

Summary of Updates

PHC P & T Committee, January 12, 2023

Effective Date: April 1, 2023

The following TAR criteria, coverage requirements, &/or restrictions, apply to PHC's Medical Drug Benefit (also referred to as Physician Administered Drugs). These are drugs that are (1) purchased by a medical office, clinic or hospital, (2) administered to the member in a medical setting (not for use at home), and (3) billed directly to PHC as a medical claim using HCPCS codes (and NDCs where appropriate). For pharmacy drug coverage, please refer to Medi-Cal Rx documents on the [State's Medi-Cal Rx web pages](#).

NOTE: Brand names are for reference only. Criteria and billing requirements apply to the drug itself (active ingredient) regardless of the manufacturer/brand, unless otherwise specified.

Effective Date for all changes below: April 1st, 2023, unless otherwise specified.

Class Review: Analgesic, Anti-inflammatory, Migraine, Gout, Anesthetics			
HCPCS	HCPCS Description	How Supplied	Summary of Updates
J0585	Injection, onabotulinumtoxinA, per 1 unit	Botox™ for injection: – Vial: 100 u, 200 u	<ul style="list-style-type: none"> • Updated covered uses • Revised criteria specifically for: <ul style="list-style-type: none"> ○ Upper or lower limb spasticity ○ Chronic migraine prophylaxis
Class Review: Cardiovascular Agents			
J1306	Injection, Inclisiran, per 1mg	Leqvio™ for subcutaneous (SC) injection: – Prefilled Syringe: 284 mg/1.5 ml	New criteria established
J3490	Injection, Sildenafil citrate, per vial size	Revatio™ for intravenous injection: – Vial: 10 mg/12.5 ml	Limited to the treatment of pulmonary hypertension (I27.0-I27.29).
Class Review: Neuromuscular and CNS Agents			
J1823	Injection, Inebilizumab-cdon, per 1 mg	Uplizna™ for intravenous injection: – Vial: 100 mg/10 ml	New criteria established
J1300	Injection, Eculizumab, per 10 mg	Soliris™ for intravenous injection: – Vial: 300 mg/30 ml	New criteria established for neuromyelitis optica spectrum disorder (NMOSD).
J1301	Injection, edaravone, per 1mg	Radicava™ for intravenous injection: – Vial: 30 mg/100 ml	Criteria updated to prefer the oral formulation to IV infusion, as the least invasive treatment when clinically indicated.

Miscellaneous Changes Falling Outside of Scheduled Drug Class Reviews

HCPCS	HCPCS Description	How Supplied	Summary of Updates
J2327	Intravenous (IV) injection, Risankizumab-rzaa, per 1 mg	Skyrizi™ for IV and SC administration: <ul style="list-style-type: none"> – Vial: 600 mg/10 ml – Auto-injector, solution cartridge & prefilled syringe: 75 mg/0.83 ml, 150 mg/ml, 180 mg/1.2 ml, 360 mg/2.4 ml 	<ul style="list-style-type: none"> • New criteria specific for Crohn's Disease • Added the indication for psoriatic arthritis
J2353	Intramuscular (IM) injection, octreotide depot, per 1 mg	Sandostatin LAR Depot™ for IM administration: <ul style="list-style-type: none"> – Vial with powder for suspension: 10 mg, 20 mg, & 30mg 	<ul style="list-style-type: none"> • Criteria updated to include accepted off label use for chemotherapy-induced diarrhea.
S0109	Methadone HCL, oral, per 5 mg	Methadone 5 & 10 mg oral tablets	<ul style="list-style-type: none"> • TAR not required for outpatient hospital, ambulatory surgery centers, and emergency departments, effective 1/1/23.

