COVID-19 UPDATE
Please refer to this link: Important Updates Regarding Coronavirus COVID-19, for authorization and coding guidelines related to the COVID-19 Pandemic.

I. Out of Network: There are no OON benefits. However for any medically necessary service not available in network, authorization will be provided

II. Inpatient Admissions: All inpatient admissions require an authorization.
Fidelis Care does not require authorization of emergency room services or any emergent service required to provide stabilization of an emergent condition. Fidelis Care does require authorization of post stabilization services and inpatient admissions after emergency room services are completed. All facility admissions are reviewed for medical necessity.

A. All acute inpatient facility services

B. Inpatient Rehabilitation Services: (acute, sub-acute and skilled nursing rehabilitation) require prior authorization.
   1. Medical rehabilitation can be completed at an acute or sub-acute level of care.

C. Transplants:
All solid organ and bone marrow / tissue transplants require authorization at the time of the transplant evaluation.
Includes but not limited to: 32850-32856, 33930-33945, 38204-38215, 38230-38242, 44133-44136, 47133-47147, 48160, 48550-48556, 50300-50380, 50547, 65710-65757.

D. Breast Cancer Surgery Centers:
Fidelis Care members must receive mastectomy and lumpectomy procedure associated with a breast cancer diagnosis, at high volume facilities. This link provides information regarding New York State policies.

E. OASAS Licensed Inpatient Substance Use Disorder Treatment:
Effective 01/01/2020: Inpatient detoxification, inpatient rehabilitation and inpatient residential treatment services (Inpatient SUD) provided by facilities in New York State that are licensed, certified or otherwise authorized by OASAS and participating in Fidelis Care’s provider network are not subject to prior authorization review by Fidelis Care. In addition, Inpatient SUD services are not subject to concurrent utilization review during the first twenty-eight (28) days of the inpatient admission,
provided that the facility notifies Fidelis Care of the inpatient admission and the initial treatment plan within two (2) business days of the admission. The facility may fax or email the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or LOCADTR@fideliscare.org. All Inpatient SUD services require facilities to perform daily clinical review of the patient. This does not require a facility to conduct a LOCADTR concurrent review module every day. In addition, all Inpatient SUD facilities must periodically consult with Fidelis Care starting on or just prior to the fourteenth (14th) day of treatment to ensure that the facilities are using the LOCADTR tool to ensure that the inpatient treatment is medically necessary for the patient. Inpatient SUD services may be subject to utilization review after the 28th day from admission or upon discharge using the LOCADTR clinical review tool. Prior to the member’s discharge, facilities must provide the member and Fidelis Care with a written discharge plan as determined using the LOCADTR clinical review tool. Further, prior to discharge, facilities must indicate to Fidelis Care whether the services included in the discharge plan are secured or determined to be reasonably available. All services may be reviewed retrospectively to assess the clinical necessity of the care.

Facilities that are outside of New York State, facilities that are not licensed, certified or otherwise authorized by OASAS, and facilities that are outside of Fidelis Care’s provider network, continue to be required to request prior authorization review for Inpatient SUD services. All Inpatient SUD services provided by such facilities are subject to concurrent review throughout the admission.

Providers with questions regarding these changes are encouraged to call Fidelis Care, during regular business hours, at 1-888-FIDELIS (1-888-343-3547), extension 16072 for Behavioral Health.

Effective January 1, 2020, Fidelis Care does not require provider notification, prior authorization, or concurrent authorization review of the following in-network and in-state outpatient substance use services:

- Outpatient office visits, therapy visits, or counseling visits
- Outpatient clinic visits for substance use disorder treatment
- Intensive outpatient treatment programs
- Outpatient rehabilitation treatment
- Opioid Treatment Programs

Out-of-state or out-of-network providers will continue to be required to request authorization for these services. Fidelis Care will utilize quality and case management oversight initiatives to manage outlier member needs. Providers interested in more detail on this can refer to our message post Behavioral Health Outliers Management Program.

