months following treatment

- Have no evidence of advanced SMA, such as one or more of the following:
 - Complete paralysis of limbs
 - Permanent ventilator dependence, defined as:
 - Requires invasive ventilation (tracheostomy with positive pressure)
 - Respiratory assistance (including noninvasive ventilator support) for at least 16 hours per day, for at least 14 days (excluding acute, reversible illness or perioperative ventilation)

Note: The prescriber must provide documentation of current clinical status (for example, Brooke Score, six-minute walk test and so on) to compare upon reevaluations of therapy.

Pegloticase (Krystexxa)

Pegloticase (Krystexxa) is an intravenous medication that breaks down uric acid. It is used for the treatment of chronic gout. IHCP reimbursement is available only when administered in a physician's office, consistent with IHCP policy concerning reimbursement for injectable pharmaceutical products.

The IHCP covers Krystexxa, billed with HCPCS code J2507 – *Injection, pegloticase, 1 mg*. Prior authorization is required. For dates of service on or after Dec. 9, 2022, this agent may be considered medically necessary in patients with gout when criteria A, B and C are met:

- *Criteria A* – Symptomatic gout with one or more of the following:
 - Three gouty flares or more in previous 18 months
 - Presence of one or more tophi
 - Chronic gouty arthritis
- *Criteria B* – Serum uric acid level
 - Serum uric acid level greater than 8 mg/dL at initiation
 - Serum uric acid levels do not exceed 6 mg/dL for continuation of therapy
- *Criteria C* – Treatment with oral xanthine oxidase inhibitors with one of the following:
 - A 90-day course of each of two xanthine oxidase inhibitor alternatives (such as allopurinol and febuxostat) is ineffective in normalizing serum uric acid levels to less than 6 mg/dL.
 - Intolerance to two xanthine oxidase inhibitor alternatives (such as allopurinol and febuxostat) occurs.
 - Use of two xanthine oxidase inhibitor alternatives (such as allopurinol and febuxostat) is contraindicated.

Note: Xanthine oxidase inhibitors should be discontinued prior to initiating Krystexxa.

Krystexxa is considered investigational when used for all other conditions, including but not limited to hyperuricemia not associated with gout and asymptomatic hyperuricemia.

When prior authorization is approved, Krystexxa may be authorized in quantities of one 8 mg infusion every two weeks, not to exceed 26 infusions in one year.

Romozumab-aqqg (Evenity)

The IHCP covers romozumab-aqqg (Evenity), billed with HCPCS code J3111 – *Injection, romosozumab-aqqg, 1 mg*. Prior authorization is required.

For dates of service on or after Dec. 9, 2022, this agent may be considered medically necessary when the member meets all the following criteria:

- Is 18 years of age or older
- Is postmenopausal woman with osteoporosis
- Has high risk for bone fracture
- Has history of failure, contraindication or intolerance to oral or intravenous bisphosphonate therapy
- Has no myocardial infraction or stroke in the previous year
- Has no uncorrected hypocalcemia
- Has no osteonecrosis of the jaw

Coverage is limited to a one-year duration of therapy over the course of the member's lifetime.

Vitamin B12 Injections

The IHCP limits vitamin B12 injections to one per 30 days per member.