New CMS & DHCS HCPCS Codes, Effective 1/1/2023

HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
Antineoplastic Agents		
J0893	Injection, decitabine (Sun Pharma), per 1 mg	No limitations
J9046	Injection, bortezomib, (Dr. Reddy's), per 0.1 mg	Minimum age 18 yrs. ICD-10 and specialist requirements.
J9048	Injection, bortezomib (Fresenius Kabi), per 0.1 mg	
J9049	Injection, bortezomib (Hospira), per 0.1 mg	
J9393	Injection, fulvestrant (Teva), per 25 mg	Minimum age: 18 yrs
J9394	Injection, fulvestrant (Fresenius Kabi), per 25 mg	
J9314	Injection, pemetrexed (Teva) , per 10 mg	Minimum age: 18 yrs Doses over 1,000 mg require documentation of BSA > 2.0 m ²
Anti-Infective Agents		
J0689	Injection, cefazolin sodium (Baxter), per 500 mg	No restrictions
J0701	Injection, Cefepime HCl (Baxter) , per 500 mg	Minimum age: 2 mo. Maximum per day: 12 units (6,000 mg)
J0703	Injection, Cefepime HCl (B Braun) , per 500 mg	
J0877	Injection, daptomycin (Hospira), per 1 mg	TAR required
J1574	Injection, ganciclovir sodium (Exela), per 500 mg	Minimum age: 18 yrs
J2021	Injection, linezolid (Hospira), per 200 mg	TAR removed as of 4/1, per DHCS State Bulletin #1035
J2184	Injection, meropenem (B Braun), per 100 mg	TAR required
J2281	Injection, moxifloxacin (Fresenius Kabi), per 100 mg	Minimum age: 18 yrs Maximum 4 units (400 mg) per day.

HPCCS	HPCCS Code & Drug Descriptions	Coverage Status
J3244	Injection, tigecycline (Accord), per 1 mg	Minimum age: 18 yrs Maximum 150 units (150 mg) per day.
J3371	Injection, vancomycin (Mylan), per 500 mg	Maximum 4 units (2 g) per day.
J3372	Injection, vancomycin (Xellia), per 500 mg	
J2247	Injection, micafungin sodium (PAR pharm), per 1 mg	Maximum 150 units (150 mg) per day.
Other		
J0134	Injection, acetaminophen (Fresenius Kabi), per 10 mg	Minimum age: 2 yrs Maximum dose 400 units (4,000 mg) per day.
J0136	Injection, acetaminophen (B Braun), per 10 mg	
J0891	Injection, argatroban, 1 mg (for non-ESRD use) (indicated for heparin induced thrombocytopenia), (Accord), per 1 mg	Minimum age: 18 yrs. Limited to treatment of heparin-induced thrombocytopenia (D75.82).
J0898	Injection, argatroban, 1 mg (for non-ESRD use) (indicated for heparin induced thrombocytopenia), (Auromedics), per 1 mg	
J0892	Injection, argatroban, 1 mg (for ESRD on dialysis) (recommended off-label by KDOQI as an anticoagulant during dialysis for those on oral anticoagulants) (Accord), per 1 mg	Minimum age: 18 yrs. Reimbursable for dialysis use. ICD-10 requirement: N17.0-N17.9, N18.5, N18.6, N18.9, or N19
J0899	Injection, argatroban, 1 mg (for ESRD on dialysis) (recommended off-label by KDOQI as an anticoagulant during dialysis for those on oral anticoagulants) (Auromedics), per 1 mg	
J1456	Injection, fosaprepitant, (antiemetic) (TEVA), per 10 mg	Minimum age: 18 yrs Maximum 150 units (150 mg) per day.
J1611	Injection, glucagon HCl (Fresenius Kabi), per 1 mg	No restrictions
J1643	Injection, heparin sodium (Pfizer), per 1,000 units	No restrictions
J0283	Injection, amiodarone HCl (Nexterone), per 30 mg	Minimum age: 18 yrs
J0611	Injection, calcium gluconate (WG Critical Care), per 10 ml	No restrictions
J2272	Injection, morphine Sulfate (Fresenius Kabi), per 10 mg	No TAR required
J2251	Injection, midazolam HCl (WG Critical Care), per 1 mg	Anesthesia-Related Drugs: Not separately payable when the claim includes a surgical CPT paired with a UA or UB modifier that include drug & supply reimbursement.
J2401	Injection, chlorprocaine hydrochloride, per 1 mg (Nesacaine™ & equivalents) (infiltration)	
J2402	Injection, chlorprocaine hydrochloride (Clorotekal), per 1 mg (intrathecal)	

Miscellaneous Changes Falling Outside of Scheduled Drug Class Reviews

J2327	Intravenous (IV) injection, Risankizumab-rzaa, per 1 mg	Skyrizi™ for IV and SC administration: – Vial: 600 mg/10 ml – Auto-injector, solution cartridge & prefilled syringe: 75 mg/0.83 ml, 150 mg/ml, 180 mg/1.2 ml, 360 mg/2.4 ml	<ul style="list-style-type: none"> • New criteria specific for Crohn’s Disease • Added the indication for psoriatic arthritis and criteria to follow is under document “Standard Requirements for Self-Administered Drugs”
J2353	Intramuscular (IM) injection, octreotide depot, per 1 mg	Sandostatin LAR Depot™ for IM administration: – Vial with powder for suspension: 10 mg, 20 mg, & 30mg	<ul style="list-style-type: none"> • Criteria updated to include accepted off label use for chemotherapy-induced diarrhea.
S0109	Methadone HCL, oral, per 5 mg	Dolophine HCL™ oral tablet Tablet: 5 mg	<ul style="list-style-type: none"> • Formulary addition with limitation for outpatient hospital providers.

Additions to NDC Covered Drugs (J3490 Unclassified NDC Claims)

Brand names are listed for reference only; coverage information also applies to generics.

Generic (Brand)	Coverage Requirements
General and Non-General Anesthesia/Anesthetics	
<p>Double billing is prohibited: The items listed below are only separately reimbursable when a surgical CPT Modifier UA &/or UB is not also paid on the same date of service. Reimbursements for anesthesia-related drugs and supplies are included in the modifier rates for UB (general anesthesia) and UA (non-general). Anesthesia-related drugs include inhaled & injected agents for induction and maintenance of general anesthesia, injected local/regional anesthetics, agents for induction and reversal of neuromuscular blockade, anticholinergics, antiemetics, muscle-relaxants and analgesics.</p>	
Anesthesia: Inhaled	Limits
Desflurane inhalation (Suprane™)	When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, claims are payable (no other limitations).
Isoflurane inhalation (Forane™)	
Sevoflurane inhalation (Ultane™)	
Anesthesia: Sedatives & Analgesics	
Dexmedetomidine IV (Precedex™)	When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, claims are payable (no other limitations).
Etomidate IV (Amidate™)	
Remifentanil IV (Ultiva™)	
Midazolam oral syrup 10 mg/5 ml, 5 mg/2.5ml, & 2 mg/2 ml unit dose (Versed™, brand has been discontinued)	Limited only to the unit dose NDCs for single patient use.

Additions to NDC Covered Drugs (J3490 Unclassified Claims)

Generic (Brand)	Coverage Requirements
Anesthesia, Local/Regional Anesthetics:	
Bupivacaine HCl bulk powder, 8.5 g, 25 g, 100 g, 500 g & 1,000 g	<p>When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, the following limits apply:</p> <ol style="list-style-type: none"> 1. Documentation requirement: Claim must include the number of grams or milligrams used for each date of service. 2. Limited to 400 mg (0.4 g) per day.
Tetracaine 1% injection, 2 ml ampule & vial (Pontocaine™ brand has been discontinued)	<p>When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, claims are payable (no other limitations).</p>
Tetracaine powder, 0.5g and 5 g NDCs	<p>When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, the following limits apply:</p> <ol style="list-style-type: none"> 1. Documentation requirement: Claim must include the number of grams or milligrams used for each date of service 2. Limited to 7 grams topical total dose and 0.3 g injected dose per date of service, all locations including ED.
Anesthesia Reversal Agents:	
Flumazenil 0.1 mg/ml, 5 ml & 10 ml IV vials (Romazicon™ brand has been discontinued)	<p>When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, the following limits apply:</p> <ol style="list-style-type: none"> 1. Limited to a maximum of 2 mg in 24 hrs
Sugammadex 100 mg/ml, 2 ml & 5 ml IV vials (Bridion™)	<p>When the provider is not also claiming UA or UB modifier surgical anesthesia-related drug payment, the following limits apply:</p> <ol style="list-style-type: none"> 1. Provider must be an outpatient hospital or ambulatory surgical center. 2. Must have a surgical procedure on the same date of service. 3. Must have a claim for rocuronium or vecuronium on same date of service. 4. Not to exceed 2 g (4 x 500 mg vials)

Additions to NDC Covered Drugs (J3490 Unclassified Claims)

Generic (Brand)	Coverage Requirements
Anesthetics: Topical & Oromucosal	
Benzocaine 20% Spray (Hurricane™, Hurracaine One™, Americaine™)	Limit of 1 per date of service.
Benzocaine 20% gel (Hurracaine™, Anbesol™, Orajel™)	Limited to 1 unit (a single 9 g tube or 1 unit dose) per date of service.
Benzocaine 14%/butamben 2%/tetracaine 2% Spray, Gel, Solution (Cetacaine™). 5 g unit-dose and 20 g single-patient multi-dose only.	Single-patient and unit-dose packaging only. Limited to 1 per date of service. Multi-dose, multi-patient packaging remains a non-benefit.
Lidocaine 4% OTC Patch (Various brands)	1. Limited to hospital locations only (outpatient & ED) 2. Limited to 4 patches per date of service.
Lidocaine 4% gel spray, 4 ml (mucosal) (Laryng-O-Jet™)	Limited to 2 each per service date
Lidocaine 4% topical solution. 50 ml	Limited to 2 x 50 ml per service date
Lidocaine 2% topical & urethral gel/jelly (Glydo™, Lidocaine Uro-Jet™)	Limit of 2 each per service date
Analgesics & NSAIDs	
Oxycodone oral solution 5 mg/5 ml, in 5 ml unit dose packaging	Limited to 12 unit doses per service date. Units of service for reimbursement are per number of unit doses used (# of cups, oral syringes, etc)
Oxycodone oral concentrate 20 mg/ml, in 0.5 ml oral syringe	
Ibuprofen suspension 100 mg/ml, 5 ml unit dose	Units of service for reimbursement is per number of unit doses used (# of cups, oral syringes, etc).
Indomethacin 50 mg rectal suppositories (Indocin™)	Payable for emergency department providers without a TAR. Other service locations: TAR required.
Antispasmodic Agents	
Atropine/Hyoscyamine/phenobarbital oral elixir (Donnatal) 5 ml unit dose. Per 5 ml: PB 16.2 mg, Hyoscyamine 0.1037 mg, Atropine 0.0194 mg, Scopolamine 0.0065 mg	Limit of 4 unit doses (20 ml) per day. Units of service for reimbursement are per number of unit doses used (# of cups, oral syringes, etc).
Atropine/Hyoscyamine/phenobarbital 16.2 mg tablets (Donnatal™)	Limit of 3 tablets per date of service
Belladonna 16.2 mg/Opium 30 mg & Belladonna 16.2 mg/Opium 60 mg suppositories	Limit of 4 suppositories per day
Cardiac Agents	
Clopidogrel 300 mg tablets (Plavix™)	Limited to 2 per day (600 mg loading dose)
Esmolol 10 mg/ml, 10 ml vials, 25s; Esmolol-Water premixed bags: 2,000 mg/100 ml, 2,500 mg/250 ml (Brevibloc™)	
Isoproterenol HCl 0.2 mg/1 ml and 1 mg/5 ml vials (Isuprel™)	

Additions to NDC Covered Drugs (J3490 Unclassified Claims)

Generic (Brand)	Coverage Requirements
Nicardipine vials: 25 mg/10 ml (no brand) & Nicardipine in NaCl bags: 20mg/200 ml; 40 mg/200 ml (Cardene IV™)	Maximum dose 360 mg in 24 hrs: 40 mg/200 ml bags limited to 9/day; 20 mg/200 ml limited to 18/day. 25 mg/10 ml vials limited to 15 per day.
Vasopressin vials 0.2 u/ml, 100 ml, 0.4 u/ml, 100 ml, 20 u/ml, 1 ml & 10 ml (Vasostriect™)	
Dermatologic and other external use agents	
Gentamicin topical 0.1% cream 15 g	Limited to 1 unit of service (1 tube, 15 g) per service date.
Gentamicin topical 0.1% ointment 15 g (Garamycin™ – brand has been discontinued)	Limited to 1 unit of service (1 tube, 15 g) per service date.
Mupirocin calcium 2% cream (Bactroban™) 15 g, 30 g	<ul style="list-style-type: none"> – Payable for emergency department providers without a TAR. – Other service locations: TAR required. – Limited to 1 unit of service (1 tube) per date of service.
Electrolytes	
Potassium Chloride oral solution, unit dose packaging, 20 mEq /15 ml, 40 mEq/15 ml, 40 mEq /30 ml	PHC reimbursement is as 1 unit=1 unit dose cup and is not paid per ML: <ul style="list-style-type: none"> – 20 mEq unit dose limited to 10 unit doses per day – 40 mEq unit dose limited to 5 unit doses per day
Potassium Chloride oral powder packets, 20 mEq	Limited to 10 packets per day
Electrolyte oral packets & pops unit dose (Pedialyte™)	
Sodium Bicarbonate 8.4% (1 mEq/ml), 5 ml, 10 ml, & 50 ml	
Sodium Bicarbonate IV 4.2% (0.5 mEq/ml), 5 ml, 10 ml &, 50 ml	
Sodium Phosphate 3 mm/ml IV	
Mag chloride/KCl/Na acetate/NaCl/Na gluc (Plasma-Lyte A pH7.4, Plasma-Lyte 148)	
Sodium Chloride 1g OTC tablets	
First Aid, Wound Care	
Povidone-Iodine 10% ointment, 15 g tube	Limited to 1 unit of service (1 tube, 15 g) per day.
Povidone-Iodine 10% ointment, 1 g unit-dose packets	

Additions to NDC Covered Drugs (J3490 Unclassified Claims)

Generic (Brand)	Coverage Status
Gastrointestinal	
Probiotics (various brands, eg VSL #3™, Culturelle™)	Generally not a covered benefit per State Medi-Cal. Added as a benefit for PHC Emergency Department providers only. Other locations: not a covered benefit except with approved TAR for medical necessity.
PEG 3350 (Miralax™ & generics), unit dose packets	
Psyllium seed packets (Metamucil™, Konsyl™)	
Na Phos, dibasic/Na Phos, monobasic (Pedia-Lax™)	
Mineral oil/petrolatum/phenylephrine rectal ointment & suppositories (Preparation H™)	Ointment is limited to 1 tube per service date.
Hematologic Agents	
Thrombin, bovine, 5,000 u vial (Thrombin-JMI™)	
Thrombin, human recombinant, 5,000 u vial (Recothrom™)	
Tranexamic acid injection, 100 mg/ml, 10 ml SDV	
Image-enhancing agents, surgical & emergency department use only <i>Imaging agents are not separately reimbursable when an imaging CPT code is being billed because the CPT rate includes the requisite dye/contrast agent). When used for cataract surgery, some agents are included in the surgical CPT UA or UB rates and cannot be double-billed as additional separate line items, as noted below.</i>	
Fluorescein sodium IV vials 10% 5 ml; 25% 2 ml	Not payable in addition to UA/UB modifier payments for cataract surgery. Other surgeries: limited to 2 vials.
Trypan blue intraocular injection 0.06% (VisionBlue™), 0.5 ml PFS	Not payable in addition to UA/UB modifier payments for cataract surgery.
Chondroitin sulfate & sodium hyaluronate (DuoVisc™, Viscoat™, DisCoVisc™)	Limited to 2 syringes or kits per date of service (1 per eye). Separate line-item reimbursement <i>is</i> allowable for cataract surgery in addition to UA/UB modifier payments.
Fluorescein sodium 1 mg ophthalmic strip (Ful-Glo™, Bioglo™, Glostrips™)	Payable for outpatient hospital and emergency department providers
Iodine/Potassium Iodide 5% solution (Lugol's™) in 1 ml, 14 ml	Limited to 1 unit of service (1 bottle, ampule, dropper, etc) per date of service.

Additions to NDC Covered Drugs (J3490 Unclassified Claims)

Generic (Brand)	Coverage Status
Mucosal	
Aluminum hydroxide/magnesium hydroxide/simethicone/diphenhydramine/lidocaine (First Mouthwash BLM™), 119 ml & 237 ml	<ul style="list-style-type: none"> – Added as a benefit for PHC Emergency Department providers only – Limited to 1 reimbursement unit (1 bottle) – Other locations: not a covered benefit except with approved TAR for medical necessity.
Nasal	
Oxymetazoline 0.05% nasal spray (Afrin™, Nozilla™)	<ul style="list-style-type: none"> – Added as a benefit for PHC Emergency Department providers only, with a limit of 1 bottle per service date. – Other locations: not a covered benefit except with approved TAR for medical necessity.
Nutritional Agents	
Amino acids, parenteral (Clinimix™, Clinisol™, etc)	Limited to 2 bags in 7 days without a TAR
Fat emulsions, parenteral (Intralipid™, Nutrilipid™, etc)	Limited to 2 bags in 7 days without a TAR
Combination Fat + AA (Kabiven™, Perikabiven™)	Limited to 2 bags in 7 days without a TAR
Multivitamin injection (Infuvite™)	Limited to 2 bags in 7 days without a TAR
Dextrose 4 g tablets (DEX4™, Glucose™), oral liquid/gel (Glutose™)	
Zinc Sulfate 220 mg tabs, caps	Payable for outpatient hospital providers
Toxicology	
Activated Charcoal suspension 72 ml, 120 ml, & 240 ml (Actidose-Aqua™)	
Ophthalmologic Agents	
<p>Double billing prohibited: Surgical drug and supply reimbursement is included in the UA & UB modifier rates for cataract surgery. The items listed below are only separately reimbursable when a surgical CPT for cataract surgery with modifier UA or UB is not also submitted for the same service date.</p>	
Calcium chloride/KCl/NaCl for irrigation 15 ml (BSS™)	Only payable when cataract surgery modifier UA/UB not also paying.
Calcium chloride/KCl/NaCl for irrigation 30 ml (BSS™)	Only payable when cataract surgery modifier UA/UB not also paying.
Calcium chloride/KCl/NaCl for irrigation 250 ml (BSS™)	<ul style="list-style-type: none"> – Only payable when cataract surgery modifier UA/UB not also paying. – Limited to 8 bottles per day
Calcium chloride/KCl/NaCl for irrigation 500 ml (BSS™)	<ul style="list-style-type: none"> – Only payable when cataract surgery modifier UA/UB not also paying. – Limited to 4 bottles per day

Acetylcholine chloride intraocular inj. 20 mg vial kit (Miochol-E™)	<ul style="list-style-type: none"> – Only payable when cataract surgery modifier UA/UB not also paying – Limit of 2 vials per date of service.
Carbachol op 1.5 ml 12s (Miostat™)	<ul style="list-style-type: none"> – Only payable when cataract surgery modifier UA/UB not also paying – Limit of 2 vials per date of service.
Cyclopentolate 1% & 2% ophthalmic solution (o/s) 2 ml, 5 ml, & 15 ml (Cyclogyl™)	<ul style="list-style-type: none"> – Only payable when cataract surgery modifier UA/UB not also paying. – Limit of 1 bottle/vial/dropperette per date of service
Cyclopentolate/phenylephrine 0.2%/1%, 2 ml, 5 ml (Cyclomydril™)	
Phenylephrine HCl 0.12% o/s 15 ml	
Phenylephrine HCl 2.5% o/s 2 ml, 3 ml, 5 ml, & 15 ml	
Phenylephrine HCl 10% o/s 5 ml	
Tropicamide 0.5% o/s 15 ml (Mydriacyl™)	
Tropicamide 1% o/s 1 ml, 2 ml, 3 ml, & 15 ml (Mydriacyl™)	
Tetracaine 0.5% o/s 4 ml (Altacaine™)	

The following items are non-benefits per State Medi-Cal and have been confirmed by P & T Committee that they will remain non-reimbursable for PHC medical providers. These are not reimbursable for any service location.

Non-FDA approved products not otherwise included as exceptions in the PHC covered drug lists or search tools, including but not limited to:

- Adult multivitamins
- B-Complex, “Stress B”
- First-Lansoprazole compounding kits
- First-Omeprazole compounding kits
- Fish Oil capsules
- Melatonin, alone and in combination
- Menthol/benzocaine sore throat lozenges
- Menthol/benzocaine/DM cough drops