**F. Elective Surgical Procedures:**
Many surgical and medical procedures which are completed within 24 hours will not be approved at an in-patient level of care. These same services when billed as an out-patient level of care do not require authorization if performed within the Fidelis Care network. Such procedures include, but are not limited to, laparoscopic procedures, and thyroid surgery if completed within 24 hours from the onset of surgery. The link provides a list of inpatient only procedures.
List of inpatient only procedures

G. Orthopedic Surgical Procedures and Spinal Surgical Procedures, performed in both inpatient and outpatient settings, require prior authorization for dates of service beginning 10/1/2019. Effective for dates of service rendered on or after 12/23/19, prior authorization has been delegated to TurningPoint Healthcare Solutions, LLC. For a list of codes requiring prior authorization, click here.

H. OMH Licensed Inpatient Mental Health Treatment
Effective 01/01/2020: Inpatient mental health treatment for members under age 18 provided by OMH licensed hospitals in New York State that are participating in Fidelis Care’s provider network are not subject to prior authorization review by Fidelis Care. Fidelis Care will not conduct concurrent utilization review during the first 14 days of inpatient admissions provided that the facility: i) notifies Fidelis Care of both the admission and the initial treatment plan within two business days of the admission by completing the OMH developed “Two-Day Notification and Initial Treatment Plan” form and submitting it to Fidelis Care by fax (718-896-1784), or by email to Mental_Health_Admission@fideliscare.org; ii) performs daily clinical review of the patient, and iii) participates in periodic consultation with Fidelis Care to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by Fidelis Care which is approved by OMH and appropriate to the age of the patient to ensure medical necessity. All services may be reviewed retrospectively using the clinical review criteria of the plan which is approved by the office of mental health.

Inpatient mental health services provided to members age 18 and older require prior authorization review by Fidelis Care and are subject to concurrent review throughout the admission. Out-of-State and Out-of-Network providers continue to be required to request prior authorization review for inpatient mental health treatment for members of all ages. All inpatient mental health services provided by such facilities are subject to concurrent review throughout the admission. Providers with questions regarding these changes are encouraged to call Fidelis Care, during regular business hours, at 1-888-FIDELIS (1-888-343-3547), extension 16072 for Behavioral Health.

III. Outpatient surgery: The following services require prior authorization:
A. Bariatric surgery: 43770-43775, S2083
B. Blepharoplasty: 15820-15823
C. Breast reconstruction: 11920-11971, 19300, 19316-19342, 19355, 19370-19396
D. Skin surgery and other dermatological procedures:
   There is no auth requirement for many skin surgery treatments and repairs when performed in the office or outpatient facility (POS 11 and 22). The following codes require authorization if completed as ambulatory surgery (POS 24): 10040, 11300-11313, 11400-11471, 11721
   Only the following codes require authorization for any place of service: 11200-11201, 11719, 15769-15829, 17340-17999
E. Services for the following codes performed in freestanding ambulatory surgery centers billing with bill type 0831 require an authorization (10060, 11100, 11900 and 17000, 20600, 20605, and 20610). Note: CPT code 20610 is non-covered when billed with one of the following diagnosis codes: M17.0, M17.10-M17.12, M17.2, M17.20-M17.32, M17.4, M17.5, M17.9
F. Ear repair and ear piercing: 69300 and 69090
G. Eyelid & ocular surgery: 65760-65771, 65772-65775, 66987–66988, 67900-67911
H. Abdominoplasty, lipectomy, panniculectomy: 15830-15839, 15847, 15876-15879
I. Reduction mammoplasty: 19300, 19318
J. Facial cosmetic, septrhplasty, rhinoplasty: 21120-21296, 30400-30450, 30460, 30465-
30520, 30620-30802, 30999, 31298, C9749, Q2028
K. Vascular procedures i.e. vein stripping, ligation, ablation and sclerotherapy: 36465-
36466, 36468-36469, 36482-36483, 37718-37785, and 37241-37244.
L. Spinal Surgery: 20932, 20933, 20934, 22867-22870, 62380.
M. Esophageal sphincter augmentation: 43284
O. Certain outpatient orthopedic and spinal surgical procedures require prior authorization
for dates of service beginning 10/1/2019. Effective for dates of service rendered on or after 12/23/19, prior authorization has been delegated to TurningPoint Healthcare Solutions, LLC. Refer to Section II – item # G above. For a list of codes requiring prior authorization, click here.

