INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form or their electronic equivalents of their successor forms. The policy applies to all participating hospitals in Connecticut (CT), New Jersey (NJ), and New York (NY).
Exceptions: This reimbursement policy does not apply to:

- Hospitals that have contracted all their separately reimbursable drugs at 165% of CMS or less.
- Hospitals whose aggregate reimbursement for the specialty drugs listed below is less than Oxford’s designated specialty pharmacy’s contracted rates for the same specialty drugs.
- Hospitals that are located outside of CT, NJ, and NY.
- Oxford members that have Medicare or another health benefit plan as the primary payer and Oxford is the secondary payer.

OVERVIEW

This policy communicates Oxford’s policy regarding the reimbursement of certain specialty medications provided in an outpatient hospital setting, including the denial of payment to hospitals for failure to follow the protocol outlined in the Specialty Pharmacy Protocol for Certain Specialty Medications Administered in an Outpatient Hospital Setting for UnitedHealthcare Oxford Commercial Members available on the provider portal (UHCprovider.com/Protocols).

REIMBURSEMENT GUIDELINES

For Oxford members, participating hospitals in CT, NJ, and NY are required to obtain certain specialty medications from the BriovaRx Specialty Pharmacy. The specialty medications included in this protocol are:

- Actemra® (tocilizumab) injection for intravenous infusion
- Cimzia (certolizumab pegol)
- Entyvio® (vedolizumab)
- Infliximab (Remicade®, Inflectra™, Renflexis™)
- Lemtrada (alemtuzumab)
- Ocrevus™ (ocrelizumab)
- Oremia® (abatacept) injection for intravenous infusion
- Simponi Aria® (golimumab) injection for intravenous infusion
- Stelara® (ustekinumab)
- Tysabri (natalizumab)

Participating hospitals located in CT, NJ, and NY must obtain the above specialty medications from BriovaRx when they are administered in an outpatient hospital setting. BriovaRx will bill Oxford directly for these specialty medications.

Outpatient Hospital is defined by the following CMS/AMA Place of Service codes:

- 19 Off-Campus - Outpatient Hospital; and
- 22 On-Campus - Outpatient Hospital

Participating hospitals located in CT, NJ, and NY:

- Will bill Oxford for the administration of the medication only.
- May not bill members for these medications.

Financial Consequence for Non-Compliance

Oxford will issue an administrative denial of payment for failure to comply with this protocol.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

Note: This list of specialty medications is subject to change upon 90 days written notice.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0129</td>
<td>Injection, abatacept, 10 mg</td>
</tr>
<tr>
<td>J0202</td>
<td>Injection, alemtuzumab, 1 mg</td>
</tr>
<tr>
<td>J0717</td>
<td>Injection, certolizumab pegol, 1 mg</td>
</tr>
<tr>
<td>J1602</td>
<td>Injection, golimumab, 1 mg, for intravenous use</td>
</tr>
<tr>
<td>J1745</td>
<td>Injection, infliximab, excludes biosimilar, 10 mg</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>J2323</td>
<td>Injection, natalizumab, 1 mg</td>
</tr>
<tr>
<td>J2350</td>
<td>Injection, ocrelizumab, 1 mg</td>
</tr>
<tr>
<td>J3262</td>
<td>Injection, tocilizumab, 1 mg</td>
</tr>
<tr>
<td>J3357</td>
<td>Ustekinumab, for subcutaneous injection, 1 mg</td>
</tr>
<tr>
<td>J3358</td>
<td>Ustekinumab, for intravenous injection, 1 mg</td>
</tr>
<tr>
<td>J3380</td>
<td>Injection, vedolizumab, 1 mg</td>
</tr>
<tr>
<td>Q5103</td>
<td>Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg</td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg</td>
</tr>
</tbody>
</table>

**QUESTIONS AND ANSWERS**

**Q:** What happens if a hospital bills for one of the drugs listed above?  
**A:** Oxford will issue an administrative denial of payment for failure to comply with the Specialty Pharmacy Protocol for Certain Specialty Medications Administered in an Outpatient Hospital Setting for UnitedHealthcare Oxford Commercial Members.

**POLICY HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Related Policies</th>
</tr>
</thead>
</table>
| 07/01/2020 | • Added reference link to the Clinical Policy titled *Tysabri® (Natalizumab)*  
• Updated policy application guidelines; added language to clarify this policy:  
  o Applies to all participating hospitals in Connecticut (CT), New Jersey (NJ), and New York (NY)  
  o Does not apply to:  
    ▪ Hospitals whose aggregate reimbursement for the specialty drugs *listed in the policy* is less than Oxford’s designated specialty pharmacy’s contracted rates *for the same specialty drugs*  
    ▪ Hospitals that are located outside of CT, NJ and NY  
• Updated policy overview; replaced language indicating “this document *articulates* Oxford’s policy regarding the reimbursement of certain *multiple sclerosis and anti-inflammatory* specialty medications provided in an outpatient hospital setting” with “this policy *communicates* Oxford’s policy regarding the reimbursement of certain specialty medications provided in an outpatient hospital setting”  
• Updated reimbursement guidelines:  
  o Added language to clarify hospitals *located in CT, NJ, and NY* are subject to the guidelines in this policy and are required to *obtain* the listed specialty medications from BriovaRx  
  o Replaced references to “*multiple sclerosis and anti-inflammatory* specialty medications” with “specialty medications”  
  o Added language to indicate “outpatient hospital” is defined by the following CMS/AMA place of service codes:  
    ▪ 19 Off-Campus - Outpatient Hospital  
    ▪ 22 On-Campus - Outpatient Hospital  
• Archived previous policy version ADMINISTRATIVE 265.1 T2 |
| 04/01/2019 |