

Medicare Part B Drug Prior Authorization Form

Last Reviewed: Sept 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Remicade[®] (infliximab) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Remicade 100 mg vial

Dose: _____ Start date: _____

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center Name of center: _____

Home Infusion Name of agency: _____

Billing options:

Physician buy and bill (J1745)

Preferred Specialty Vendor

Other: _____

Diagnosis:

Rheumatoid Arthritis– ICD code: _____

Psoriatic Arthritis– ICD code: _____

Ankylosing Spondylitis– ICD code: _____

Plaque psoriasis– ICD code: _____

Active Crohn's Disease– ICD code: _____

Fistulizing Crohn's Disease– ICD code: _____

Ulcerative Colitis– ICD code: _____

Pyoderma gangrenosum– ICD code: _____

Hidradenitis suppurativa– ICD code: _____

Uveitis– ICD code: _____

Wegener's granulomatosis– ICD code: _____

Sarcoidosis– ICD code: _____

Behcet's Syndrome– ICD code: _____

- Colitis– ICD code: _____
- Felty's Syndrome– ICD code: _____
- Juvenile Chronic polyarthritis– ICD code: _____
- Other: _____ – ICD code: _____ Please provide rationale for use:

Patient's age: _____

Patient's weight: _____

Results of annual (within the past 12 months) TB test:

- Positive
- Negative Date: _____
- Test not done – Rationale for use: _____

Patient has moderate to severe heart failure:

- Yes – Rationale for use: _____
- No

Rheumatoid Arthritis

Patient has had at least a 3 month trial of methotrexate:

- Yes
- No – Rationale for use: _____

Patient will be treated concurrently with methotrexate (unless intolerant or contraindicated):

- Yes
- No – Rationale for use: _____

Patient is intolerant to methotrexate or has a contraindication:

- Yes
- No – Rationale for use: _____

For continuation of therapy beyond 30 weeks (both are required):

Patient has experienced at least a 20% improvement in tender joint count

- Yes
- No – Rationale for use: _____

Patient has experienced at least a 20% improvement in swollen joint count

- Yes
- No – Rationale for use: _____

Ankylosing Spondylitis or Psoriatic Arthritis

Patient has psoriasis in conjunction with polyarthritis (Dactylitis or typical x-ray changes of psoriatic arthritis can be substituted for the presence of psoriasis.):

- Yes
 No – Rationale for use: _____

Patient has greater than or equal to 6 tender and greater than or equal to 6 swollen joints or major impairment from inflammatory arthritis in more than one large weight bearing joint including ankle, knee and hip.

- Yes
 No – Rationale for use: _____

The patient has an erythrocyte sedimentation rate (ESR) greater than or equal to 30 mm in one hour or a C-reactive protein (CRP) level greater than 50% above the upper limit of normal.

- Yes
 ESR level: _____ mm
 OR
 CRP level: _____ ULN: _____
 No – Rationale for use: _____

The patient has failed more than two non-steroidal anti-inflammatory drugs (NSAIDs)

- Yes
 NSAID: _____ Dose: _____ Trial dates: _____
 NSAID: _____ Dose: _____ Trial dates: _____
 No – Rationale for use: _____

The patient has failed a three-month trial of both methotrexate 20 mg per week and sulfasalazine 3 grams daily given singly or in combination. Failure will include lack of efficacy, adverse effects prohibiting further use of the drug or medical contraindications such as sulfa allergy, alcoholism or chronic liver disease. Failure of cyclosporine at 3 mg/kg body weight for three months, or leflunomide 10-20 mg per day for two months, can be substituted for either sulfasalazine or methotrexate.

- Yes
 Drug: _____ Dose: _____ Trial dates: _____
 Drug: _____ Dose: _____ Trial dates: _____
 No – Rationale for use: _____

Chronic, Severe (i.e. extensive or disabling) Plaque Psoriasis

Patient has had a documented trial and clinical failure with phototherapy (UVA, UVB):

- Yes
 Type of therapy: _____ Trial dates: _____
 No – Rationale for use: _____

Patient has a contraindication to phototherapy (UVA, UVB):

- Yes - List the contraindication: _____
 No

Patient has had a documented trial and clinical failure of one or more systemic treatments (e.g. azathioprine, Neoral, methotrexate, cyclosporine, Soriatane):

- Yes
 Drug: _____ Dose: _____ Trial dates: _____
 Drug: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Patient has a contraindication to systemic treatments:

- Yes - List the contraindication: _____
- No

Moderately to Severely Active Crohn's Disease

Patient has had an inadequate response to conventional therapy (e.g. corticosteroids, aminosalicylates such as 5-ASA mesalamine, immunomodulators such as 6-mercaptopurine/azathioprine):

- Yes
 Drug: _____ Dose: _____ Trial dates: _____
 Drug: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Fistulizing Crohn's Disease

Patient has fistulizing Crohn's and needs infliximab therapy to reduce the number of draining enterocutaneous and rectovaginal fistulas and maintain fistula closure

- Yes
- No

Moderate to Severe, Active Ulcerative Colitis

Patient has had an inadequate response to conventional therapy (e.g. corticosteroids, aminosalicylates such as 5-ASA mesalamine, immunomodulators such as 6-mercaptopurine/azathioprine):

- Yes
 Drug: _____ Dose: _____ Trial dates: _____
 Drug: _____ Dose: _____ Trial dates: _____
- No – Rationale for use: _____

Other CMS approved uses for Remicade (check which applies):

- Pyoderma gangrenosum with coexisting inflammatory bowel disease
- Hidradenitis suppurativa, severe, refractory
- Uveitis, refractory; adjunct
- Wegener's granulomatosis, refractory, in combination with corticosteroids
- Sarcoid refractory to treatment with steroids and other standard drug regimens

- Behcet's Syndrome
- Colitis
- Felty's Syndrome
- Juvenile Chronic polyarthritis

The following Local Coverage Determination (LCD) information was obtained from the US Department of Health & Human Services Center for Medicare & Medicaid Services (available www.cms.hhs.gov and www.wpsmedicare.com). The primary jurisdiction for coverage outlined in this LCD is Michigan. For Priority Health Medicare members receiving this service outside the state of Michigan, please refer to the LCD for that state for coverage requirements. If no LCD is available for the state in which this service is being provided, coverage will be determined as outlined in this prior authorization document.

Article for INFLIXIMAB (e.g. Remicade) – Related to LCD L25820 (A46764)

Indications:

Infliximab is indicated for the following clinical indications:

Crohn's Disease

Infliximab is indicated for:

1. moderately to severely active Crohn's disease for the reduction of signs and symptoms and for inducing and maintaining clinical remission in patients who have had an inadequate response to conventional therapy (e.g., corticosteroids, aminosalicylates such as 5-ASA mesalamine, immuno-modulators such as 6-mercaptopurine [6-MP]/azathioprine); or
2. fistulizing Crohn's disease for the reduction in the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure. (See Remicade® package insert.)

Rheumatoid Arthritis

Infliximab in combination with methotrexate is indicated for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderate to severe, active rheumatoid arthritis and who have had an inadequate response to methotrexate. An adequate trial of methotrexate should last a minimum of three (3) months. Infliximab without concurrent administration of methotrexate may be covered only for those cases where the patient is intolerant to methotrexate or for whom methotrexate is contraindicated.

Psoriatic Arthropathy and Ankylosing Spondylitis

Infliximab therapy is indicated for reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis. It is also indicated for reducing signs and symptoms in patients with active ankylosing spondylitis. Infliximab therapy is covered for psoriatic arthropathy and ankylosing spondylitis in patients demonstrating an inadequate response to conventional treatment.

Patients should meet the following diagnostic, disease activity and treatment failure criteria:

- Diagnostic criteria: The patient must have psoriasis in conjunction with polyarthritis. Dactylitis or

typical x-ray changes of psoriatic arthritis can be substituted for the presence of psoriasis.

- Activity level: There should be greater than or equal to 6 tender and greater than or equal to 6 swollen joints or major impairment from inflammatory arthritis in more than one large weight bearing joint including ankle, knee and hip. The patient should also have an erythrocyte sedimentation rate (ESR) greater than or equal to 30 mm in one hour or a C-reactive protein (CRP) level greater than 50% above the upper limit of normal.
- Treatment failure: The patient should have failed more than two nonsteroidal anti-inflammatory drugs (NSAIDs) as well as a three-month trial of both methotrexate 20 mg per week and sulfasalazine 3 grams daily given singly or in combination. Failure will include lack of efficacy, adverse effects prohibiting further use of the drug or medical contraindications such as sulfa allergy, alcoholism or chronic liver disease. Failure of cyclosporine at 3 mg/kg body weight for three months, or leflunomide 10-20 mg per day for two months, can be substituted for either sulfasalazine or methotrexate.