IV. Behavioral Health - Outpatient services
A. Psychological/Neuropsychological Testing:
   96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146.
   Authorization is required: All requests should be submitted on the Psychological/Neuropsychological testing request form.
B. Developmental Pediatric Testing:
   96112, 96113. Authorization is required. Note: 96110 is a non-covered service.
C. Outpatient ECT:
   90870
D. Partial Hospitalization (Mental Health)
   Revenue code 912, 913, 944, and 945; HCPCS code H0035
E. Intensive Outpatient Treatment
   Revenue code 905 or 912, CPT code 90899, S9480, HCPCS code H2013
F. Autism Spectrum Disorder (ASD):
   The State has expanded benefits for members with ASD to include increased case management services, certain DME items to assist speech performance, and Applied Behavior Analysis (ABA), a form of enhanced behavioral modification.
   1. Authorization is required for DME speech generation equipment.
   2. Authorization is required from Behavioral Health for Applied Behavior Analysis.
   3. Attestation of the diagnosis of ASD must be provided, at the time of request, by a licensed physician or psychologist.
G. Residential Treatment
   CPT codes: 1001 and 1002 residential treatment
   HCPCS codes: H0017-H0019, H2036

V. Outpatient and DME Services: The following services require prior authorization:
A. Diagnostic testing
   1. Sleep Studies, including Home Sleep Studies
   2. Breast Cancer testing (BRCA) and other Genetic Testing (Note: Authorization is not required for CPT 81220, 81329 and 81336. CPT 81220 has a lifetime limit of 1. CPT 81329 and 81336 have a combined limit of 1 per lifetime.)
   3. Wireless Capsule Endoscopy 91110 – 91111
   4. Gastroenterology Procedures – The following procedures require authorization if performed in POS 19 and 22 when there is an office-based or ambulatory surgery center available to provide the service: 43235, 43239, 43248, 45378, 45380,
Metal-Level Products

45384, 45385, 46255, 46260, and 46270. Authorization is not required for these services when performed in POS 11 or 24.

B. Durable Medical Equipment/Supplies:
1. Orthotics are not covered
2. These DME codes that do not require an authorization:
3. Other DME codes require an authorization.
4. Supplies requiring authorization:
   a. Compression garments/compression gradient stockings
   b. Electric breast pumps
   c. Electric heat pads and hot water bottles
   d. Surgical stockings
   e. Protective helmets
   f. Wigs
   g. Insulin pumps
   h. Insulin infusion pumps

C. Home Health Care: Home care approvals are based on the medical need for skilled services. The benefit maximum is 40 visits per plan year.

D. Hospice Care: Hospice care must be provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. When medically necessary, coverage is available for up to 210 days.

E. Imaging Studies: The following services require authorization:
1. The first 4 OB ultrasounds for a normal pregnancy can be performed without an authorization. Five or more ultrasounds for a normal pregnancy (dx code Z32.01, Z33.1, Z34.00-Z34.03, Z34.80-Z34.83, Z34.9-Z34.93) require authorization. OB ultrasounds for a high risk pregnancy (dx code O09.00-O09.03, O09.1-O09.2, O09.11-009.12, O09.21-O09.22, O09.219, O09.291-O09.293-O09.299-O09.299-O09.33, O09.40-O09.43, O09.511-O09.513, O09.519, O09.521-O09.523, O09.529, O09.611-O09.613, O09.619, O09.621-O09.623, O09.629, O09.70-O09.73, O09.811-O09.813, O09.819, O09.821-O09.823, O09.829, O09.891-O09.893, O09.899-O09.93, O36.80X0-O36.80X9, O36.80X9) do not require authorization.
2. Radiology services require prior authorization through eviCore healthcare. A full list of CPT codes can be found at https://www.evicore.com/healthplan/fideliscare.

