

Injections: Drugs S-Z Policy

This section outlines policy related to billing for injection services, listed in alphabetical order by generic drug name or drug type. For general billing policy information regarding injections services, refer to the *Injections: An Overview* section in this manual. Additional policy information for injection services can be found in the following sections of this manual:

- *Injections: Drugs A–D Policy*
- *Injections: Drugs E–H Policy*
- *Injections: Drugs I–M Policy*
- *Injections: Drugs N–R Policy*
- *Injections: Hydration*
- *Immunizations*

Sargramostim

Sargramostim is a recombinant human granulocyte-macrophage colony stimulating factor (rhu GM-CSF) produced by recombinant DNA technology in a yeast expression system. GM-CSF is a hematopoietic growth factor which induces partially committed progenitor cells to divide and differentiate in the granulocyte-macrophage pathways including neutrophils, monocytes/macrophages and myeloid-derived dendritic cells.

Indications

Sargramostim is indicated for use:

- Following induction chemotherapy in acute myelogenous leukemia
- In mobilizing and following transplantation of autologous peripheral blood progenitor cells
- In myeloid reconstitution after autologous or allogeneic bone marrow transplantation
- In bone marrow transplantation failure or engraftment delay
- In neutropenia induced by chemotherapy

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Dosage The recommended dose varies according to the condition being treated. Please see the appropriate medical literature for details.

Required Codes One of the following ICD-9-CM codes is required for reimbursement:

- 288.03
- V42.82
- V58.11
- V59.02

Billing HCPCS code J2820 (injection, sargramostim [GM-CSF], 50 mcg).

Secretin	<p>Secretin is indicated for use in secretin stimulation testing to:</p> <ul style="list-style-type: none">• Aid in the diagnosis of pancreatic exocrine dysfunction• Aid in the diagnosis of gastrinoma• Facilitate the identification of the ampulla of Vater and accessory papilla during endoscopic retrograde cholangiopancreatography.
Dosage	The maximum allowable dosage is 48 mcg.
Billing	HCPCS code J2850 (injection, secretin, synthetic, human, 1 mcg).
Sodium Ferric Gluconate Complex in Sucrose	<p>Sodium ferric gluconate complex in sucrose, 12.5 mg injection (HCPCS code J2916) is reimbursable when used to treat recipients with iron deficiency anemia and for recipients undergoing long term hemodialysis and who are also receiving supplemental erythropoietin (EPO) therapy. Ferrlecit may be used as an alternative to oral iron therapy.</p>
Dosage	<p>The recommended dosage is 10 ml (125 mg of elemental iron) administered intravenously during the dialysis session. Recipients may continue to require therapy with sodium ferric gluconate complex in sucrose at the lowest dose necessary to maintain target levels of hemoglobin.</p> <p>The maximum dosage is 125 mg per day.</p>

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**Sodium Hyaluronate
(Euflexxa)**

Sodium hyaluronate (Euflexxa) for intra-articular injection is reimbursable for treatment of the knees. Authorization is required and documentation must be submitted with the TAR that satisfies all of the following conditions:

- Painful osteoarthritis of one or both knees
- Inadequate response to conservative nonpharmacologic therapy
- Inadequate response to simple analgesics (for example, acetaminophen) and non-steroidal anti-inflammatory drugs

Dosage

The usual dose is 2 ml of sodium hyaluronate (Euflexxa) into the affected knee at weekly intervals for three weeks for a total of three injections per affected knee.

Billing

HCPCS code J7323 Hyaluranon or derivative, Euflexxa, for intra-articular injection, per dose

**Sodium Hyaluronate
(Hyalgan)**

Sodium hyaluronate (Hyalgan) for intra-articular injection is reimbursable for treatment of the knees. Authorization is required and documentation must be submitted with the TAR that satisfies all of the following conditions:

- Painful osteoarthritis of one or both knees
- Inadequate response to conservative nonpharmacologic therapy
- Inadequate response to simple analgesics (for example, acetaminophen) and non-steroidal anti-inflammatory drugs

Dosage

The usual dose is 2 ml of sodium hyaluronate (Hyalgan) into the affected knee at weekly intervals for up to five weeks for a total of five injections per affected knee. Some patients may experience benefit with three injections at weekly intervals.