Ulcerative Colitis

Infliximab therapy is indicated for reducing signs and symptoms, achieving clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderate to severe, active ulcerative colitis who have had an inadequate response to conventional therapy.

Plaque Psoriasis

Infliximab therapy is indicated for the treatment of adult patients with chronic, severe (i.e., extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy and who have failed to respond to other systemic therapies, or who have a contraindication to, or are intolerant of, other systemic therapy including cyclosporins, methotrexate or psoralen—ultraviolet- light (PUVA) therapy.

Infliximab is indicated for inducing and maintaining clinical remission in patients with moderately to severely active Crohn's disease with or without fistulizing complications.

- Infliximab is indicated for the treatment of pyoderma gangrenosum with coexisting inflammatory bowel disease.
- Infliximab is indicated for reducing signs and symptoms, achieving clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.
- Infliximab is often indicated for reduction in signs and symptoms of rheumatoid arthritis, psoriasis/psoriatic arthritis and ankylosing spondylitis in patients who have had inadequate response to methotrexate (ACR response of less than 20 after 12.5-20 mg of methotrexate weekly for four (4) months). Infliximab should be given in combination with methotrexate. Usage of infliximab in patients with rheumatoid arthritis should not necessarily be the initial course of treatment, but can be if the disease is moderate to severe. Individual consideration will be given in cases of rheumatoid arthritis, psoriasis/psoriatic arthritis and ankylosing spondylitis, when the patient has moderate to severe disease, or has failed on a previous disease modifying agent, or is intolerant to methotrexate, or in whom methotrexate is contraindicated. It will also be given individual consideration in cases of Still's Disease.

Infliximab is also indicated for:

Hidradenitis suppurativa, severe, refractory

Uveitis, refractory; adjunct

Wegener's granulomatosis, refractory, in combination with corticosteroids

Indications expanded per this Article:

Infliximab is indicated for sarcoid refractory to treatment with steroids and other standard drug regimens.

Limitations:

Claims submitted for rheumatoid arthritis (ICD-9-CM codes 714.0-714.2) will be denied if, on review, the patient's medical record does not document that the patient is also receiving methotrexate or does not clearly indicate the reason that the patient cannot take methotrexate.

Patients with Crohn's disease who do not respond by week 14 are unlikely to respond with continued dosing and consideration should be given to discontinue infliximab in these patients. (See Remicade® package insert.)

Services performed for excessive frequency are subject to denial as not medically necessary. Frequency is considered excessive when services are performed more frequently than recommended in the FDA-approved package insert.

"Efficacy and safety of Remicade® treatment beyond 50 weeks have not been evaluated in patients with plaque psoriasis." (See Remicade® package insert revised September 26, 2006.)

Documentation Requirements:

For the treatment of **Crohn's disease**, relevant information includes, but is not limited to, the presence and severity of abdominal pain, the presence and severity of extra-intestinal manifestations, the degree to which diarrhea is controlled, the site(s) and number of draining enterocutaneous and/or rectovaginal fistulae, and the patient's height, weight and hematocrit. Episodic retreatment for patients with Crohn's disease will be covered if the medical record substantiates that the patient had a reduction in the clinical signs and symptoms of the disease after the initial treatment.

For the treatment of **rheumatoid arthritis**, the diagnosis of rheumatoid arthritis must be unequivocal. Using accepted diagnosis criteria guidelines, such as those published by the American College of Rheumatology (ACR) is recommended. The medical record must clearly indicate that the patient:

- Had an inadequate response to methotrexate in reducing signs and symptoms of the disease and is receiving infliximab in combination with methotrexate; or
- cannot tolerate methotrexate; or
- has a medical condition that contraindicates the use of methotrexate.

To support the continued use of infliximab beyond 30 weeks for the treatment of rheumatoid arthritis, the medical record must include evidence of at least 20% improvement in tender joint count and at least 20% improvement in swollen joint count.

For the treatment of **psoriatic arthropathy and ankylosing spondylitis, and ulcerative colitis**, the patient's medical record must include clear documentation that the patient had an inadequate response to conventional treatment.

For the treatment of plaque psoriasis, medical record documentation must substantiate the medical necessity for the use of infliximab by clearly indicating that the patient's condition is chronic, severe, and

extensive or disabling. For example, such documentation could include objective findings of chronic, stable plaque with the percent body surface area (BSA) noted; Psoriasis Area Severity Index (PASI) score; Psoriasis Disability Index (PDI) score; and/or results from other psoriasis assessment tool(s). The medical record should also indicate that the patient is a candidate for systemic therapy and that other systemic therapies failed or are contraindicated.