F. Effective 10/1/2019, Outpatient Therapy, including services rendered in the home: Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST): all services performed by a therapy provider after the initial evaluation will require prior authorization through National Imaging Associates (NIA). (Excludes PT, OT, ST performed in an Inpatient setting, Emergency Room, Skilled Nursing Facility, or during an Observation stay.)

Services rendered on or after 10/1/2019, require prior authorization*
*PT, OT, and ST initial evaluations do not require a prior authorization. However, all other billed procedure codes, even if performed on the same date as the initial evaluation date, will require authorization prior to billing.

**Non-Therapy Providers** (MD, DO, DPM, etc.) should request prior authorization for all services after the initial evaluation directly through Fidelis Care.

1. **Rehabilitation**: The benefit is limited to 60 visits per condition per plan year. The visit limit applies to all therapies combined.

2. **Habilitation**: The benefit is limited to 60 visits per condition per plan year. The visit limit applies to all therapies combined.

**G. Podiatry Services:**
Authorization is not required for podiatric services rendered to members with a confirmed diagnosis of Diabetes Mellitus. The Diabetes diagnosis must be included on the claim when services are billed. Podiatric services to members without a diagnosis of diabetes will continue to require authorization. Podiatrists will continue to require authorization for all DME codes that are supplied in the office, regardless of member diagnosis. Routine foot care for non-diabetics is not covered.

**H. Therapeutic Services:**
1. Phototherapy (96567, 96573-96574, 96900, 96910, 96912, 96913, 96920)

2. Hyperbaric Oxygen Therapy (99183 and C1300)

3. Pain Management Codes (i.e. injections, TENS, therapeutic services):
   - 20526, 20550-20553, 21073, 27096, 62263-62264, 62273, 62280-62282, 62290, 62310-62311, 62318-62319, 62320-62327, 62370, 64400-64530, 64553-64595, 64600-64640, C1823, C9752, C9753. (for non-orthopedists only).

4. The following services are not covered for members with a diagnosis of Low Back Pain:
   
   a. Prolotherapy;
   
   b. Therapeutic facet joint steroid injections in the lumbar and sacral regions with or without CT fluoroscopic image guidance;
   
   c. Therapeutic injections of steroids into intervertebral discs; and
   
   d. Continuous or intermittent traction.


6. Radiation Therapy services require prior authorization through eviCore healthcare. A full list of CPT codes can be found at [https://www.evicore.com/healthplan/fideliscare](https://www.evicore.com/healthplan/fideliscare).


**I. Chiropractic Services:**
The following codes require prior authorization: 98940-98943, rev code 0940.

**J. Telehealth**
Authorization is required for G2010 and G2012.

**VI. Counseling Services**
A. Diabetes Self-Management Training (DSMT)
Members are allowed 10 hours/20 units in a continuous 12-month period. These services must be provided by certified providers and no longer require authorization. Services are covered when billed with codes G0108 and G0109.

VII. New Technology/Experimental Treatment: Prior authorization is required and based on medical necessity.

VIII. Services provided by outside vendors
A. Orthodontic and Major Dental services require prior authorization by DentaQuest 1-800-516-9615.
B. Vision: Prior authorizations by Davis Vision 1-800-601-3383
C. Transportation: Non-emergency ambulance transportation by a licensed provider may be covered between Facilities when the transport is any of the following:
   - From a Non-Participating Hospital to a Participating Hospital
   - To a Hospital that provides a higher level of care that was not available at the original Hospital.
   - To a more cost-effective acute care Facility.
   - From an acute Facility to a sub-acute setting.