Billing

HCPCS code J7321 Hyaluranon or derivative, Hyalgan or Supartz, for intra-articular injection, per dose.

Sodium Hyaluronate (Supartz)

Sodium hyaluronate (Supartz) for intra-articular injection is reimbursable for treatment of the knees. Authorization is required and documentation must be submitted with the TAR that satisfies all of the following conditions:

- Painful osteoarthritis of one or both knees
- Inadequate response to conservative nonpharmacologic therapy
- Inadequate response to analgesics (for example, acetaminophen) and non-steroidal anti-inflammatory drugs

Dosage

The usual dose is 2.5 ml of sodium hyaluronate (Supartz) into the affected knee at weekly intervals for up to five weeks for a total of five injections per affected knee. Some patients may experience benefit with three injections at weekly intervals.

Billing

HCPCS code J7321 Hyaluranon or derivative, Hyalgan or Supartz, for intra-articular injection, per dose.

**Somatropin
for HIV-Associated Wasting**

Somatropin is used for the treatment of HIV-associated wasting and is reimbursable only with an approved TAR. A TAR will be granted in four-week intervals to a maximum of 12 continuous weeks of therapy. Treatment must be reevaluated after four weeks and eight weeks of therapy.

Initial Therapy: Criteria

Criteria for the initial 28 days of treatment of HIV-associated wasting with somatropin:

- Documentation in the medical record of complete history and physical examination including:
 - History of nutritional status including appetite, estimation of caloric intake, gastrointestinal function including presence of diarrhea and number of daily stools, and history of endoscopic procedures
 - Psychosocial evaluation, including presence of significant anxiety and/or depression affecting food intake
- Record of the following measurements:
 - Height, weight, ideal body weight, body mass index (BMI)
 - Body cell mass (BCM) by bioelectrical impedance analysis (BIA)
 - Serial measurements – weekly
- Recipients must meet one of the following criteria for HIV-associated wasting:
 - 5 percent BCM loss within the preceding six months
 - In men: BCM less than 35 percent of total body weight and BMI less than 27 kg/m²
 - In women: BCM less than 23 percent of total body weight and BMI less than 27 kg/m²
 - BMI less than 20 kg/m²
 - BMI greater than 20 kg/m² and less than 25 kg/m²

and

 - ❖ 10 percent unintentional weight loss within the preceding 12 months

or

 - ❖ 7.5 percent unintentional weight loss within the preceding six months

- Recipients should have an evaluation of gastrointestinal function with attention to the presence of malabsorption, a review of food intake, amount of daily calories and estimate of physical activity level.
- An active malignancy other than Kaposi's sarcoma has been excluded clinically, through diagnostic laboratory examination, and/or radiographically.
- Male recipients should have a serum testosterone level and, if low, a trial of testosterone replacement therapy.
- Recipients must have a viral load assay and a CD4 count and must be undergoing treatment with an appropriate antiretroviral therapy regimen.
- Recipients should have a trial with an appetite stimulant if the recipient has inadequate caloric intake and anorexia.
- For male recipients, an initial trial of androgen is recommended for HIV-associated wasting. If this is omitted, a statement should be provided documenting the clinical decision to proceed directly with somatropin therapy.
- Recipients must receive somatropin within recommended dosing guidelines for body weight.

Reassessment of Therapy
Through 12 Weeks: Criteria

Criteria for reassessment of therapy through 12 weeks:

- Treatment must be re-evaluated after four weeks and eight weeks of therapy. Repeat weight assessment and documentation is required at four weeks and eight weeks of therapy to assure weight stabilization.
- Therapy must be discontinued in recipients who continue to lose weight in the first four weeks of treatment.
- If, after four weeks of therapy, weight loss has stopped or if the recipient is gaining weight, somatropin may be continued for another 28 days.
- If, after eight weeks of therapy, the recipient is losing or has failed to gain weight from the original measurement, somatropin must be stopped.
- If the recipient had initially gained weight at four weeks, but has neither gained nor lost weight at the eight-week re-evaluation, somatropin may be continued for another 28 days.
- A maximum of 12 weeks of treatment is allowed with authorization. Claims without authorization will be denied.

Note: Authorization is limited to four-week intervals.

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Continued Therapy Beyond
12 Weeks: Criteria

Criteria for continued therapy beyond the initial 12 weeks:

- All recipients must stop somatropin following the initial 12-week treatment for an eight-week period of observation unless there is documentation that HIV-associated wasting is still present. During the eight-week observation period, body weight, BMI and BCM should be monitored on a weekly basis.
- Therapy beyond 12 weeks may be continued with a recipient who has demonstrated a beneficial response to somatropin during the initial 12 weeks of therapy (defined as a 2 percent or greater increase in body weight or BCM)

and

- Still exhibits evidence of wasting (BMI less than 20 kg/m²)

or

- Has a BCM not yet normalized (BCM less than 40 percent in non-obese men or less than 28 percent in non-obese women).

- As long as the recipient continues to gain weight or BCM, somatropin may be extended every 28 days, with authorization, until BCM and/or weight are normalized.
- Once BCM and/or weight have normalized, somatropin should be stopped.

Reinitiating Somatropin Therapy
Within Six Months: Criteria

Criteria for reinitiating somatropin therapy within six months:

- Recipients may resume somatropin therapy within six months of initial therapy if there is documentation of an unintentional 5 percent loss of body weight or BCM loss of greater than 5 percent or any of the criteria for HIV-associated wasting within six months after completion of an uninterrupted 12-week course of somatropin therapy.
- Reinitiating somatropin is allowed for up to an additional 12 weeks, with reassessments required at the same four and eight week intervals during the second 12-week course of therapy. A recent copy of the recipient's BIA documenting the BCM loss is required with TAR submission.

Repeat Somatropin Therapy
After Cessation: Criteria

Criteria for repeat somatropin therapy six months after cessation of treatment:

- If the recipient has not re-initiated somatropin six months after completing an uninterrupted 12-week course of therapy, somatropin may be repeated, provided the criteria for initial 28 days of therapy are met. Reinitiating somatropin is allowed for up to an additional 12 weeks, with reassessments required at the same four- and eight-week intervals during the second 12-week course of therapy. A recent copy of the recipient's BIA is required with TAR submission.
- Trials of alternate treatment may be omitted if previous use in the recipient was unsuccessful. The use of somatropin beyond the initial 12-week course must meet the criteria stated above for continued treatment.

Taliglucerase Alfa

Taliglucerase alfa, a hydrolytic lysosomal glucocerebroside-specific enzyme for intravenous infusion, is a recombinant active form of the lysosomal enzyme, β -glucocerebrosidase, which is expressed in genetically modified carrot plant root cells cultured in a disposable bioreactor system. B-glucocerebrosidase is a lysosomal glycoprotein enzyme that catalyzes the hydrolysis of the glycolipid glucocerebroside to glucose and ceramide.

Indications

For use for adults with confirmed diagnosis of Type 1 Gaucher disease.

Authorization

The *Treatment Authorization Request* (TAR) must include a diagnosis of Type 1 Gaucher disease. For other TAR requirements, refer to the "Enzyme Replacement Drugs" topic in the *Injections: Drugs E-H Policy* section in this manual.

Dosage

The recommended dose is 60 units/kg of body weight administered once every two weeks as a 60-120 minute intravenous infusion. The maximum dose is 8,160 mg per day.

Billing

HCPCS code J3060 (injection, taliglucerase alfa, 10 units).

Tbo-Filgrastim

Tbo-filgrastim is a non-glycosylated recombinant methionyl human granulocyte colony-stimulating growth factor (r-metHuG-CSF) manufactured by recombinant DNA technology using the bacterium strain E coli K802. It binds to G-CSF receptors and stimulates proliferation neutrophils. G-CSF is known to stimulate differentiation commitment and some end-cell functional activation, which increases neutrophil counts and activity.

Indications

To reduce the duration of severe neutropenia in adult patients (18 years of age and older) with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

Dosage

The recommended dose of tbo-filgrastim is 5 mcg/kg per day administered as a subcutaneous injection. Administer the first dose of tbo-filgrastim no earlier than 24 hours following myelosuppressive chemotherapy.

Required Codes	Tbo-filgrastim is reimbursable when billed with one of the following ICD-9-CM codes: <ul style="list-style-type: none"> • 288.03 • V58.11 • V66.2
Billing	HCPCS code J1446 (injection, tbo-filgrastim, 5 mcg)
Thyrotropin Alfa	Thyrotropin alfa is reimbursable for use in the following groups: (1) as a diagnostic tool for serum thyroglobulin testing with or without radioiodine imaging in the follow-up of patients with well-differentiated thyroid cancer and (2) as an adjunctive treatment for radioiodine ablation of thyroid tissue remnants in patients who have undergone a near-total or total thyroidectomy for well-differentiated thyroid cancer and who do not have evidence of metastatic thyroid cancer.
Dosage	<p>A two-injection regimen is recommended. The two-injection regimen is thyrotropin alfa 0.9 mg intramuscularly (IM) followed by a second 0.9 mg IM injection 24 hours later.</p> <p>For imaging or remnant ablation, radioiodine administration should be given 24 hours following the final thyrotropin alfa injection. A post-ablation scan should be performed three to five days after radioiodine administration. A diagnostic serum thyroglobulin with or without scanning should be performed 48 hours after radioiodine administration.</p>
Authorization	An approved <i>Treatment Authorization Request (TAR)</i> is required for reimbursement.
Billing	HCPCS code J3240 (injection, thyrotropin alpha, 0.9 mg) provided in 1.1 mg vial.
Tigecycline	<p>Tigecycline, 1 mg (HCPCS code J3243) has a maximum daily dosage of 100 mg.</p> <p>Safety warning: All-cause mortality was higher in recipients treated with tigecycline than comparators in a meta-analysis of clinical trials. Tigecycline should be reserved for use in situations when alternative treatments are not suitable.</p>

Tocilizumab

Tocilizumab is a humanized anti-human interleukin-6 (IL-6) receptor antibody that is made by grafting the complementary-determining regions of a mouse anti-human IL-6 receptor monoclonal antibody onto human IgG1. Tocilizumab competes for both the membrane-bound and soluble forms of the human IL-6 receptor, thereby inhibiting the binding of the native cytokine to its receptor and interfering with the cytokine's effects.

Indications

Tocilizumab is indicated for the treatment of:

- Rheumatoid Arthritis (RA) in adult patients with moderately to severely active RA who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs).
- Polyarticular Juvenile Idiopathic Arthritis (PJIA) in patients 2 years of age and older with active PJIA.
- Systemic Juvenile Idiopathic Arthritis (SJIA) in patients 2 years of age and older *with* active SJIA.

Dosage

RA:

Tocilizumab may be used as monotherapy or concurrently with methotrexate or other DMARDs. The recommended dose is 4 mg/kg every 28 days or four weeks, followed by an increase to 8 mg/kg based on clinical response. The maximum recommended dose is 800 mg over a period of four weeks.

PJIA:

Tocilizumab may be used alone or in combination with methotrexate. The recommended dose is 10 mg/kg (less than 30 kg) or 8 mg/kg (equal to or greater than 30 kg) and is given once every four weeks. A maximum dose of 800 mg is allowed over a period of four weeks.

SJIA:

Tocilizumab may be used alone or in combination with methotrexate. The recommended dose is 12 mg/kg (less than 30 kg) or 8 mg/kg (equal to or greater than 30 kg) and is given once every two weeks. A maximum dose of 800 mg is allowed over a period of four weeks.

Tocilizumab has not been studied and its use should be avoided in combination with biological DMARDs such as tumor necrosis factor antagonists, interleukin-1R antagonists, anti-CD20 monoclonal antibodies and selective co-stimulation modulators because of the possibility of increased immunosuppression and increased risk of infection.

It is recommended that tocilizumab not be initiated in patients with neutropenia, thrombocytopenia or elevated liver enzymes.

Required Codes

ICD-9-CM diagnosis codes 714.0 – 714.33

Billing

HCPCS code J3262 (injection, tocilizumab, 1 mg)
One (1) unit = 1 mg

Treprostinil

Treprostinil, 1 mg, (HCPCS code J3285) is reimbursable for patients 16 years of age or older with pulmonary hypertension. Claims require authorization.

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Ustekinumab

Ustekinumab is a human IgG1 κ monoclonal antibody that binds with high affinity and specificity to the p40 protein subunit used by both the interleukin (IL)-12 and IL-23 cytokines. IL-12 and IL-23 are naturally occurring cytokines that are involved in inflammatory and immune responses, such as natural killer cell activation and CD4+ T-cell differentiation and activation.

Indications

For the treatment of adult patients 18 years of age and older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Required Codes

Restricted to ICD-9-CM diagnosis code 696.1.

Dosage

Ustekinumab is administered by subcutaneous injection.

For patients weighing <100 kg, the recommended dose is 45 mg initially and four weeks later, followed by 45 mg every 12 weeks.

For patients weighing >100 kg, the recommended dose is 90 mg initially and four weeks later, followed by 90 mg every 12 weeks.

Billing

HCPCS code J3357 (injection, ustekinumab, 1 mg).

Vancomycin

Vancomycin is a glycopeptide antibiotic that is reimbursable when used for the treatment of serious or severe infections caused by susceptible strains of gram positive bacteria.

Dosage

The initial intravenous dose should be based on actual body weight, with subsequent dosing based on serum trough vancomycin concentrations.

Billing

HCPCS code J3370 (injection, vancomycin HCl, 500 mg)
One (1) unit = 500 mg

Vedolizumab	Vedolizumab is a humanized IgG ₁ monoclonal antibody produced in Chinese hamster ovary cells that binds to the human $\alpha 4\beta 7$ integrin and blocks the interaction of $\alpha 4\beta 7$ integrin with mucosal addressin cell adhesion molecule-1 (MAdCAM-1) and inhibits migration of memory T-lymphocytes across the endothelium into inflamed gastrointestinal parenchymal tissue. The interaction of the $\alpha 4\beta 7$ integrin with MAdCAM-1 has been implicated as an important contributor to the chronic inflammation that is a hallmark of ulcerative colitis (UC) and Crohn's disease (CD).
Indications	<p>Ulcerative Colitis: Adult patients 18 years of age and older with moderately to severely active UC who have had an inadequate response with, lost response to or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to or demonstrated dependence on corticosteroids.</p> <p>Crohn's Disease: Adult patients 18 years of age and older with moderately to severely active CD who have had an inadequate response with, lost response to or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to or demonstrated dependence on corticosteroids.</p>
Authorization	An approved <i>Treatment Authorization Request</i> (TAR) is required for reimbursement.
Dosage	The recommended dosage is 300 mg infused intravenously over approximately 30 minutes at zero, two and six weeks, then every eight weeks thereafter.
Billing	HCPCS code C9026 (injection, vedolizumab, 1 mg)

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Velaglucerase Alfa

For detailed billing policy information about velaclucerase alfa, refer to the “Enzyme Replacement Drugs” topic in the *Injections: Drugs E-H Policy* section in this manual.

Verteporfin

Policy for intravenous verteporfin, HCPCS code J3396 (injection, verteporfin, 0.1 mg), is located in the *Ophthalmology* section of the Part 2 manual.

Visualization Adjunct

HCPCS code Q9968 (injection, non-radioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg (one unit = 1 mg) is billed “By Report.”

Vitamin B-12 Cyanocobalamin

Vitamin B-12 cyanocobalamin (injection, up to 1000 mcg) is billed with HCPCS code J3420.

Required Codes

Code J3420 must be billed in conjunction with one of the following ICD-9-CM codes:

- 266.2
- 281.0
- 281.1
- 281.3
- 336.2

Dosage

The maximum dosage is 1,000 mcg per day.

Ziprasidone	<p>Ziprasidone is reimbursable for acute and long-term treatment of adult schizophrenia.</p> <p>Ziprasidone has been shown to be effective for the acute and long-term management of agitation experienced by patients with schizophrenia.</p> <p>Note: There is a Food and Drug Administration warning on ziprasidone about its greater capacity to prolong the QT/QTc intervals as opposed to other antipsychotic drugs. Prolongation of the QTc interval has been associated with the development of a potentially fatal condition of ventricular tachycardia and sudden death.</p>
Dosage	The maximum dosage is 40 mg per day.
Billing	For billing ziprasidone mesylate, 10 mg injection, use HCPCS code J3486.

Zoledronic Acid

Zoledronic acid is a bisphosphonic acid which is an inhibitor of osteoclastic bone resorption. Although the antiresorptive mechanism is not completely understood, several factors are thought to contribute to this action. In vitro, zoledronic acid inhibits osteoclastic activity and induces osteoclast apoptosis. It also blocks the osteoclastic resorption of mineralized bone and cartilage through its binding to bone. Finally, it inhibits the increased osteoclastic activity and skeletal calcium release induced by various stimulatory factors released by tumors.

Indications

Zoledronic acid is used for both malignant and non-malignant conditions and is indicated for the treatment of:

- Patients with multiple myeloma and patients with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy. Prostate cancer should have progressed after treatment with at least one hormonal therapy.
- Prevention of postmenopausal osteoporosis
- Osteoporosis in men
- Prevention of glucocorticoid-induced osteoporosis
- Paget's disease of bone in men and women
- Hypercalcemia of malignancy

Dosage	The dose varies depending upon which disease or condition is being treated. For the use of zoledronic acid in non-malignant conditions, coverage is limited to one 5 mg injection, once every 12 months.
Required Codes	<p>ICD-9-CM Codes</p> <p>One of the following codes <u>is required</u> if the drug is being used for <u>malignant</u> conditions:</p> <ul style="list-style-type: none">• 198.5• 203.00• 203.02• Any diagnosis code identifying a malignancy resulting in hypercalcemia (140.0 – 239.9) <p>One of the following codes <u>is required</u> if the drug is being used for <u>non-malignant</u> conditions:</p> <ul style="list-style-type: none">• 256.2• 256.31• 627.0 – 627.9• 731.0• 733.0 – 733.09• V07.4• V49.81
Billing	<p>HCPCS code J3489 (injection, zoledronic acid, 1 mg).</p> <p>In addition to the diagnosis code used for hypercalcemia of malignancy, a statement identifying the malignancy must be placed in the <i>Remarks</i> field (Box 80) on the <i>UB-04</i> claim or <i>Additional Claim Information</i> field (Box 19) on the <i>CMS-1500</i> claim. Also, to eliminate a professional review and expedite payment, the diagnosis code must be provided in the unlabeled primary diagnosis field (Box 67) on the <i>UB-04</i> claim or the <i>Diagnosis or Nature of Illness or Injury</i> field (Box 21) on the <i>CMS-1500</i> claim.</p>