Utilization:

Standard usage of infliximab for rheumatoid arthritis which meet the criteria in the “Indications and Limitations of Coverage” section will be covered at a dose of 3 mg/kg followed with additional similar doses at 2 and 6 weeks after the first infusion then every 8 weeks thereafter. Infliximab should be given in combination with methotrexate. For patients who have an incomplete response, consideration may be given to doses up to 10 mg/kg.

- Standard usage of infliximab for Crohn’s disease with or without fistulizing complications will be covered at a dose 5 mg/kg given as an induction regimen at 0, 2, and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter. For patients who respond and then lose their response, consideration may be given to treatment with 10 mg/kg. Patients who do not respond by week 14 are unlikely to respond with continued dosing. Consideration should be given to discontinue infliximab in these patients.
- Standard usage of infliximab for ankylosing spondylitis will be covered at a dose of 5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 6 weeks thereafter.
- Standard usage of infliximab for psoriatic arthritis will be covered at a dose of 5 mg/kg will be covered as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion then every 8 weeks thereafter. Infliximab can be used with or without methotrexate.
- Standard usage of infliximab for ulcerative colitis will be covered at a dose of 5 mg/kg given as an induction regimen at 0, 2, and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter.
- Standard usage of infliximab for pyoderma gangrenosum will follow the regimens of inflammatory bowel disease until the lesions are controlled.

Coding Guidelines:***General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC:***

Infliximab is given by intravenous infusion over a period of not less than two (2) hours. Infliximab can aggravate and cause the spread of an existing infection. Tuberculosis (TB), invasive fungal infections, and other opportunistic infections have been observed in patients receiving infliximab. As a result, infliximab should not be given to patients with a clinically important, active infection. Patients should be evaluated for latent tuberculosis infection through a detailed medical evaluation and with a TB skin test (PPD). Treatment of latent tuberculosis infection should be initiated prior to therapy with infliximab. (See Remicade® package insert.)

Infliximab has been associated with adverse outcomes in patients with heart failure, and should not be administered at doses greater than 5 mg/kg in patients with moderate to severe heart failure. (See Remicade® package insert.)

Infliximab given to treat plaque psoriasis should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician. Psoriasis patients should be monitored for nonmelanoma skin cancers, particularly those patients who have had prior prolonged phototherapy treatment. (See Remicade® package insert revised September 26, 2006.)

Modifier EJ (subsequent claims for a defined course of treatment, e.g., EPO, sodium hyaluronate, infliximab) should be appended to HCPCS code J1745 when subsequent infusions are given.

Claims submitted for treatment of pyoderma gangrenosum with coexisting inflammatory bowel disease must be submitted with a primary ICD-9-CM code of 686.01 and a secondary ICD-9-CM code of 555.0-555.9 or 556.0-556.9. If both the primary and secondary diagnosis ICD-9-CM codes are not indicated on the claim, the service will be denied.

Carrier Guidelines:

For claims submitted to the carrier or Part B MAC:

1. Infliximab should be billed using chemotherapy administration codes and is payable in the following places of service: office (11), and nursing facility (32), independent clinic (49), and state or local public health clinic (71), only when supplied as an “incident to” service by the physician.
2. Infliximab is available in 100-mg vials. The dosage associated with the HCPCS code is 10 mg. The number of units (rounded up to a whole unit) used, should be entered in Item 24G of the CMS 1500 claim form or the electronic equivalent.
3. The following is an example of the correct reporting methodology for infliximab: If the dosage administered is 375 mg, 4 vials (or a total of 400 mg) will be used. Report this with a "40" in the units field. Since this will result in product wastage, it is encouraged that more than one patient is scheduled.

Coding Information

Bill Type Codes: [back to top](#)

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

11x Hospital-inpatient (including Part A)

13x Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)

85x Special facility or ASC surgery-rural primary care hospital (eff 10/94)

CPT/HCPCS Codes [back to top](#)

J1745 INJECTION INFLIXIMAB, 10 MG

ICD-9 Codes that are Covered [back to top](#)

The following ICD-9-CM codes should be reported for Crohn's disease with or without fistulizing complications; and for ulcerative colitis.