IX. Pharmacy
For monthly updates to the formulary please check the website at: 
https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services

A. Enteral Therapy-HCPCS codes B4034-B4162 describe the available enteral formulas or disposable items that require authorization.
   Benefit applies to:
   1. Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
   2. Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn’s disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies

B. Self-administered medications are covered under the pharmacy benefit. Self-administered medications are medications that are typically administered by a patient or caregiver, safely and effectively, without medical supervision or direct observation.

C. These codes require authorization (with the exception of B4088). Please submit prior authorization requests to our Pharmacy Team electronically via fax (e-fax) to: 1-877-533-2405.
<table>
<thead>
<tr>
<th>J7179</th>
<th>vWF recombinant (Vonvendi)</th>
<th>J7312</th>
<th>dexamethasone intravitreal implant (Ozurdex)</th>
<th>J7642</th>
<th>glycopyrrolate inh</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7180</td>
<td>factor XIII human (Corifact)</td>
<td>J7313</td>
<td>fluocinolone acetonide, intravitreal implant (Iluvien)</td>
<td>J7643</td>
<td>glycopyrrolate inh</td>
</tr>
<tr>
<td>J7181</td>
<td>factor XIII A-subunit recombinant (Tretten)</td>
<td>J7314</td>
<td>fluocinolone acetonide, intravitreal implant (Yutiq)</td>
<td>J7659</td>
<td>isoproterenol inh</td>
</tr>
<tr>
<td>J7182</td>
<td>factor VIII recombinant (NovoEight)</td>
<td>J7318</td>
<td>hyaluronan (Durolane)</td>
<td>J7677</td>
<td>revafenac inh</td>
</tr>
<tr>
<td>J7183</td>
<td>vWF human (Wilate)</td>
<td>J7320</td>
<td>hyaluronan (Genvisc)</td>
<td>J7680</td>
<td>terbutaline inh</td>
</tr>
<tr>
<td>J7185</td>
<td>factor VIII recombinant (Xyntha)</td>
<td>J7321</td>
<td>hyaluronan (Hyalgan, Supartiz, Visco-3)</td>
<td>J7681</td>
<td>terbutaline inh</td>
</tr>
<tr>
<td>J7186</td>
<td>VIII/WVF complex human (Alphanate)</td>
<td>J7322</td>
<td>hyaluronan (Hymovis)</td>
<td>J7683</td>
<td>triamcinolone inh</td>
</tr>
<tr>
<td>J7187</td>
<td>vWF complex (Humate-P)</td>
<td>J7323</td>
<td>hyaluronan (Euflexa)</td>
<td>J7684</td>
<td>triamcinolone inh</td>
</tr>
<tr>
<td>J7188</td>
<td>factor VIII recombinant (Obizur)</td>
<td>J7324</td>
<td>hyaluronan (Orthovisc)</td>
<td>J7685</td>
<td>tobramycin inh</td>
</tr>
<tr>
<td>J7189</td>
<td>factor VIIa recombinant (Novoseven)</td>
<td>J7325</td>
<td>hyaluronan (Synvisc, Synvisc-One)</td>
<td>J7686</td>
<td>treprostinil (Tyvaso)</td>
</tr>
<tr>
<td>J7190</td>
<td>factor VIII anti-hemophilic human (Hemofil M, Koate-DVI, Monoclate-P)</td>
<td>J7326</td>
<td>hyaluronan (Gel-One)</td>
<td>J7999</td>
<td>misc compounded drug</td>
</tr>
<tr>
<td>J7191</td>
<td>factor VIII anti-hemophilic factor [porcine]</td>
<td>J7327</td>
<td>hyaluronan (Monovisc)</td>
<td>J8499</td>
<td>rx drug oral non-chemo</td>
</tr>
<tr>
<td>J7192</td>
<td>factor VII recombinant (NovoSeven)</td>
<td>J7328</td>
<td>hyaluronan (Gelsyn)</td>
<td>J8510</td>
<td>busulfan (Myleran)</td>
</tr>
<tr>
<td>J7193</td>
<td>factor IX non-recomb (AlphaNine/Mononine)</td>
<td>J7329</td>
<td>hyaluronan (Trivisc)</td>
<td>J8515</td>
<td>cabergoline</td>
</tr>
<tr>
<td>J7194</td>
<td>factor IX complex (Bebulin, Profilnine)</td>
<td>J7331</td>
<td>hyaluronan (Synojoynt)</td>
<td>J8520</td>
<td>capcitabine 150 mg</td>
</tr>
<tr>
<td>J7195</td>
<td>factor IX recombinant (Ixinity/Benefit)</td>
<td>J7332</td>
<td>hyaluronan (Triluron)</td>
<td>J8521</td>
<td>capecitabine 500mg</td>
</tr>
<tr>
<td>J7196</td>
<td>antithrombin (Aryn)</td>
<td>J7336</td>
<td>capsaicin 8% patch</td>
<td>J8560</td>
<td>etoposide (Vepesid)</td>
</tr>
<tr>
<td>J7197</td>
<td>antithrombin (Thrombate III)</td>
<td>J7342</td>
<td>ciprofloxacan otic (Otipiro)</td>
<td>J8562</td>
<td>fludarabine</td>
</tr>
<tr>
<td>J7198</td>
<td>anti-inhibitor (Feiba)</td>
<td>J7401</td>
<td>Mometasone furoate implant (Sinuva)</td>
<td>J8597</td>
<td>antiemetic oral</td>
</tr>
<tr>
<td>J7199</td>
<td>hemophilia Clot Factor Noc</td>
<td>J7504</td>
<td>anti-thymocyte glob equine</td>
<td>J8600</td>
<td>melphalan (Alkeran)</td>
</tr>
<tr>
<td>J7200</td>
<td>factor IX recombinant (Rixubis)</td>
<td>J7515</td>
<td>cyclosporine 25mg oral</td>
<td>J8650</td>
<td>nabline (Cesamet)</td>
</tr>
<tr>
<td>J7201</td>
<td>factor IX FC fusion recom (Alprolix)</td>
<td>J7516</td>
<td>cyclosporine 250mg inj</td>
<td>J8655</td>
<td>netupitant palonosetron 300/0.5mg (Akyzone)</td>
</tr>
<tr>
<td>J7202</td>
<td>factor IX album fusion recom (Idelvion)</td>
<td>J7517</td>
<td>mycophenolate mofetil 250mg (Cellcept)</td>
<td>J8700</td>
<td>temozolomide (Temodar)</td>
</tr>
<tr>
<td>J7203</td>
<td>factor IX recombinant glycopegylated (Rebiny)</td>
<td>J7518</td>
<td>mycophenolic acid 180 mg (Myfortic)</td>
<td>J8999</td>
<td>rx oral chemo</td>
</tr>
<tr>
<td>J7204</td>
<td>factor VIII recombinant (Adynovate)</td>
<td>J7520</td>
<td>sirolimus (Rapamune)</td>
<td>J9022</td>
<td>atezolizumab (Tecentriq)</td>
</tr>
<tr>
<td>J7205</td>
<td>factor VIII V/Fc fusion protein recombinant (Eloctate)</td>
<td>J7525</td>
<td>tacrolimus 5mg (Prograf)</td>
<td>J9023</td>
<td>avelumab (Bavencio)</td>
</tr>
<tr>
<td>J7207</td>
<td>factor VIII recombinant pegyl (Adynovate)</td>
<td>J7527</td>
<td>everolimus 0.25mg</td>
<td>J9042</td>
<td>brentuximab (Adcetris)</td>
</tr>
<tr>
<td>J7208</td>
<td>factor VIII recombinant pegyl (Jivi)</td>
<td>J7599</td>
<td>immunosuppress Drug Noc</td>
<td>J9057</td>
<td>copanlisib (Aliqopa)</td>
</tr>
<tr>
<td>J7209</td>
<td>factor VIII recombinant (Nuiq)</td>
<td>J7607</td>
<td>levalbuterol comp con</td>
<td>J9118</td>
<td>calaspargase pegol-mknl (Asparlas)</td>
</tr>
<tr>
<td>J7210</td>
<td>factor VIII recombinant (Afstyla)</td>
<td>J7609</td>
<td>albuterol comp DME</td>
<td>J9119</td>
<td>cemiplimab-rwlc (Libtayo)</td>
</tr>
<tr>
<td>J7211</td>
<td>factor VIII recombinant (Kovaltry)</td>
<td>J7610</td>
<td>albuterol comp</td>
<td>J9173</td>
<td>durvalumab Imfinzi</td>
</tr>
<tr>
<td>J7308</td>
<td>aminolev acid top (Levulan)</td>