Coding Information

555.0	REGIONAL ENTERITIS OF SMALL INTESTINE
555.1	REGIONAL ENTERITIS OF LARGE INTESTINE
555.2	REGIONAL ENTERITIS OF SMALL INTESTINE WITH LARGE INTESTINE
555.9	REGIONAL ENTERITIS OF UNSPECIFIED SITE
556.0	ULCERATIVE (CHRONIC) ENTEROCOLITIS
556.1	ULCERATIVE (CHRONIC) ILEOCOLITIS
556.2	ULCERATIVE (CHRONIC) PROCTITIS
556.3	ULCERATIVE (CHRONIC) PROCTOSIGMOIDITIS
556.4	PSEUDOPOLYPOSIS OF COLON
556.5	LEFT-SIDED ULCERATIVE (CHRONIC) COLITIS
556.6	UNIVERSAL ULCERATIVE (CHRONIC) COLITIS
556.8	OTHER ULCERATIVE COLITIS
556.9	ULCERATIVE COLITIS UNSPECIFIED

The following ICD-9-CM codes should be reported for reductions of signs and symptoms of rheumatoid arthritis in patients who have had inadequate response to methotrexate.

696.0	PSORIATIC ARTHROPATHY
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
714.0	RHEUMATOID ARTHRITIS
714.1	FELTY'S SYNDROME
714.2	OTHER RHEUMATOID ARTHRITIS WITH VISCERAL OR SYSTEMIC INVOLVEMENT
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
714.81	RHEUMATOID LUNG
720.0	ANKYLOSING SPONDYLITIS

The following ICD-9-CM code should be reported for other conditions for which patients have failed to respond to standard pharmacologic therapy.

135	SARCOIDOSIS
364.00	ACUTE AND SUBACUTE IRIDOCYCLITIS, UNSPECIFIED
364.01	PRIMARY IRIDOCYCLITIS
364.02	RECURRENT IRIDOCYCLITIS
364.03	SECONDARY IRIDOCYCLITIS, INFECTIOUS
364.04	SECONDARY IRIDOCYCLITIS, NONINFECTIOUS
364.05	HYPOPYON
364.10	CHRONIC IRIDOCYCLITIS, UNSPECIFIED
364.11	CHRONIC IRIDOCYCLITIS IN DISEASES CLASSIFIED ELSEWHERE
364.21	FUCHS' HETEROCHROMIC CYCLITIS
364.22	GLAUCOMATOCYCLITIC CRISES
364.23	LENS-INDUCED IRIDOCYCLITIS
364.24	VOGT-KOYANAGI SYNDROME
364.3	UNSPECIFIED IRIDOCYCLITIS
446.4	WEGENER'S GRANULOMATOSIS
705.83	HIDRADENITIS

For the treatment of pyoderma gangrenosum with coexisting inflammatory bowel disease, a primary

Coding Information

ICD-9-CM code of 686.01 must be reported and associated with inflammatory bowel disease which may be described by regional enteritis, ulcerative colitis, or pseudopolyposis of the colon.

Primary Diagnosis

686.01	PYODERMA GANGRENOSUM
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Secondary Diagnosis

- 555.0 REGIONAL ENTERITIS OF SMALL INTESTINE
- 555.1 REGIONAL ENTERITIS OF LARGE INTESTINE
- 555.2 REGIONAL ENTERITIS OF SMALL INTESTINE WITH LARGE INTESTINE
- 555.9 REGIONAL ENTERITIS OF UNSPECIFIED SITE
- 556.0 ULCERATIVE (CHRONIC) ENTEROCOLITIS
- 556.1 ULCERATIVE (CHRONIC) ILEOCOLITIS
- 556.2 ULCERATIVE (CHRONIC) PROCTITIS
- 556.3 ULCERATIVE (CHRONIC) PROCTOSIGMOIDITIS
- 556.4 PSEUDOPOLYPOSIS OF COLON
- 556.5 LEFT-SIDED ULCERATIVE (CHRONIC) COLITIS
- 556.6 UNIVERSAL ULCERATIVE (CHRONIC) COLITIS
- 556.8 OTHER ULCERATIVE COLITIS
- 556.9 ULCERATIVE COLITIS UNSPECIFIED

Other Information

Other Comments [back to top](#)

Sources of Information

American Society of Health-System Pharmacists, Inc. *AHFS Drug Information*®. Bethesda, MD: 2007.

Baughman RP, Lower EE. Infliximab for Refractory Sarcoidosis. *Sarcoidosis Vasculitis and Diffuse Lung Diseases*. 2001;18:70-74.

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Doty JD. Treatment of Sarcoidosis with Infliximab. *Chest*. 2005;127(3):1064-71.