<td>J7622</td>
<td>beclomethasone inh, comp</td>
<td>J9203</td>
<td>gentuzumab (Mylotarg)</td>
</tr>
<tr>
<td>J7309</td>
<td>methyl aminolevulinate top</td>
<td>J7624</td>
<td>bethamethasone inh</td>
<td>J9204</td>
<td>morganulizumab-kp (Poteligio)</td>
</tr>
<tr>
<td>J7311</td>
<td>fluocinolone acetonide, intravitreal implant (Retisert)</td>
<td>J7626</td>
<td>budesonide (Pulmicort)</td>
<td>J9210</td>
<td>emapalumab (Gamifant)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7629</td>
<td>budesonide inh</td>
<td>J9216</td>
<td>interferon gamma 1b</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7631</td>
<td>budesonide inhalation</td>
<td>J9217</td>
<td>leuprolide depot 7.5mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7633</td>
<td>budesonide inh comp</td>
<td>J9225</td>
<td>histrelin imp (Vantas)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7634</td>
<td>budesonide comp con</td>
<td>J9226</td>
<td>histrelin imp (Supprelin LA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7635</td>
<td>atropine inh</td>
<td>J9228</td>
<td>ipilimumab (Yervoy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7636</td>
<td>atropine inh</td>
<td>J9229</td>
<td>inotuzumab ozo (Besponsa)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7637</td>
<td>dexamethasone inh</td>
<td>J9269</td>
<td>tagraxofusp (Elzonris)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7638</td>
<td>dexamethasone inh UD</td>
<td>J9271</td>
<td>pembrolizumab (Keytruda)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7639</td>
<td>dornase alfa (Pulmozyme)</td>
<td>J9299</td>
<td>nivolumab (Opdivo)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J7641</td>
<td>flunisolide inh</td>
<td>J9302</td>
<td>ofatumumab (Arzerra)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>J9311</td>
<td>rituximab hyaluronidase (Rituxan Hycela)*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>J9312</td>
<td>rituximab (Rituxan)*</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Code</td>
<td>Description</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------</td>
<td>-------</td>
<td>------------------------------------------</td>
<td>-------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>J9313</td>
<td>moxetumomab pasudotox-tdfk (Lumoxiti)</td>
<td>Q3028</td>
<td>interferon beta-1a, SC (Rebif)</td>
<td>Q5109</td>
<td>infliximab-qbtx Ixifi)</td>
</tr>
<tr>
<td>J9999</td>
<td>misc chemo</td>
<td>Q4081</td>
<td>epoetin alfa ESRD (Epogen, Procrit)</td>
<td>S0122</td>
<td>menotropins</td>
</tr>
<tr>
<td>Q2041</td>
<td>axicabtagene (Yescarta)</td>
<td>Q5103</td>
<td>infliximab-dyyb (Inflectra)</td>
<td>S0126</td>
<td>follitropin alfa</td>
</tr>
<tr>
<td>Q2042</td>
<td>tisagenlecleucel (Kymriah)</td>
<td>Q5104</td>
<td>infliximab-abda (Renflexis)</td>
<td>S0128</td>
<td>follitropin beta</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>S0189</td>
<td>testosterone pellet (Testopel)</td>
</tr>
</tbody>
</table>

*authorization is not required for oncology indications

X. All services for “Unlisted” or “Temporary” Codes require authorization