Keystone EC. The Utility of Tumour Necrosis Factor Blockade in Orphan Diseases. *Annals of*

Other Information

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NCCN Drugs and Biologics Compendium accessed at: <http://www.nccn.org/>

Scott D. Roberts SD, Wilkes DS, Burgett RA, Knox KS. Refractory Sarcoidosis Responding to Infliximab. *Chest*. 2003;124:2028-2031.

Thomson Micromedex DrugDex® accessed at: <http://www.thomsonhc.com/home/dispatch>

Thomson Healthcare DrugPoints® at <http://www.thomsonhc.com/home/dispatch>

U.S. Food and Drug Administration label approved 08/24/1998 accessed on line at <http://www.accessdata.fda.gov/scripts/cder/drugsatfda/> on 02/01/2008.

United States Pharmacopoeia (USP), Volume I; Drug Information for the Health Care Professional, 2007.

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this Article as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this article as the claims processing for New Hampshire and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

Revision History Explanation [back to top](#)

Article published January 2009: Source of revision – Internal - The “Article Text” and “Sources of Information” have been revised to include compendia recognized by CMS based on Change Request 6191 (Compendia as Authoritative Sources for Use in the Determination of a Medically Accepted Indication of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen, effective 11/25/2008). This article has been reviewed using all listed compendia and has been revised to add ICD-9-CM code, 714.30 to the ICD-9 list for rheumatoid arthritis effective for dates of service on or after 11/25/2008. Minor changes were made to reflect current template language.

This revised article is effective for all National Government Services jurisdictions on July 18, 2008 with these exceptions: for Connecticut – Part B the article is effective on August 1, 2008; for Upstate New York – Part B, the article is effective on September 1, 2008; and for New York and Connecticut – Part A, the article is effective on November 14, 2008. For New York – Part A (contract 00308), the content of this article is currently in effect but the article will be transferred to the J-13 contract number 13201 on November 14, 2008.

This article was revised to add the Jurisdiction 13 (J-13) MAC contractor numbers and to retain the most clinically appropriate medical policy information within the jurisdiction, including off-label indications and approved indications from DrugPoints®.

The following indications have been added: hidradenitis suppurativa, severe, refractory, uveitis, refractory; adjunct, Wegener's granulomatosis, refractory, in combination with corticosteroids; The following ICD-9-CM codes have been added: 364.00, 364.01, 364.02, 364.03, 364.04, 364.05, 364.10, 364.11, 364.21, 364.22, 364.23, 364.24, 364.3, 446.4 and 708.53. Thomson Healthcare DrugPoints® has been added to the “Article Text” paragraph and “Sources of Information”.

Other Information

Article published March 2008: [Original version of article.](#)

The original version of the corresponding LCD became effective on 12/01/2007.

08/18/2008 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00454 was removed from this article as the claims processing for American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands was transitioned to Palmetto GBA, the Part A/Part B MAC contractor in these states.

11/14/2008 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00308 is removed from this article. Effective on this date, claims processing for Delaware is performed by Highmark Medicare Services, the Part A/Part B MAC contractor for this state, and the claims processing for New York and Connecticut is performed by National Government Services under the J-13 MAC contract; carrier number 00805 is removed, and claims processing for New Jersey is performed by Highmark Medicare Services, the Part A/Part B MAC contractor for this state.

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this Article as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this article as the claims processing for New Hampshire and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

Related Documents [back to top](#)

LMRP(s) Article(s)

[A44930 - Drugs and Biologicals, Coverage of, for Label and Off-Label Uses - Supplemental Instructions Article](#)

LCD(s)

[L25820 - Drugs and Biologicals, Coverage of, for Label and Off-Label Uses](#)

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Updated on 05/28/2009 with effective dates 06/05/2009 - N/A

[Updated on 05/28/2009 with effective dates 05/15/2009 - 06/04/2009](#)

[Updated on 05/07/2009 with effective dates 05/15/2009 - N/A](#)

[Updated on 12/23/2008 with effective dates 01/01/2009 - 05/14/2009](#)

[Updated on 11/07/2008 with effective dates 11/14/2008 - N/A](#)

[Updated on 08/06/2008 with effective dates 08/18/2008 - 11/13/2008](#)

[Updated on 08/06/2008 with effective dates 08/18/2008 - N/A](#)

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[Updated on 05/23/2008 with effective dates 07/18/2008 - N/A](#)

[Updated on 05/23/2008 with effective dates 07/18/2008 - N/A](#)

[Updated on 02/21/2008 with effective dates 03/01/2008 - N/A](#)

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX