



Authorization Requirements for Medications Under the Medical Benefit

| HCPC/MOD | GA MCD | BRAND NAME | LONG DESCRIPTION | SHORT DESCRIPTION | Limits |
|----------|---|------------------|---|--|-------------------------|
| 90375 | No Prior Authorization Required | HyperRab | Rabies Immune Globulin (Human) | Rabies Immune Globulin (Human) | |
| 90378 | Prior Authorization Required | Synagis | Palivizumab | Synagis | Up to 5 treatments |
| 90380 | No Prior Authorization Required | Beyfortus | Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use | | |
| 90381 | No Prior Authorization Required | Beyfortus | Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use | | |
| 90675 | No Prior Authorization Required | Imovax, Rabavert | Rabies vaccine, for intramuscular use (Code price is per 1 mL) | Rabies vaccine, for intramuscular use | |
| 91304 | No Prior Authorization Required | Novavax | Novavax Covid-19 Vaccine, Adjuvanted (Aged 12 years and older) | SARSCOV2 VAC 5MCG/0.5ML IM | |
| 96380 | No Prior Authorization Required | (RSV ADMIN) | Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional | | |
| 96381 | No Prior Authorization Required | (RSV ADMIN) | Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection | | |
| 99501 | No Prior Authorization Required | | Postpartum Maternal Newborn Assessment Service | Postpartum Maternal Newborn Assessment Service | 4 Units Within 180 days |
| 99502 | No Prior Authorization Required | | Newborn Assessment | Newborn Assessment | 4 Units Within 180 days |
| 99506 | Prior Authorization Required | | Home Nursing Visit for Medication Administration | Home Nursing Visit for Medication Administration | |
| 99600 | No Prior Authorization Required | | 17Alpha-hydroxyprogesterone Caproate (17P) Administration Nursing Service | 17Alpha-hydroxyprogesterone Caproate (17P) Administration Nursing Service | |
| 99601 | No Prior Authorization Required | | Home infusion/specialty drug administration, per visit (up to 2 hours) | Home infusion/specialty drug administration, per visit (up to 2 hours) | Up to 2 hours per day |
| 99602 | No Prior Authorization Required | | Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code 99601 for primary procedure) (Use 99602 in conjunction with 99601) | Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code 99601 for primary procedure) (Use 99602 in conjunction with 99601) | Up to 2 hours per day |
| 0054A[4] | No Prior Authorization Required | Pfizer | Pfizer-BioNTech Covid-19 Vaccine Pre-Diluted (Gray Cap) Administration - Booster | ADM SARSCV2 30MCG TRS-SUCR B | |
| 0064A[4] | No Prior Authorization Required | Moderna | Moderna Covid-19 Vaccine (Red Cap) (Low Dose) Administration - Booster | ADM SARSCOV2 50MCG/0.25MLBST | |
| 90480 | No Prior Authorization Required | | Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose | | |
| 90623 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y-tetanus toxoid carrier, and Men B-FHbp, for intramuscular use | | |
| 90678 | No Prior Authorization Required | | Respiratory syncytial virus vaccine, pref, subunit, bivalent, for intramuscular use | | |
| 90679 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Respiratory syncytial virus vaccine, pref, recombinant, subunit, adjuvanted, for intramuscular use | | |
| 90683 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use | | |
| 91313 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use | | |
| 91314 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use | | |
| 91315 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use | | |
| 91317 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 3 mcg/0.2 mL dosage | | |
| 91318 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, tris-sucrose formulation, | | |

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| 91319 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, | | |
| 91320 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, | | |
| 91321 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use | | |
| 91322 | No Prior Authorization Required | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use | | |
| A4216 | No Prior Authorization Required | Sterile water | Sterile water, saline, and/or dextrose, diluent/flush, 10 mL | Sterile water | |
| A4221 | No Prior Authorization Required | | Supp non-insulin inf cath/wk | Supp non-insulin inf cath/wk | |
| A4222 | No Prior Authorization Required | | Infusion supplies with pump | Infusion supplies with pump | |
| A4223 | No Prior Authorization Required | | Infusion supplies w/o pump | Infusion supplies w/o pump | |
| A4238 | Prior Authorization Required | Guardian | Supply allowance for adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service | | |
| A4239 | Pharmacy Benefit | Freestyle Libre Dexcom | Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service | | |
| A9276 | Prior Authorization Required | Simplera™ continuous glucose monitor (CGM) | Sensor; invasive (e.g., subcutaneous), disposable, for use with non-durable medical equipment interstitial continuous glucose monitoring system, one unit = 1 day supply | | |
| A9277 | Prior Authorization Required | (CGM) | Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system | | |
| A9278 | Prior Authorization Required | (CGM) | Receiver (monitor); external, for use with non-durable medical equipment interstitial continuous glucose monitoring system | | |
| A9513 | Prior Authorization Required | Lutathera | Lutetium lu, dotatete, therapeutic, 1 millicurie | lutetium lu 177 | |
| A9606 | Prior Authorization Required | Xofigo | Radium Ra 223 dichloride | Xofigo | |
| A9615 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, pegulicanine, 1 mg | Inj, pegulicanine, 1 mg | |
| B4148 | No Prior Authorization Required | | Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | Enteral feed elastomer daily | |
| B4164 | No Prior Authorization Required | | Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - home mix | Parenteral 50% dextrose solu | |
| B4168 | No Prior Authorization Required | | Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - home mix | Parenteral sol amino acid 3. | |
| B4172 | No Prior Authorization Required | | Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix | Parenteral sol amino acid 5. | |
| B4176 | No Prior Authorization Required | | Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix | Parenteral sol amino acid 7- | |
| B4178 | No Prior Authorization Required | | Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml = 1 unit) - home mix | Parenteral sol amino acid > | |
| B4180 | No Prior Authorization Required | | Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) - home mix | Parenteral sol carb > 50% | |
| B4185 | No Prior Authorization Required | Clinolipid, Nutrilipid, Smolipid, Intralipid | Parenteral nutrition solution, not otherwise specified, 10 grams lipids | Pn soln nos 10 grams lipids | |
| B4187 | No Prior Authorization Required | Omegaven | Omegaven, 10 grams lipids | Omegaven, 10 grams lipids | |
| B4189 | No Prior Authorization Required | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix | Parenteral sol amino acid & | |
| B4193 | No Prior Authorization Required | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix | Parenteral sol 52-73 gm prot | |
| B4197 | No Prior Authorization Required | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix | Parenteral sol 74-100 gm pro | |

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| B4199 | No Prior Authorization Required | | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix | Parenteral sol > 100gm prote | |
| B4216 | No Prior Authorization Required | | Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes), home mix, per day | Parenteral nutrition additiv | |
| B4220 | No Prior Authorization Required | | Parenteral nutrition supply kit; premix, per day | Parenteral supply kit premix | |
| B4222 | Prior Authorization Required | | Parenteral nutrition supply kit; home mix, per day | Parenteral supply kit homemi | |
| B4224 | No Prior Authorization Required | | Parenteral nutrition administration kit, per day | Parenteral administration ki | |
| B5000 | No Prior Authorization Required | | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-aminosyn-rf, nephramine, renamine-premix | Parenteral sol renal-amirosy | |
| B5100 | No Prior Authorization Required | | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-premix | Parenteral solution hepatic | |
| B5200 | No Prior Authorization Required | | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix | Parenteral sol hepatic fream | |
| B9006 | Prior Authorization Required | | Parenteral nutrition infusion pump, stationary | Parenteral infus pump statio | |
| B9999 | Prior Authorization Required | | Noc for parenteral supplies | Parenteral supp not othrws c | |
| C9046 | Prior Authorization Required | Cocaine, Goprelto | Cocaine hydrochloride nasal solution for topical administration, 1 mg | Cocaine hcl nasal solution | |
| C9047 | Prior Authorization Required | Cablivi | Injection, caplacizumab-yhdp, 1 mg | Injection, caplacizumab-yhdp | |
| C9088 | Prior Authorization Required | Zynrelief | Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg | Instill, bupivac and meloxic | |
| C9089 | Not Covered on state fee schedule (Provider's Administered Drug List) | Xaracoll | Bupivacaine, collagen-matrix implant, 1 mg | Bupivacaine implant, 1 mg | |
| C9143 | Prior Authorization Required | Numbrino | Cocaine hydrochloride nasal solution (Numbrino), 1 mg | | |
| C9144 | Prior Authorization Required | Posimir | Injection, bupivacaine (Posimir), 1 mg | | |
| C9145 | No Prior Authorization Required | Aponvie | Injection, aprepitant, (Aponvie), 1 mg | Inj, aponvie, 1 mg | |
| C9173 | Not Covered on state fee schedule (Provider's Administered Drug List) | Nypozi | Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram | Inj, nypozi, 1 mcg | |
| C9248 | No Prior Authorization Required | Cleviprex | Injection, clevidipine butyrate, 1 mg | Inj, clevidipine butyrate | |
| C9254 | No Prior Authorization Required | Vimpat | Injection, lacosamide, 1 mg | Injection, lacosamide | |
| C9257 | Prior Authorization Required | Avastin | Injection, bevacizumab, 0.25 mg | Bevacizumab injection | |
| C9285 | No Prior Authorization Required | Synera | Lidocaine 70 mg/tetracaine 70 mg, per patch | Patch, lidocaine/tetracaine | |
| C9293 | No Prior Authorization Required | Voraxaze | Injection, glucarpidase, 10 units | Injection, glucarpidase | |
| C9399 | Prior Authorization Required | Unclassified code | Unclassified drugs or biologicals | Unclassified drugs or biolog | |
| C9460 | No Prior Authorization Required | Kengreal | Injection, cangrelor, 1 mg | Injection, cangrelor | |
| C9462 | Prior Authorization Required | Baxdela | Injection, delafloxacin, 1 mg | Injection, delafloxacin | |
| C9488 | Prior Authorization Required | Vaprisol | Injection, conivaptan hydrochloride, 1 mg | Conivaptan hcl | |
| E2102 | Prior Authorization Required | Guardian | Adjunctive, non-implanted continuous glucose monitor or receiver | | |
| E2103 | Pharmacy Benefit | Freestyle Libre Dexcom | Non-adjunctive, non-implanted continuous glucose monitor or receiver | | |
| G0012 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection of pre-exposure prophylaxis (PrEP) drug for HIV prevention, under skin or into muscle | Injection of hiv prep drug | |
| G0532 | Not Covered on state fee schedule (Provider's Administered Drug List) | Nalmafene | Take-home supply of nasal nalmeferene hydrochloride; one carton of two, 2.7 mg per 0.1 ml nasal sprays (provision of the services by a medicare-enrolled opioid treatment program);(list separately in addition to each primary code) | Take home supp nasal spray | |
| G0533 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Medication assisted treatment, buprenorphine (injectable) administered on a weekly basis; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program) | Buprenorphine inj weekly | |
| G1028 | Not Covered on state fee schedule (Provider's Administered Drug List) | Naloxone | Take-home supply of nasal naloxone; 2-pack of 8 mg per 0.1 ml nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addit | Take home supply 8mg per 0.1 | |

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| G2082 | Not Covered on state fee schedule (Provider's Administered Drug List) | Spravato | Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation | Visit esketamine 56m or less | |
| G2083 | Not Covered on state fee schedule (Provider's Administered Drug List) | Spravato | Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation | Visit esketamine, > 56m | |
| J0121 | Prior Authorization Required | Nuzyra | Injection, omadacycline, 1 mg | Inj., omadacycline, 1 mg | |
| J0122 | Prior Authorization Required | Xerava | Injection, eravacycline, 1 mg | Inj., eravacycline, 1 mg | |
| J0129 | Prior Authorization Required | Orencia | Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Abatacept injection | Self-administered: 4 units per 28 days Infusion: 100 units per 28 days |
| J0131 | No Prior Authorization Required | Ofirmev | Injection, acetaminophen, 10 mg | Acetaminophen injection | |
| J0132 | No Prior Authorization Required | Mucomyst | Injection, acetylcysteine, 100 mg | Acetylcysteine injection | |
| J0133 | No Prior Authorization Required | Zovirax | Injection, acyclovir, 5 mg | Acyclovir injection | |
| J0134 | Prior Authorization Required | | Injection, acetaminophen (Fresenius Kabi) not therapeutically equivalent to J0131, 10 mg | | |
| J0136 | Prior Authorization Required | | Injection, acetaminophen (B. Braun) not therapeutically equivalent to J0131, 10 mg | | |
| J0137 | No Prior Authorization Required | | Injection, acetaminophen (Hikma) not therapeutically equivalent to J0131, 10 mg | Inj, acetaminophen (hikma) | |
| J0138 | No Prior Authorization Required | COMBOGESIC 10MG/ML-3MG/ML Solution | Injection, acetaminophen 10 mg and ibuprofen 3 mg | Injection, acetaminoph 10 mg | |
| J0139 | Prior Authorization Required | | Injection, adalimumab, 1 mg | Inj, adalimumab, 1 mg | |
| J0153 | No Prior Authorization Required | Adenosine | Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds) | Adenosine inj 1mg | |
| J0171 | No Prior Authorization Required | Epinephrine | Injection, adrenalin, epinephrine, 0.1 mg | Adrenalin epinephrine inject | |
| J0172 | Prior Authorization Required | Aduhelm | Injection, aducanumab-avwa, 2 mg | Inj, aducanumab-avwa, 2 mg | |
| J0173 | Prior Authorization Required | | Injection, epinephrine (Belcher) not therapeutically equivalent to J0171, 0.1 mg | | |
| J0174 | Prior Authorization Required | Leqembi | Injection, lecanemab-irmb, 1 mg | Inj, lecanemab-irmb, 1 mg | |
| J0177 | Prior Authorization Required | Eylea HD | Injection, aflibercept HD, 1 mg | Inj, aflibercept hd, 1 mg | |
| J0178 | Prior Authorization Required | Eylea | Injection, aflibercept, 1 mg | Aflibercept injection | |
| J0179 | Prior Authorization Required | Beovu | Injection, brolocizumab-dbl, 1 mg | brolocizumab-dbl | |
| J0179 | Prior Authorization Required | Beovu | Injection, brolocizumab-dbl, 1 mg | Inj, brolocizumab-dbl, 1 mg | |
| J0180 | Prior Authorization Required | Fabrazyme | Injection, agalsidase beta, 1 mg | Agalsidase beta injection | |
| J0184 | Not Covered on state fee schedule (Provider's Administered Drug List) | Barhemsys | Injection, amisulpride, 1 mg | Inj, amisulpride, 1 mg | |
| J0185 | Prior Authorization Required | Cinvanti | Injection, aprepitant, 1 mg | Inj., aprepitant, 1 mg | |
| J0202 | Prior Authorization Required | Lemtrada | Injection, alemtuzumab, 1 mg | Injection, alemtuzumab | |
| J0205 | Prior Authorization Required | Ceredase | Injection, alglucerase, per 10 units | Alglucerase injection | |
| J0206 | Not Covered on state fee schedule (Provider's Administered Drug List) | Allopurinol | Injection, allopurinol sodium, 1 mg | Inj allopurinol sodium 1 mg | |
| J0207 | Not Covered on state fee schedule (Provider's Administered Drug List) | Ethylol | Injection, amifostine, 500 mg | Amifostine | |
| J0208 | Prior Authorization Required | PEDMARK | Injection, sodium thiosulfate, 100 mg | Inj sodium thiosulfate 100mg | |
| J0209 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, sodium thiosulfate (Hope), 100 mg | Inj, sod thiosulfate (hope) | |
| J0211 | Prior Authorization Required | Nithiodote | Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg (nithiodote) | Inj, nithiodote, 3mg / 125mg | |
| J0215 | Prior Authorization Required | AMEVIVE | Injection, alefacept, 0.5 mg | Alefacept | |
| J0216 | Not Covered on state fee schedule (Provider's Administered Drug List) | Alfentanil | Injection, alfentanil HCl, 500 mcg | Inj, alfentanil hcl, 500mcg | |
| J0217 | Prior Authorization Required | Lamzede | Injection, velmanase alfa-tycv, 1 mg | Inj velmanase alfa-tycv 1 mg | |
| J0218 | Prior Authorization Required | Xenpozyme | Injection, olipudase alfa-rpcp, 1 mg | Inj olipudase alfa-rpcp 1mg | |
| J0219 | Prior Authorization Required | Nexviazyme | Injection, avalglucosidase alfa-ngpt, 4 mg | | |
| J0220 | Prior Authorization Required | Lumizyme | Injection, alglucosidase alfa, 10 mg, not otherwise specified | Alglucosidase alfa injection | |
| J0221 | Prior Authorization Required | Lumizyme | Injection, alglucosidase alfa, (lumizyme), 10 mg | Lumizyme injection | |
| J0222 | Prior Authorization Required | Onpattro | Injection, patisiran, 0.1 mg | Inj., patisiran, 0.1 mg | |

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| J0223 | Prior Authorization Required | Givlaari | Injection, givosiran, 0.5 mg | Inj givosiran 0.5 mg | |
| J0224 | Prior Authorization Required | Oxlumo | Injection, lumasiran, 0.5 mg | Inj. lumasiran, 0.5 mg | |
| J0225 | Prior Authorization Required | AMVUTTRA | Injection, vutrisiran, 1 mg | | |
| J0248 | No Prior Authorization Required | Veklury | Injection, remdesivir, 1 mg | Inj. remdesivir, 1 mg | |
| J0256 | Prior Authorization Required | Aralast NP Prolastin-C | Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg | Alpha 1 proteinase inhibitor | 60mg/kg once weekly |
| J0257 | Prior Authorization Required | Glassia | Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg | Glassia injection | |
| J0270 | No Prior Authorization Required | Edex | Injection, alprostadil, 1.25 mcg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Alprostadil for injection | |
| J0275 | No Prior Authorization Required | Muse | Alprostadil urethral suppository (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Alprostadil urethral suppos | |
| J0278 | No Prior Authorization Required | Amikacin | Injection, amikacin sulfate, 100 mg | Amikacin sulfate injection | |
| J0280 | No Prior Authorization Required | Aminophylline | Injection, aminophyllin, up to 250 mg | Aminophyllin 250 mg inj | |
| J0282 | No Prior Authorization Required | Amiodarone | Injection, amiodarone hydrochloride, 30 mg | Amiodarone hcl | |
| J0283 | Prior Authorization Required | NEXTERONE | Injection, amiodarone HCl (Nexterone), 30 mg | | |
| J0285 | No Prior Authorization Required | Amphotericin B | Injection, amphotericin b, 50 mg | Amphotericin b | |
| J0287 | No Prior Authorization Required | Abelcet | Injection, amphotericin b lipid complex, 10 mg | Amphotericin b lipid complex | |
| J0289 | No Prior Authorization Required | Ambisome | Injection, amphotericin b liposome, 10 mg | Amphotericin b liposome inj | |
| J0290 | No Prior Authorization Required | Ampicillin | Injection, ampicillin sodium, 500 mg | Ampicillin 500 mg inj | |
| J0291 | No Prior Authorization Required | Zemdri | Injection, plazomicin, 5 mg | Inj., plazomicin, 5 mg | |
| J0295 | No Prior Authorization Required | Unasyn | Injection, ampicillin sodium/sulbactam sodium, per 1.5 gm | Ampicillin sulbactam 1.5 gm | |
| J0300 | Not Covered | Amytal | Injection, amobarbital, up to 125 mg | Amobarbital 125 mg inj | |
| J0330 | No Prior Authorization Required | Succinylcholine | Injection, succinylcholine chloride, up to 20 mg | Succinylcholine chloride inj | |
| J0348 | No Prior Authorization Required | Eraxis | Injection, anidulafungin, 1 mg | Anidulafungin injection | |
| J0349 | Prior Authorization Required | Rezzayo | Injection, rezafungin, 1 mg | Inj, rezafungin, 1 mg | |
| J0360 | No Prior Authorization Required | Apresoline | Injection, hydralazine hcl, up to 20 mg | Hydralazine hcl injection | |
| J0364 | Prior Authorization Required | Apokyn | Injection, apomorphine hydrochloride, 1 mg | Apomorphine hydrochloride | |
| J0391 | No Prior Authorization Required | Artesunate | Injection, artesunate, 1 mg | Inj, artesunate, 1mg | |
| J0401 | No Prior Authorization Required | Abilify Maintena | Injection, aripiprazole, extended release, 1 mg | Inj aripiprazole ext rel 1mg | |
| J0402 | Prior Authorization Required | Abilify Asimtufii | Injection, aripiprazole (Abilify Asimtufii), 1 mg | Inj, abilify asimtufii, 1 mg | |
| J0456 | No Prior Authorization Required | Zithromax | Injection, azithromycin, 500 mg | Azithromycin | |
| J0457 | Not Covered on state fee schedule (Provider's Administered Drug List) | AZACTAM | Injection, aztreonam, 100 mg | Injection, aztreonam, 100 mg | |
| J0461 | No Prior Authorization Required | Atropine | Injection, atropine sulfate, 0.01 mg | Atropine sulfate injection | |
| J0470 | No Prior Authorization Required | Ban in Oil | Injection, dimecaprol, per 100 mg | Dimecaprol injection | |
| J0475 | No Prior Authorization Required | Lioresal | Injection, baclofen, 10 mg | Baclofen 10 mg injection | |
| J0476 | No Prior Authorization Required | Lioresal IT | Injection, baclofen, 50 mcg for intrathecal trial | Baclofen intrathecal trial | |
| J0480 | No Prior Authorization Required | Simlect | Injection, basiliximab, 20 mg | Basiliximab | |
| J0485 | No Prior Authorization Required | Nulojix | Injection, belatacept, 1 mg | Belatacept injection | |
| J0490 | Prior Authorization Required | Benlysta | Injection, belimumab, 10 mg | Belimumab injection | |
| J0491 | Prior Authorization Required | Saphnelo | Injection, anifrolumab-fnia, 1 mg | | |
| J0500 | No Prior Authorization Required | Bentyl | Injection, dicyclomine hcl, up to 20 mg | Dicyclomine injection | |
| J0515 | No Prior Authorization Required | Cogentin | Injection, benzotropine mesylate, per 1 mg | Inj benzotropine mesylate | |
| J0517 | Prior Authorization Required | Fasenra | Injection, benralizumab, 1 mg | Inj., benralizumab, 1 mg | |
| J0558 | No Prior Authorization Required | Bicillin C-R | Injection, penicillin g benzathine and penicillin g procaine, 100,000 units | PenG benzathine/procaine inj | |
| J0561 | No Prior Authorization Required | Bicillin L-A | Injection, penicillin g benzathine, 100,000 units | Penicillin g benzathine inj | |
| J0565 | Prior Authorization Required | Zinplava | Injection, bezlotoxumab, 10 mg | Inj, bezlotoxumab, 10 mg | |
| J0567 | Prior Authorization Required | Brineura | Injection, cerliponase alfa, 1 mg | Inj., cerliponase alfa 1 mg | |
| J0571 | Pharmacy Benefit | Subutex | Buprenorphine, oral, 1 mg | Buprenorphine oral 1mg | |
| J0572 | Pharmacy Benefit | Suboxone | Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine | Bupren/nal up to 3mg bupreno | |
| J0573 | Pharmacy Benefit | Suboxone | Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine | Bupren/nal 3.1 to 6mg bupren | |

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| J0574 | Pharmacy Benefit | Suboxone | Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine | Bupren/nal 6.1 to 10mg bupre | |
| J0575 | Pharmacy Benefit | Suboxone | Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine | Bupren/nal over 10mg bupreno | |
| J0577 | Prior Authorization Required | Brixadi | Injection, buprenorphine extended-release (Brixadi), less than or equal to 7 days of therapy | Inj, brixadi, 7 days or less | |
| J0578 | Prior Authorization Required | Brixadi | Injection, buprenorphine extended-release (Brixadi), greater than 7 days and up to 28 days of therapy | Inj brixadi, more than 7 day | |
| J0583 | No Prior Authorization Required | Angiomax | Injection, bivalirudin, 1 mg | Bivalirudin | |
| J0584 | Prior Authorization Required | Crysvita | Injection, burosumab-twza 1 mg | Injection, burosumab-twza 1m | |
| J0585 | Prior Authorization Required | Botox | Injection, onabotulinumtoxin a, 1 unit | Injection, onabotulinumtoxin a | |
| J0586 | Prior Authorization Required | Dysport | Injection, abobotulinumtoxin a, 5 units | Abobotulinumtoxin a | |
| J0587 | Prior Authorization Required | Myobloc | Injection, rimabotulinumtoxin b, 100 units | Inj, rimabotulinumtoxin b | |
| J0588 | Prior Authorization Required | Xeomin | Injection, incobotulinumtoxin a, 1 unit | Incobotulinumtoxin a | |
| J0589 | Prior Authorization Required | Daxxify | Injection, daxibotulinumtoxina-lanm, 1 unit | Inj daxibotulinumtoxina-lanm | |
| J0591 | Prior Authorization Required | Kybella | Injection, deoxycholic acid, 1 mg | Inj deoxycholic acid, 1 mg | |
| J0592 | No Prior Authorization Required | Buprenex | Injection, buprenorphine hydrochloride, 0.1 mg | Buprenorphine hydrochloride | |
| J0593 | Pharmacy Benefit | Takhyzo | Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) | Inj., lanadelumab-flyo, 1 mg | |
| J0594 | No Prior Authorization Required | Busulfex | injection, busulfan, 1 mg | Busulfan injection | |
| J0595 | No Prior Authorization Required | Stadol | Injection, butorphanol tartrate, 1 mg | Butorphanol tartrate 1 mg | |
| J0596 | Prior Authorization Required | Ruconest | Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units | Injection, ruconest | 56mL per 30 days |
| J0597 | Prior Authorization Required | Beriner | Injection, c-1 esterase inhibitor (human), beriner, 10 units | C-1 esterase, beriner | Adult: 50mL per 30 days Pediatric: 30mL per 30 days |
| J0598 | Prior Authorization Required | Cinryze | Injection, c-1 esterase inhibitor (human), cinryze, 10 units | C-1 esterase, cinryze | |
| J0599 | Prior Authorization Required | Haegarda | Injection, c-1 esterase inhibitor (human), (haegarda), 10 units | Inj., haegarda 10 units | |
| J0600 | No Prior Authorization Required | Calcium Disodium Versenate | Injection, edetate calcium disodium, up to 1000 mg | Edetate calcium disodium inj | |
| J0601 | No Prior Authorization Required | | Sevelamer carbonate (renvela or therapeutically equivalent), oral, 20 mg (for esrd on dialysis) | Sevelamer carbonate 20 mg | |
| J0602 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Sevelamer carbonate (renvela or therapeutically equivalent), oral, powder, 20 mg (for esrd on dialysis) | Sevelamer carbonate pdr 20mg | |
| J0603 | No Prior Authorization Required | | Sevelamer hydrochloride (renagel or therapeutically equivalent), oral, 20 mg (for esrd on dialysis) | Sevelamer hydrochloride 20mg | |
| J0604 | No Prior Authorization Required | Sensipar | Cinacalcet, oral, 1 mg, (for esrd on dialysis) | Cinacalcet, esrd on dialysis | |
| J0605 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Sucroferric oxyhydroxide, oral, 5 mg (for esrd on dialysis) | Sucroferric oxyhydroxide 5mg | |
| J0606 | Prior Authorization Required | Parsabiv | Injection, etelcalcetide, 0.1 mg | Inj, etelcalcetide, 0.1 mg | |
| J0607 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Lanthanum carbonate, oral, 5 mg (for esrd on dialysis) | Lanthanum carbonate oral 5mg | |
| J0608 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to j0607 (for esrd on dialysis) | Lanthanum carbonate pwr 5mg | |
| J0609 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis) | Ferric citrate orl 3 mg iron | |
| J0612 | No Prior Authorization Required | Calcium gluconate | Injection, calcium gluconate (Fresenius Kabi), per 10 mg | Calcium glucon (fresenius) | |
| J0613 | No Prior Authorization Required | Calcium gluconate - sodium chloride | Injection, calcium gluconate (WG Critical Care), per 10 mg | Calcium glucon (wg critical) | |
| J0615 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Calcium acetate, oral, 23 mg (for esrd on dialysis) | Calcium acetate, oral, 23 mg | |
| J0630 | No Prior Authorization Required | Miacalcin | Injection, calcitonin salmon, up to 400 units | Calcitonin salmon injection | |
| J0636 | No Prior Authorization Required | Calcitrol | Injection, calcitriol, 0.1 mcg | Inj calcitriol per 0.1 mcg | |
| J0637 | No Prior Authorization Required | Cancidas | Injection, caspofungin acetate, 5 mg | Caspofungin acetate | |
| J0638 | Pharmacy Benefit | Ilaris | Injection, canakinumab, 1 mg | Canakinumab injection | 2 units per 28 days |
| J0640 | No Prior Authorization Required | Leucovorin Calcium | Injection, leucovorin calcium, per 50 mg | Leucovorin calcium injection | |
| J0641 | No Prior Authorization Required | Fusilev | Injection, levoleucovorin, not otherwise specified, 0.5 mg | Inj levoleucovorin nos 0.5mg | |
| J0642 | Prior Authorization Required | Khapzory | Injection, levoleucovorin (khapzory), 0.5 mg | Injection, khapzory, 0.5 mg | |
| J0650 | Not Covered on state fee schedule (Provider's Administered Drug List) | Levothyroxine sodium | Injection, levothyroxine sodium, not otherwise specified, 10 mcg | Inj, levothyroxine nos 10mcg | |
| J0651 | Not Covered on state fee schedule (Provider's Administered Drug List) | Levothyroxine sodium | Injection, levothyroxine sodium (Fresenius Kabi) not therapeutically equivalent to J0650, 10 mcg | Inj, levothyroxine, freskabi | |
| J0652 | Not Covered on state fee schedule (Provider's Administered Drug List) | Levothyroxine sodium | Injection, levothyroxine sodium (Hikma) not therapeutically equivalent to J0650, 10 mcg | Inj, levothyroxine, hikma | |

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| J0665 | No Prior Authorization Required | Marcaine | Injection, bupivacaine, not otherwise specified, 0.5 mg | Inj, bupivacaine, nos, 0.5mg | |
| J0666 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, bupivacaine liposome, 1 mg | Inj, bupivacaine liposome | |
| J0670 | No Prior Authorization Required | Carbocaine | Injection, mepivacaine hydrochloride, per 10 ml | Inj mepivacaine hcl/10 ml | |
| J0687 | Prior Authorization Required | Cefazolin | Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg | Inj cefazolin (wg crit care) | |
| J0688 | No Prior Authorization Required | CEFAZOLIN SODIUM 2G Solution Reconstituted | Injection, cefazolin sodium (Hikma), not therapeutically equivalent to J0690, 500 mg | Inj cefazolin sodium, hikma | |
| J0689 | Prior Authorization Required | Cefazolin sodium - dextrose | Injection, cefazolin sodium (Baxter), not therapeutically equivalent to J0690, 500 mg | | |
| J0690 | No Prior Authorization Required | Kefzol | Injection, cefazolin sodium, 500 mg | Cefazolin sodium injection | |
| J0691 | Prior Authorization Required | Xenleta | Injection, lefamulin, 1 mg | Inj lefamulin 1 mg | |
| J0692 | No Prior Authorization Required | Maxipime | Injection, cefepime hydrochloride, 500 mg | Cefepime hcl for injection | |
| J0694 | No Prior Authorization Required | Cefoxitin | Injection, cefoxitin sodium, 1 gm | Cefoxitin sodium injection | |
| J0695 | No Prior Authorization Required | Zerbaxa | Injection, ceftolozane 50 mg and tazobactam 25 mg | Inj ceftolozane tazobactam | |
| J0696 | No Prior Authorization Required | Rocephil | Injection, ceftriaxone sodium, per 250 mg | Ceftriaxone sodium injection | |
| J0697 | No Prior Authorization Required | Zinacef | Injection, sterile cefuroxime sodium, per 750 mg | Sterile cefuroxime injection | |
| J0698 | No Prior Authorization Required | Claforan | Injection, cefotaxime sodium, per gm | Cefotaxime sodium injection | |
| J0699 | Not Covered on state fee schedule (Provider's Administered Drug List) | Fetroja | Injection, cefiderocol, 10 mg | Inj, cefiderocol, 10 mg | |
| J0701 | Prior Authorization Required | Cefepime | Injection, cefepime HCl (Baxter), not therapeutically equivalent to Maxipime, 500 mg | | |
| J0702 | No Prior Authorization Required | Celestone Soluspan | Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg | Betamethasone acet&sod phosp | |
| J0703 | Prior Authorization Required | Cefepime - dextrose | Injection, cefepime HCl (B. Braun), not therapeutically equivalent to Maxipime, 500 mg | | |
| J0706 | No Prior Authorization Required | Cafcit | Injection, caffeine citrate, 5 mg | Caffeine citrate injection | |
| J0712 | No Prior Authorization Required | Teflaro | Injection, ceftaroline fosamil, 10 mg | Ceftaroline fosamil inj | |
| J0713 | No Prior Authorization Required | Fortaz Tazicef | Injection, ceftazidime, per 500 mg | Inj ceftazidime per 500 mg | |
| J0714 | Prior Authorization Required | Avycaz | Injection, ceftazidime and avibactam, 0.5 g/0.125 g | Ceftazidime and avibactam | |
| J0716 | No Prior Authorization Required | Anascorp | Injection, centruroides immune f(ab)2, up to 120 milligrams | Centruroides immune f(ab) | |
| J0717 | Prior Authorization Required | Cimzia | Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Certolizumab pegol inj 1mg | 1200 units per 28 days |
| J0720 | No Prior Authorization Required | Chloramphenicol | Injection, chloramphenicol sodium succinate, up to 1 gm | Chloramphenicol sodium injec | |
| J0725 | Prior Authorization Required | Novarel Pregnyl | Injection, chorionic gonadotropin, per 1,000 usp units | Chorionic gonadotropin/1000u | |
| J0735 | No Prior Authorization Required | Duraclon | Injection, clonidine hydrochloride, 1 mg | Clonidine hydrochloride | |
| J0736 | No Prior Authorization Required | CLEOCIN | Injection, clindamycin phosphate, 300 mg | Inj, clindamycin phosp 300mg | |
| J0737 | No Prior Authorization Required | Clindamycin | Injection, clindamycin phosphate (Baxter), not therapeutically equivalent to J0736, 300 mg | Inj, clindamycin (baxter) | |
| J0739 | Prior Authorization Required | Apretude | Injection, cabotegravir, 1 mg | | |
| J0740 | No Prior Authorization Required | Cidofovir | Injection, cidofovir, 375 mg | Cidofovir injection | |
| J0741 | Prior Authorization Required | Cabenuva | Injection, cabotegravir and rilpivirine, 2 mg/3 mg | Inj, cabote rilpivir 2mg 3mg | |
| J0742 | Prior Authorization Required | Recarbrio | Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg | Inj imip 4 cilas 4 releb 2mg | |
| J0743 | No Prior Authorization Required | Timentin | Injection, cilastatin sodium; imipenem, per 250 mg | Cilastatin sodium injection | |
| J0744 | No Prior Authorization Required | Cipro | Injection, ciprofloxacin for intravenous infusion, 200 mg | Ciprofloxacin iv | |
| J0750 | Not Covered on state fee schedule (Provider's Administered Drug List) | Truvada | Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg, oral, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV) | Hiv prep, ftc/tdf 200/300mg | |
| J0751 | Not Covered on state fee schedule (Provider's Administered Drug List) | Descovy | Emtricitabine 200 mg and tenofovir alafenamide 25 mg, oral, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV) | Hiv prep, ftc/taf 200/25mg | |
| J0770 | No Prior Authorization Required | Coly-Mycin M | Injection, colistimethate sodium, up to 150 mg | Colistimethate sodium inj | |
| J0775 | Prior Authorization Required | Xiaflex | Injection, collagenase, clostridium histolyticum, 0.01 mg | Collagenase, clost hist inj | |
| J0780 | No Prior Authorization Required | Compazine | Injection, prochlorperazine, up to 10 mg | Prochlorperazine injection | |
| J0791 | Prior Authorization Required | Adakveo | Injection, crizanlizumab-tmca, 5 mg | Inj crizanlizumab-tmca 5mg | |

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| J0795 | No Prior Authorization Required | Acthrel | Injection, corticorelin ovine triflutate, 1 microgram | Corticorelin ovine triflutal | |
| J0799 | Not Covered on state fee schedule (Provider's Administered Drug List) | | FDA-approved prescription drug, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV), not otherwise classified | Hiv prep, fda approved, noc | |
| J0801 | Prior Authorization Required | Acthar | Injection, corticotropin (Acthar Gel), up to 40 units | Inj. acthar gel to 40 units | |
| J0802 | Prior Authorization Required | Cortrophin | Injection, corticotropin (ANI), up to 40 units | Inj. (ani), up to 40 units | |
| J0834 | No Prior Authorization Required | Cosyntropin | Injection, cosyntropin, 0.25 mg | Inj., cosyntropin, 0.25 mg | |
| J0840 | No Prior Authorization Required | CroFab | Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram | Crotalidae poly immune fab | |
| J0841 | No Prior Authorization Required | Anavip | Injection, crotalidae immune f(ab')2 (equine), 120 mg | Inj crotalidae im f(ab')2 eq | |
| J0850 | Prior Authorization Required | Cytogam | Injection, cytomegalovirus immune globulin intravenous (human), per vial | Cytomegalovirus imm iv /vial | |
| J0870 | Prior Authorization Required | | Injection, imetelstat, 1 mg | Injection, imetelstat, 1 mg | |
| J0872 | Prior Authorization Required | Daptomycin | Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg | Daptomycin (xellia) unrefrig | |
| J0873 | No Prior Authorization Required | DAPTOMYCIN 350MG Solution Reconstituted | Injection, daptomycin (Xellia), not therapeutically equivalent to J0878, 1 mg | Inj, daptomycin (xellia) | |
| J0874 | No Prior Authorization Required | Daptomycin | Injection, daptomycin (Baxter), not therapeutically equivalent to J0878, 1 mg | Inj, daptomycin (baxter) | |
| J0875 | No Prior Authorization Required | Dalvance | Injection, dalbavancin, 5 mg | Injection, dalbavancin | |
| J0877 | No Prior Authorization Required | Hospira | Injection, daptomycin (Hospira), not therapeutically equivalent to J0878, 1 mg | | |
| J0878 | No Prior Authorization Required | Cubicin | Injection, daptomycin, 1 mg | Daptomycin injection | |
| J0879 | No Prior Authorization Required | Korsuva | Injection, difelikefalin, 0.1 microgram, (for ESRD on dialysis) | | |
| J0881 | Prior Authorization Required | Aranesp | Injection, darbepoetin alfa, 1 microgram (non-esrd use) | Darbepoetin alfa, non-esrd | |
| J0882 | No Prior Authorization Required | Aranesp | Injection, darbepoetin alfa, 1 microgram (for esrd on dialysis) | Darbepoetin alfa, esrd use | |
| J0883 | No Prior Authorization Required | Argatroban | Injection, argatroban, 1 mg (for non-esrd use) | Argatroban nonesrd use 1mg | |
| J0884 | No Prior Authorization Required | Argatroban | Injection, argatroban, 1 mg (for esrd on dialysis) | Argatroban esrd dialysis 1mg | |
| J0885 | Prior Authorization Required | Epogen Procrit | Injection, epoetin alfa, (for non-esrd use), 1000 units | Epoetin alfa, non-esrd | |
| J0887 | Prior Authorization Required | Mircera | Injection, epoetin beta, 1 microgram, (for esrd on dialysis) | Epoetin beta esrd use | |
| J0888 | Prior Authorization Required | Mircera | Injection, epoetin beta, 1 microgram, (for non esrd use) | Epoetin beta non esrd | |
| J0889 | Prior Authorization Required | Jesduvrog | Daprodustat, oral, 1 mg, (for ESRD on dialysis) | Daprodustat oral 1mg esrd | |
| J0890 | Prior Authorization Required | OMONYTYS | Injection, peginesatide, 0.1 mg (for esrd on dialysis) | Peginesatide injection | |
| J0891 | Prior Authorization Required | Argatroban | Injection, argatroban (Accord), not therapeutically equivalent to J0883, 1 mg (for non-ESRD use) | | |
| J0892 | Prior Authorization Required | Argatroban | Injection, argatroban (Accord), not therapeutically equivalent to J0884, 1 mg (for ESRD on dialysis) | | |
| J0893 | Prior Authorization Required | Decitabine | Injection, decitabine (Sun Pharma) not therapeutically equivalent to J0894, 1 mg | | |
| J0894 | Prior Authorization Required | Dacogen | Injection, decitabine, 1 mg | Decitabine injection | |
| J0895 | Prior Authorization Required | Desferal | Injection, deferoxamine mesylate, 500 mg | Deferoxamine mesylate inj | |
| J0896 | Prior Authorization Required | Reblozyl | Injection, luspatercept-aamt, 0.25 mg | Inj luspatercept-aamt 0.25mg | |
| J0897 | Prior Authorization Required | Prolia Xgeva | Injection, denosumab, 1 mg | Denosumab injection | |
| J0898 | Prior Authorization Required | Argatroban | Injection, argatroban (AuroMedics), not therapeutically equivalent to J0883, 1 mg (for non-ESRD use) | | |
| J0899 | Prior Authorization Required | Argatroban | Injection, argatroban (AuroMedics), not therapeutically equivalent to J0884, 1 mg (for ESRD on dialysis) | | |
| J0901 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Vadadustat, oral, 1 mg (for esrd on dialysis) | Vadadustat oral 1mg for esrd | |
| J0911 | No Prior Authorization Required | Drfencath | Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis) | Inst tauro 1.35mg/hep 100u | |
| J1000 | No Prior Authorization Required | Depo-Estradiol | Injection, depo-estradiol cypionate, up to 5 mg | Depo-estradiol cypionate inj | |
| J1010 | No Prior Authorization Required | Depo-Medrol | Injection, methylprednisolone acetate, 1 mg | Inj, methylpred acetate 1 mg | |
| J1050 | No Prior Authorization Required | Depo-Provera | Injection, medroxyprogesterone acetate, 1 mg | Medroxyprogesterone acetate | |
| J1071 | No Prior Authorization Required | Depo-Testosterone | Injection, testosterone cypionate, 1 mg | Inj testosterone cypionate | |
| J1095 | Prior Authorization Required | Dexycu | Injection, dexamethasone 9 percent, intraocular, 1 microgram | Injection, dexamethasone 9% | |
| J1096 | Prior Authorization Required | Dextenza | Dexamethasone, lacrimal ophthalmic insert, 0.1 mg | Dexametha ophth insert 0.1 mg | |

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| J1097 | No Prior Authorization Required | Omidria | Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml | Phenylep ketorolac oph soln | |
| J1100 | No Prior Authorization Required | Decadron | Injection, dexamethasone sodium phosphate, 1 mg | Dexamethasone sodium phos | |
| J1105 | Not Covered on state fee schedule (Provider's Administered Drug List) | Igalmi | Dexmedetomidine, oral, 1 mcg | Dexmedetomidine film, 1 mcg | |
| J1110 | No Prior Authorization Required | D.H.E. | Injection, dihydroergotamine mesylate, per 1 mg | Inj dihydroergotamine mesylt | |
| J1120 | No Prior Authorization Required | Acetazolamide | Injection, acetazolamide sodium, up to 500 mg | Acetazolamid sodium injectio | |
| J1160 | No Prior Authorization Required | Lanoxin | Injection, digoxin, up to 0.5 mg | Digoxin injection | |
| J1162 | No Prior Authorization Required | Digifab | Injection, digoxin immune fab (ovine), per vial | Digoxin immune fab (ovine) | |
| J1165 | No Prior Authorization Required | Dilantin | Injection, phenytoin sodium, per 50 mg | Phenytoin sodium injection | |
| J1171 | No Prior Authorization Required | HYDROMORPHONE HCL 1MG/ML Solution | Injection, hydromorphone, 0.1 mg | Inj, hydromorphone, 0.1 mg | |
| J1190 | No Prior Authorization Required | Zinecard | Injection, dexrazoxane hydrochloride, per 250 mg | Dexrazoxane hcl injection | |
| J1200 | No Prior Authorization Required | Benadryl | Injection, diphenhydramine hcl, up to 50 mg | Diphenhydramine hcl injectio | |
| J1201 | Not Covered on state fee schedule (Provider's Administered Drug List) | Quzyttir | Injection, cetirizine hydrochloride, 0.5 mg | Inj. cetirizine hcl 0.5mg | |
| J1202 | Prior Authorization Required | Opfolda | Miglustat, oral, 65 mg | Miglustat oral 65 mg | |
| J1203 | Prior Authorization Required | Pombiliti | Injection, cipaglucoisidase alfa-atga, 5 mg | Inj, cipaglucoisidase, 5 mg | |
| J1205 | No Prior Authorization Required | Diuril | Injection, chlorothiazide sodium, per 500 mg | Chlorothiazide sodium inj | |
| J1212 | No Prior Authorization Required | Rimso-50 | Injection, dmsol, dimethyl sulfoxide, 50%, 50 ml | Dimethyl sulfoxide 50% 50 ml | |
| J1230 | No Prior Authorization Required | Methadone | Injection, methadone hcl, up to 10 mg | Methadone injection | |
| J1240 | No Prior Authorization Required | Dimenhydrinate | Injection, dimenhydrinate, up to 50 mg | Dimenhydrinate injection | |
| J1245 | No Prior Authorization Required | Persantine | Injection, dipyridamole, per 10 mg | Dipyridamole injection | |
| J1250 | No Prior Authorization Required | Dobutamine | Injection, dobutamine hydrochloride, per 250 mg | Inj dobutamine hcl/250 mg | |
| J1265 | No Prior Authorization Required | Dopamine | Injection, dopamine hcl, 40 mg | Dopamine injection | |
| J1270 | No Prior Authorization Required | Hectero | Injection, doxercalciferol, 1 mcg | Injection, doxercalciferol | |
| J1290 | Prior Authorization Required | Kalbitor | Injection, ecallantide, 1 mg | Ecallantide injection | 6 mL per fill (18 mL per 30 days) |
| J1299 | Prior Authorization Required | Soliris | Injection, eculizumab, 2 mg | Eculizumab injection | |
| J1301 | Prior Authorization Required | Radicava | Injection, edaravone, 1 mg | Injection, edaravone, 1 mg | |
| J1302 | Prior Authorization Required | Enjaymo | Injection, sutimlimab-jome, 10 mg | Inj, sutimlimab-jome, 10 mg | |
| J1303 | Prior Authorization Required | Ultomiris | Injection, ravulizumab-cwvz, 10 mg | Inj., ravulizumab-cwvz 10 mg | |
| J1304 | Not Covered on state fee schedule (Provider's Administered Drug List) | QALSODY 100MG/15ML Solution | Injection, tofersen, 1 mg | Inj tofersen intrathec 1 mg | |
| J1305 | Prior Authorization Required | Evkeeza | Injection, evinacumab-dgnb, 5 mg | Inj, evinacumab-dgnb, 5mg | |
| J1307 | Prior Authorization Required | | Injection, crovalimab-akkz, 10 mg | Inj, crovalimab-akkz, 10 mg | |
| J1322 | Prior Authorization Required | Vimizim | Injection, elosulfase alfa, 1 mg | Elosulfase alfa, injection | |
| J1323 | Prior Authorization Required | Elfrexio | Injection, elranatamab-bcmm, 1 mg | Inj, elranatamab-bcmm, 1 mg | |
| J1324 | Prior Authorization Required | Fuzeon | Injection, enfuvirtide, 1 mg | Enfuvirtide injection | |
| J1325 | Prior Authorization Required | Flolan Veletri | Injection, epoprostenol, 0.5 mg | Epoprostenol injection | |
| J1327 | No Prior Authorization Required | Integrilin | Injection, eptifibatide, 5 mg | Eptifibatide injection | |
| J1335 | No Prior Authorization Required | Invanz | Injection, ertapenem sodium, 500 mg | Ertapenem injection | |
| J1364 | No Prior Authorization Required | Erythrocin Lactobionate | Injection, erythromycin lactobionate, per 500 mg | Erythro lactobionate /500 mg | |
| J1380 | No Prior Authorization Required | Delestrogen | Injection, estradiol valerate, up to 10 mg | Estradiol valerate 10 mg inj | |
| J1410 | No Prior Authorization Required | Premarin | Injection, estrogen conjugated, per 25 mg | Inj estrogen conjugate 25 mg | |
| J1411 | Prior Authorization Required | Hemgenix | Injection, etranacogene dezaparvovec-drlb, per therapeutic dose | Inj, hemgenix, per tx dose | |
| J1412 | Prior Authorization Required | ROCTAVIAN Suspension | Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10 ¹³ vector genomes | Inj roctavian ml 2x10 ¹³ vc g | |
| J1413 | Prior Authorization Required | ELEVIDYS Kit | Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose | Inj delandistrogene mox rokl | |
| J1414 | Not Covered on state fee schedule (Provider's Administered Drug List) | Beqvez | Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose | Inj, beqvez, per tx dose | |
| J1426 | Prior Authorization Required | Amondys 45 | Injection, casimersen, 10 mg | Injection, casimersen, 10 mg | |
| J1428 | Prior Authorization Required | Exondys | Injection, eteplirsen, 10 mg | Inj, eteplirsen, 10 mg | |

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| J1429 | Prior Authorization Required | Vyondys 53 | Injection, golodirsén, 10 mg | Inj golodirsén 10 mg | |
| J1430 | No Prior Authorization Required | Ethamolin | Injection, ethanolamine oleate, 100 mg | Ethanolamine oleate 100 mg | |
| J1434 | No Prior Authorization Required | Focinvez | Injection, fosaprepitant (Focinvez), 1 mg | Inj, focinvez, 1mg | |
| J1437 | Prior Authorization Required | Monoferric | Injection, ferric derisomaltose, 10 mg | Inj. fe derisomaltose 10 mg | |
| J1438 | Pharmacy Benefit | Enbrel | Injection, etanercept, 25 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Etanercept injection | 8 unts per 28 days |
| J1439 | Prior Authorization Required | Injectafer | Injection, ferric carboxymaltose, 1 mg | Inj ferric carboxymaltos 1mg | |
| J1440 | Prior Authorization Required | REBYOTA | Fecal microbiota, live - jsIm, 1 ml | Fecal microbiota jsIm 1 ml | |
| J1442 | Prior Authorization Required | Neupogen | Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram | Inj filgrastim excl biosimil | |
| J1443 | Prior Authorization Required | Triferic | Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron | Inj ferric pyrophosphate cit | |
| J1444 | Prior Authorization Required | Triferic | Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron | Fe pyro cit pow 0.1 mg iron | |
| J1445 | Prior Authorization Required | Triferic | Injection, ferric pyrophosphate citrate solution (Triferic AVNU), 0.1 mg of iron | Inj triferic avnu 0.1mg iron | |
| J1447 | Prior Authorization Required | Granix | Injection, tbo-filgrastim, 1 microgram | Inj tbo filgrastim 1 microg | |
| J1448 | Prior Authorization Required | Cosela | Injection, trilaciclib, 1 mg | Injection, trilaciclib, 1mg | |
| J1449 | Prior Authorization Required | Rolvedon | Injection, eflapegrastim-xnst, 0.1 mg | Inj eflapegrastim-xnst 0.1mg | |
| J1450 | No Prior Authorization Required | Diflucan | Injection fluconazole, 200 mg | Fluconazole | |
| J1451 | No Prior Authorization Required | Antizole | Injection, fomepizole, 15 mg | Fomepizole, 15 mg | |
| J1453 | No Prior Authorization Required | Emend | Injection, fosaprepitant, 1 mg | Fosaprepitant injection | |
| J1454 | Prior Authorization Required | Akynzeo | Injection, fosnetupitant 235 mg and palonosetron 0.25 mg | Inj fosnetupitant, palonoset | |
| J1455 | No Prior Authorization Required | Foscavir | Injection, foscarnet sodium, per 1000 mg | Foscarnet sodium injection | |
| J1456 | Prior Authorization Required | Teva | Injection, fosaprepitant (Teva), not therapeutically equivalent to J1453, 1 mg | | |
| J1458 | Prior Authorization Required | Naglazyme | Injection, galsulfase, 1 mg | Galsulfase injection | |
| J1459 | Prior Authorization Required | Privigen | Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg | Inj ivig privigen 500 mg | |

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| J1460 | Prior Authorization Required | Gamastan | Injection, gamma globulin, intramuscular, 1 cc | Gamma globulin 1 cc inj | |
| J1551 | Prior Authorization Required | Cutaquig | Injection, immune globulin (cutaquig), 100 mg | | |
| J1552 | Prior Authorization Required | Alyglo | Injection, immune globulin (alyglo), 500 mg | Inj, alyglo, 500 mg | |
| J1555 | Prior Authorization Required | Cuvitru | Injection, immune globulin (cuvitru), 100 mg | Inj cuvitru, 100 mg | |
| J1556 | Prior Authorization Required | Bivigam | Injection, immune globulin (bivigam), 500 mg | Inj, imm glob bivigam, 500mg | |
| J1557 | Prior Authorization Required | Gammaplex | Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg | Gammaplex injection | |
| J1558 | Prior Authorization Required | Xembify | Injection, immune globulin (xembify), 100 mg | Inj. xembify, 100 mg | |
| J1559 | Prior Authorization Required | Hizentra | Injection, immune globulin (hizentra), 100 mg | Hizentra injection | |
| J1560 | Prior Authorization Required | Gamastan | Injection, gamma globulin, intramuscular, over 10 cc | Gamma globulin > 10 cc inj | |
| J1561 | Prior Authorization Required | Gamunex-C Gammaked | Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg | Gamunex-c/gammaked | |
| J1562 | Prior Authorization Required | Vivaglobin | Injection, immune globulin (vivaglobin), 100 mg | Vivaglobin, inj | |
| J1566 | Prior Authorization Required | Carimune NF Panglobulin NF Gammagard S/D | Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg | Immune globulin, powder | |
| J1568 | Prior Authorization Required | Octagam | Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg | Octagam injection | |
| J1569 | Prior Authorization Required | Gammagard | Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg | Gammagard liquid injection | |
| J1570 | No Prior Authorization Required | Cytovene | Injection, ganciclovir sodium, 500 mg | Ganciclovir sodium injection | |
| J1571 | Prior Authorization Required | Hepagam B | Injection, hepatitis b immune globulin (hepagam b), intramuscular, 0.5 ml | Hepagam b im injection | |
| J1572 | Prior Authorization Required | Flebogamma | Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg | Flebogamma injection | |
| J1573 | Prior Authorization Required | Hepagam B | Injection, hepatitis b immune globulin (hepagam b), intravenous, 0.5 ml | Hepagam b intravenous, inj | |
| J1574 | Prior Authorization Required | Excela | Injection, ganciclovir sodium (Exela) not therapeutically equivalent to J1570, 500 mg | | |
| J1575 | Prior Authorization Required | Hyqvia | Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin | Hyqvia 100mg immunoglobulin | |
| J1576 | Not Covered | Panzyga | Injection, immune globulin (Panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg | Inj, panzyga, 500 mg | |
| J1580 | No Prior Authorization Required | Garamycin | Injection, garamycin, gentamicin, up to 80 mg | Garamycin gentamicin inj | |
| J1595 | Pharmacy Benefit | Glatopa | Injection, glatiramer acetate, 20 mg | Injection glatiramer acetate | |
| J1596 | Not Covered on state fee schedule (Provider's Administered Drug List) | GLYCOPYRROLATE 0.2MG/ML Solution | Injection, glycopyrrolate, 0.1 mg | Inj, glycopyrrolate, 0.1 mg | |
| J1597 | Prior Authorization Required | Glyrx-PF | Injection, glycopyrrolate (glyrx-pf), 0.1 mg | Inj glycopyrrolate, glyrx-pf | |
| J1598 | Prior Authorization Required | GLYCOPYRROLATE 0.6MG/3ML Solution Prefilled Syringe | Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to j1596, 0.1 mg | Inj glycopyrrolate fres kabi | |
| J1599 | Prior Authorization Required | Immune Globulin (Human) | Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg | Ivig non-lyophilized, nos | |
| J1602 | Prior Authorization Required | Simponi Aria | Injection, golimumab, 1 mg, for intravenous use | Golimumab for iv use 1mg | 120 units every 56 days |
| J1610 | No Prior Authorization Required | Glucagen Hypokit | Injection, glucagon hydrochloride, per 1 mg | Glucagon hydrochloride/1 mg | |
| J1611 | Prior Authorization Required | Glucagon Emergency Kit | Injection, glucagon HCl (Fresenius Kabi), not therapeutically equivalent to J1610, per 1 mg | | |
| J1626 | No Prior Authorization Required | Kytril | Injection, granisetron hydrochloride, 100 mcg | Granisetron hcl injection | |
| J1627 | Prior Authorization Required | Sustol | Injection, granisetron, extended-release, 0.1 mg | Inj, granisetron, xr, 0.1 mg | |
| J1628 | Prior Authorization Required | Tremfya | Injection, guselkumab, 1 mg | Inj., guselkumab, 1 mg | |
| J1630 | No Prior Authorization Required | Haldol Decanoate | Injection, haloperidol, up to 5 mg | Haloperidol injection | |
| J1631 | No Prior Authorization Required | Haldol Decanoate | Injection, haloperidol decanoate, per 50 mg | Haloperidol decanoate inj | |
| J1632 | Prior Authorization Required | Zulresso | Injection, brexanolone, 1 mg | Inj., brexanolone, 1 mg | |
| J1640 | Prior Authorization Required | Panhematin | Injection, hemin, 1 mg | Hemin, 1 mg | |
| J1642 | No Prior Authorization Required | Heparin Lock Flush | Injection, heparin sodium, (heparin lock flush), per 10 units | Inj heparin sodium per 10 u | |
| J1643 | Prior Authorization Required | Porcine | Injection, heparin sodium (Pfizer), not therapeutically equivalent to J1644, per 1000 units | | |

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| J1644 | No Prior Authorization Required | Heparin | Injection, heparin sodium, per 1000 units | Inj heparin sodium per 1000u | |
| J1645 | No Prior Authorization Required | Fragmin | Injection, dalteparin sodium, per 2500 iu | Dalteparin sodium | |
| J1650 | No Prior Authorization Required | Lovonox | Injection, enoxaparin sodium, 10 mg | Inj enoxaparin sodium | |
| J1652 | No Prior Authorization Required | Arixtra | Injection, fondaparinux sodium, 0.5 mg | Fondaparinux sodium | |
| J1670 | No Prior Authorization Required | Hypertet | Injection, tetanus immune globulin, human, up to 250 units | Tetanus immune globulin inj | |
| J1720 | No Prior Authorization Required | Solu-Cortef | Injection, hydrocortisone sodium succinate, up to 100 mg | Hydrocortisone sodium succ i | |
| J1726 | Approval withdrawn by FDA 4/6/23 | Makena | Injection, hydroxyprogesterone caproate, (makena), 10 mg | Makena, 10 mg | |
| J1729 | Prior Authorization Required | Hydroxyprogesterone Caproate | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg | Inj hydroxyprogst capoat nos | |
| J1729 | Prior Authorization Required | Hydroxyprogesterone Caproate | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg | Inj hydroxyprogst capoat nos | |
| J1738 | Prior Authorization Required | Anjeso | Injection, meloxicam, 1 mg | Inj. meloxicam 1 mg | |
| J1740 | Prior Authorization Required | Boniva | Injection, ibandronate sodium, 1 mg | Ibandronate sodium injection | |
| J1741 | No Prior Authorization Required | Caldolor | Injection, ibuprofen, 100 mg | Ibuprofen injection | |
| J1742 | No Prior Authorization Required | Corvert | Injection, ibutilide fumarate, 1 mg | Ibutilide fumarate injection | |
| J1743 | Prior Authorization Required | Elaprase | Injection, idursulfase, 1 mg | Idursulfase injection | |
| J1744 | Prior Authorization Required | Firazyr | Injection, icatibant, 1 mg | Icatibant injection | 18mL per 30 days |
| J1745 | Prior Authorization Required | Remicade | Injection, infliximab, excludes biosimilar, 10 mg | Infliximab not biosimil 10mg | 5mg/kg every 8 weeks |
| J1746 | Prior Authorization Required | Trogarzo | Injection, ibalizumab-uiyk, 10 mg | Inj., ibalizumab-uiyk, 10 mg | |
| J1747 | Prior Authorization Required | Spevigo | Injection, spesolimab-sbzo, 1 mg | Inj, spesolimab-sbzo, 1 mg | |
| J1748 | Prior Authorization Required | Zymfentra | Injection, infliximab-dyyb (zymfentra), 10 mg | Inj, zymfentra, 10 mg | |
| J1749 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, iloprost, 0.1 mcg | Inj, iloprost, 0.1 mcg | |
| J1750 | No Prior Authorization Required | Infed | Injection, iron dextran, 50 mg | Inj iron dextran | |
| J1756 | No Prior Authorization Required | Venofer | Injection, iron sucrose, 1 mg | Iron sucrose injection | |
| J1786 | Prior Authorization Required | Cerezyme | Injection, imiglucerase, 10 units | Imglucerase injection | |
| J1790 | No Prior Authorization Required | Inapsine | Injection, droperidol, up to 5 mg | Droperidol injection | |
| J1800 | No Prior Authorization Required | Inderal | Injection, propranolol hcl, up to 1 mg | Propranolol injection | |
| J1805 | Not Covered on state fee schedule (Provider's Administered Drug List) | BREVIBLOC | Injection, esmolol HCl, 10 mg | Inj, esmolol hcl, 10mg | |
| J1806 | Not Covered on state fee schedule (Provider's Administered Drug List) | Esnolol | Injection, esmolol HCl (WG Critical Care) not therapeutically equivalent to J1805, 10 mg | Inj esmolol hcl wg crit care | |
| J1811 | Not Covered on state fee schedule (Provider's Administered Drug List) | Fiasp | Insulin (Fiasp) for administration through DME (i.e., insulin pump) per 50 units | Fiasp for insulin pump use | |
| J1812 | Not Covered on state fee schedule (Provider's Administered Drug List) | Fiasp Flextouch | Insulin (Fiasp), per 5 units | Inj. insulin (fiasp) | |
| J1813 | Not Covered on state fee schedule (Provider's Administered Drug List) | LYUMJEV | Insulin (Lyumjev) for administration through DME (i.e., insulin pump) per 50 units | Lyumjev for insulin pump use | |
| J1814 | Not Covered on state fee schedule (Provider's Administered Drug List) | LYUMJEV | Insulin (Lyumjev), per 5 units | Inj. insulin (lyumjev) | |
| J1815 | Pharmacy Benefit | Insulin | Injection, insulin, per 5 units | Insulin injection | |
| J1817 | Pharmacy Benefit | Insulin | Insulin for administration through dme (i.e., insulin pump) per 50 units | Insulin for insulin pump use | |
| J1823 | Prior Authorization Required | Uplizna | Inj. inebilizumab-cdon, 1 mg | Injection, inebilizumab-cdon, 1 mg | |
| J1826 | Pharmacy Benefit | Avonex | Injection, interferon beta-1a, 30 mcg | Interferon beta-1a inj | |
| J1830 | Prior Authorization Required | Betaseron | Injection, interferon beta-1b, 0.25 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Interferon beta-1b / .25 mg | |
| J1833 | Prior Authorization Required | Cresemba | Injection, isavuconazonium, 1 mg | Injection, isavuconazonium | |
| J1836 | No Prior Authorization Required | Metronidazole | Injection, metronidazole, 10 mg | Inj, metronidazole, 10 mg | |

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| J1885 | No Prior Authorization Required | Torodal | Injection, ketorolac tromethamine, per 15 mg | Ketorolac tromethamine inj | |
| J1920 | Not Covered on state fee schedule (Provider's Administered Drug List) | Labetalol | Injection, labetalol HCl, 5 mg | Inj, labetalol hcl, 5mg | |
| J1921 | Not Covered on state fee schedule (Provider's Administered Drug List) | Labetalol | Injection, labetalol HCl (Hikma) not therapeutically equivalent to J1820, 5 mg | Inj labetalol hcl hikma, 5mg | |
| J1930 | Prior Authorization Required | Somatuline Depot | Injection, lanreotide, 1 mg | Lanreotide injection | |
| J1931 | Prior Authorization Required | Aldurazyme | Injection, laronidase, 0.1 mg | Laronidase injection | |
| J1932 | Prior Authorization Required | Cipla | Injection, lanreotide, (cipla), 1 mg | Inj, lanreotide, (cipla) 1mg | |
| J1939 | Not Covered on state fee schedule (Provider's Administered Drug List) | BUMETANIDE 0.25MG/ML Solution | Injection, bumetanide, 0.5 mg | Inj, bumetanide, 0.5 mg | |
| J1940 | No Prior Authorization Required | Lasix | Injection, furosemide, up to 20 mg | Furosemide injection | |
| J1941 | Not Covered on state fee schedule (Provider's Administered Drug List) | FUROSCIX | Injection, furosemide (Furoscix), 20 mg | Inj, furoscix, 20 mg | |
| J1943 | No Prior Authorization Required | Aristada | Injection, aripiprazole lauroxil, (aristada initio), 1 mg | Inj., aristada initio, 1 mg | |
| J1944 | No Prior Authorization Required | Aristada | Injection, aripiprazole lauroxil, (aristada), 1 mg | Aripiprazole lauroxil 1 mg | |
| J1950 | Prior Authorization Required | Lupron Depot | Injection, leuprolide acetate (for depot suspension), per 3.75 mg | Leuprolide acetate / 3.75 mg | Endometriosis: -every 84 days -only 1 reauth permitted Uterine Fibroids/Leiomyoma: every 84 days |
| J1951 | Prior Authorization Required | Fensolvi | Injection, leuprolide acetate for depot suspension (Fensolvi), 0.25 mg | Inj fensolvi 0.25 mg | |
| J1952 | Prior Authorization Required | Camcevi | Leuprolide injectable, camcevi, 1 mg | Leuprolide inj, camcevi, 1mg | |
| J1953 | No Prior Authorization Required | Keppra | Injection, levetiracetam, 10 mg | Levetiracetam injection | |
| J1954 | Prior Authorization Required | Leuprolide | Injection, leuprolide acetate for depot suspension (Lutrate), 7.5 mg | | |
| J1955 | No Prior Authorization Required | Carnitor | Injection, levocarnitine, per 1 gm | Inj levocarnitine per 1 gm | |
| J1956 | No Prior Authorization Required | Levaquin | Injection, levofloxacin, 250 mg | Levofloxacin injection | |
| J1961 | Prior Authorization Required | Sunlenca | Injection, lenacapavir, 1 mg | Inj, lenacapavir, 1 mg | |
| J1980 | No Prior Authorization Required | Levsin | Injection, hyoscyamine sulfate, up to 0.25 mg | Hyoscyamine sulfate inj | |
| J2002 | Not Covered on state fee schedule (Provider's Administered Drug List) | LIDOCAINE IN D5W 4-5MG/ML-% Solution | Injection, lidocaine hcl in 5% dextrose, 1 mg | Inj, lidocaine in d5w, 1 mg | |
| J2003 | Not Covered on state fee schedule (Provider's Administered Drug List) | LIDOCAINE HCL 2% Solution | Injection, lidocaine hydrochloride, 1 mg | Inj, lidocaine hcl, 1 mg | |
| J2004 | Not Covered on state fee schedule (Provider's Administered Drug List) | LIGNOSPAN STANDARD 2%-1:100K CARTRIDGE | Injection, lidocaine hcl with epinephrine, 1 mg | Inj, lidocaine w epinephrine | |
| J2010 | Prior Authorization Required | Lincocin | Injection, lincomycin hcl, up to 300 mg | Lincomycin injection | |
| J2020 | No Prior Authorization Required | Zyvox | Injection, linezolid, 200 mg | Linezolid injection | |
| J2021 | Prior Authorization Required | Zyvox | Injection, linezolid (Hospira) not therapeutically equivalent to J2020, 200 mg | | |
| J2060 | No Prior Authorization Required | Ativan | Injection, lorazepam, 2 mg | Lorazepam injection | |
| J2062 | Prior Authorization Required | Adasuve | Loxapine for inhalation, 1 mg | Loxapine for inhalation 1 mg | |
| J2150 | No Prior Authorization Required | Mannitol | Injection, mannitol, 25% in 50 ml | Mannitol injection | |
| J2170 | Prior Authorization Required | Increlex | Injection, mecasermin, 1 mg | Mecasermin injection | |
| J2175 | No Prior Authorization Required | Demerol | Injection, meperidine hydrochloride, per 100 mg | Meperidine hydrochl /100 mg | |
| J2182 | Prior Authorization Required | Nucala | Injection, mepolizumab, 1 mg | Injection, mepolizumab, 1mg | |
| J2183 | Prior Authorization Required | Meropenem | Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg | Inj meropenem (wg crit care) | |
| J2184 | Prior Authorization Required | Meropenem | Injection, meropenem (B. Braun) not therapeutically equivalent to J2185, 100 mg | | |
| J2185 | No Prior Authorization Required | Merrem | Injection, meropenem, 100 mg | Meropenem | |
| J2186 | No Prior Authorization Required | Vabomere | Injection, meropenem and vaborbactam, 10mg/10mg (20mg) | Inj., meropenem, vaborbactam | |
| J2210 | No Prior Authorization Required | Methergine | Injection, methylergonovine maleate, up to 0.2 mg | Methylergonovin maleate inj | |
| J2212 | Prior Authorization Required | Relistor | Injection, methylnaltrexone, 0.1 mg | Methylnaltrexone injection | |
| J2246 | Prior Authorization Required | Micafungin | Injection, micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1 mg | Inj, micafungin (baxter) | |
| J2247 | Prior Authorization Required | Byfavo | Injection, micafungin sodium (Par Pharm) not therapeutically equivalent to J2248, 1 mg | | |
| J2248 | No Prior Authorization Required | Mycamine | Injection, micafungin sodium, 1 mg | Micafungin sodium injection | |

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| J2249 | Not Covered on state fee schedule (Provider's Administered Drug List) | BYFAVO | Injection, remimazolam, 1 mg | Inj, remimazolam, 1 mg | |
| J2250 | No Prior Authorization Required | Versed | Injection, midazolam hydrochloride, per 1 mg | Inj midazolam hydrochloride | |
| J2251 | Prior Authorization Required | Midazolam | Injection, midazolam HCl (WG Critical Care) not therapeutically equivalent to J2250, per 1 mg | | |
| J2252 | Not Covered on state fee schedule (Provider's Administered Drug List) | MIDAZOLAM-SODIUM CHLORIDE (PF) 100-0.8MG/100ML-% Solution | Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to j2250, 1 mg | Inj midazolam in 0.8% nacl | |
| J2253 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, midazolam (seizalam), 1 mg | Inj midazolam (seizalam) | |
| J2260 | No Prior Authorization Required | Primacor | Injection, milrinone lactate, 5 mg | Inj milrinone lactate / 5 mg | |
| J2265 | No Prior Authorization Required | Minocin | Injection, minocycline hydrochloride, 1 mg | Minocycline hydrochloride | |
| J2267 | Prior Authorization Required | OmvoH | Injection, mirikizumab-mrkz, 1 mg | Inj, mirikizumab-mrkz, 1 mg | |
| J2270 | No Prior Authorization Required | Morphin | Injection, morphine sulfate, up to 10 mg | Morphine sulfate injection | |
| J2272 | Prior Authorization Required | Morphine sulfate | Injection, morphine sulfate (Fresenius Kabi) not therapeutically equivalent to J2270, up to 10 mg | | |
| J2274 | No Prior Authorization Required | Duramorph | Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg | Inj morphine pf epid ithc | |
| J2277 | Not Covered on state fee schedule (Provider's Administered Drug List) | Aphexda | Injection, motixafortide, 0.25 mg | Inj, motixafortide, 0.25 mg | |
| J2278 | Prior Authorization Required | Prialt | Injection, ziconotide, 1 microgram | Ziconotide injection | |
| J2280 | No Prior Authorization Required | Avelox | Injection, moxifloxacin, 100 mg | Inj, moxifloxacin 100 mg | |
| J2281 | Prior Authorization Required | Moxifloxacin | Injection, moxifloxacin (Fresenius Kabi) not therapeutically equivalent to J2280, 100 mg | | |
| J2290 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, nafcillin sodium, 20 mg | Inj, nafcillin sodium, 20 mg | |
| J2300 | No Prior Authorization Required | Nubain | Injection, nalbuphine hydrochloride, per 10 mg | Inj nalbuphine hydrochloride | |
| J2305 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, nitroglycerin, 5 mg | Inj, nitroglycerin, 5 mg | |
| J2310 | No Prior Authorization Required | Narcan | Injection, naloxone hydrochloride, per 1 mg | Inj naloxone hydrochloride | |
| J2311 | Prior Authorization Required | Zimhi | Injection, naloxone HCl (Zimhi), 1 mg | | |
| J2315 | No Prior Authorization Required | Vivitrol | Injection, naltrexone, depot form, 1 mg | Naltrexone, depot form | |
| J2323 | Prior Authorization Required | Tysabri | Injection, natalizumab, 1 mg | Natalizumab injection | 300mg per 28 days |
| J2326 | Prior Authorization Required | Spinraza | Injection, nusinersen, 0.1 mg | Inj, nusinersen, 0.1mg | 12mg (5mL) per treatment |
| J2327 | Prior Authorization Required | Skyrizi | Injection, risankizumab-rzaa, intravenous, 1 mg | | |
| J2329 | Prior Authorization Required | Briumvi | Injection, ublituximab-xiy, 1mg | Inj ublituximab-xiy, 1 mg | |
| J2350 | Prior Authorization Required | Ocrevus | Injection, ocrelizumab, 1 mg | Injection, ocrelizumab, 1 mg | 600MG every 6 months |
| J2353 | Prior Authorization Required | Sandostatin LAR | Injection, octreotide, depot form for intramuscular injection, 1 mg | Octreotide injection, depot | |
| J2354 | Prior Authorization Required | Sandostatin | Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg | Octreotide inj, non-depot | |
| J2355 | Prior Authorization Required | NEUMEGA | Injection, oprelvekin, 5 mg | Oprelvekin injection | |
| J2356 | Prior Authorization Required | Tezspire | Injection, tezepelumab-ekko, 1 mg | | |
| J2357 | Prior Authorization Required | Xolair | Injection, omalizumab, 5 mg | Omalizumab injection | |
| J2358 | No Prior Authorization Required | Zyprexa Relprevv | Injection, olanzapine, long-acting, 1 mg | Olanzapine long-acting inj | |
| J2359 | Prior Authorization Required | Zyprexa | Injection, olanzapine, 0.5 mg | Inj. olanzapine, 0.5mg | |
| J2360 | No Prior Authorization Required | Norflex | Injection, orphenadrine citrate, up to 60 mg | Orphenadrine injection | |
| J2371 | No Prior Authorization Required | VAZCULEP | Injection, phenylephrine HCl, 20 mcg | Inj phenylephrine hcl 20 mcg | |
| J2372 | No Prior Authorization Required | Biorphen | Injection, phenylephrine HCl (Biorphen), 20 mcg | Inj, biorphen, 20 micrograms | |
| J2373 | Prior Authorization Required | Immphantiv | Injection, phenylephrine hydrochloride (immphantiv), 20 micrograms | Inj, immphantiv, 20 mcg | |
| J2401 | Prior Authorization Required | Nesacaine | Injection, chloroprocaine HCl, per 1 mg | | |
| J2402 | Prior Authorization Required | Clorotekal | Injection, chloroprocaine HCl (Clorotekal), per 1 mg | | |
| J2403 | Not Covered on state fee schedule (Provider's Administered Drug List) | lheezo | Chloroprocaine HCl ophthalmic, 3% gel, 1 mg | Chloroprocaine opht gel, 1mg | |
| J2404 | Not Covered on state fee schedule (Provider's Administered Drug List) | NICARDIPINE HCL 2.5MG/ML Solution | Injection, nicardipine, 0.1 mg | Inj, nicardipine 0.1 mg | |

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| J2405 | No Prior Authorization Required | Zofran | Injection, ondansetron hydrochloride, per 1 mg | Ondansetron hcl injection | |
| J2406 | Prior Authorization Required | Kimyrsa | Injection, oritavancin, 10 mg | | |
| J2407 | Prior Authorization Required | Orbactiv | Injection, oritavancin, 10 mg | Injection, oritavancin | |
| J2425 | No Prior Authorization Required | Kepivance | Injection, palifermin, 50 micrograms | Palifermin injection | |
| J2426 | No Prior Authorization Required | Invega Sustenna | Injection, paliperidone palmitate extended release, 1 mg | Paliperidone palmitate inj | |
| J2427 | Prior Authorization Required | Invega Trinza | Injection, paliperidone palmitate extended release (Invega Hafyera or Invega Trinza), 1 mg | Inj, invega hafyera/trinza | |
| J2430 | Prior Authorization Required | Pamidronate disodium | Injection, pamidronate disodium, per 30 mg | Pamidronate disodium /30 mg | |
| J2440 | No Prior Authorization Required | Papaverine | Injection, papaverine hcl, up to 60 mg | Papaverin hcl injection | |
| J2468 | Prior Authorization Required | | Injection, palonosetron hydrochloride (avyxa), not therapeutically equivalent to j2469, 25 micrograms | Inj, palonosetron (avyxa) | |
| J2469 | No Prior Authorization Required | Aloxi | Injection, palonosetron hcl, 25 mcg | Palonosetron hcl | |
| J2470 | No Prior Authorization Required | Protonix | Injection, pantoprazole sodium, 40 mg | Inj pantoprazole sodium 40mg | |
| J2471 | No Prior Authorization Required | Pantoprazole | Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg | Inj pantoprazole(hikma) 40mg | |
| J2472 | No Prior Authorization Required | | Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg | Inj, pantoprazole sodium chl | |
| J2501 | No Prior Authorization Required | Zemplar | Injection, paricalcitol, 1 mcg | Paricalcitol | |
| J2502 | Prior Authorization Required | Signifor LAR | Injection, pasireotide long acting, 1 mg | Inj, pasireotide long acting | |
| J2503 | Prior Authorization Required | Macugen | Injection, pegaptanib sodium, 0.3 mg | Pegaptanib sodium injection | |
| J2504 | Prior Authorization Required | ADAGEN | Injection, pegademase bovine, 25 iu | Pegademase bovine, 25 iu | |
| J2506 | Prior Authorization Required | Neulasta | Injection, pegfilgrastim, excludes biosimilar, 0.5 mg | | |
| J2507 | Prior Authorization Required | Krystexxa | Injection, pegloticase, 1 mg | Pegloticase injection | |
| J2508 | Prior Authorization Required | ELFABRIO 20MG/10ML Solution | Injection, pegunigalsidase alfa-iwxj, 1 mg | Pegunigalsidase alfa-iwxj | |
| J2510 | No Prior Authorization Required | Penicillin G Procaine | Injection, penicillin g procaine, aqueous, up to 600,000 units | Penicillin g procaine inj | |
| J2515 | No Prior Authorization Required | Nembutal | Injection, pentobarbital sodium, per 50 mg | Pentobarbital sodium inj | |
| J2540 | No Prior Authorization Required | Penicillin G Potassium | Injection, penicillin g potassium, up to 600,000 units | Penicillin g potassium inj | |
| J2543 | No Prior Authorization Required | Zosyn | Injection, piperacillin sodium/tazobactam sodium, 1 gram/0.125 grams (1.125 grams) | Piperacillin/tazobactam | |
| J2545 | No Prior Authorization Required | Nebupent | Pentamidine isethionate, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per 300 mg | Pentamidine non-comp unit | |
| J2547 | Prior Authorization Required | Rapivab | Injection, peramivir, 1 mg | Injection, peramivir | |
| J2550 | No Prior Authorization Required | Phenergan | Injection, promethazine hcl, up to 50 mg | Promethazine hcl injection | |
| J2560 | No Prior Authorization Required | Phenobarbital | Injection, phenobarbital sodium, up to 120 mg | Phenobarbital sodium inj | |
| J2561 | Prior Authorization Required | Sezaby | Injection, phenobarbital sodium (Sezaby), 1 mg | Inj, sezaby, 1 mg | |
| J2562 | Prior Authorization Required | Mozobil | Injection, plerixafor, 1 mg | Plerixafor injection | |
| J2590 | No Prior Authorization Required | Pitocin | Injection, oxytocin, up to 10 units | Oxytocin injection | |
| J2597 | No Prior Authorization Required | DDAVP | Injection, desmopressin acetate, per 1 mcg | Inj desmopressin acetate | |
| J2598 | Not Covered on state fee schedule (Provider's Administered Drug List) | Vasopressin | Injection, vasopressin, 1 unit | Inj, vasopressin, 1 unit | |
| J2599 | Not Covered on state fee schedule (Provider's Administered Drug List) | Vasopressin | Injection, vasopressin (American Regent) not therapeutically equivalent to J2598, 1 unit | Inj vasopressin (am reg) 1 u | |
| J2601 | Not Covered on state fee schedule (Provider's Administered Drug List) | VASOPRESSIN-SODIUM CHLORIDE 20-0.9UT/100ML-% Solution | Injection, vasopressin (baxter), 1 unit | Inj, vasopressin (baxter) | |
| J2675 | No Prior Authorization Required | Progesterone | Injection, progesterone, per 50 mg | Inj progesterone per 50 mg | |
| J2679 | Not Covered on state fee schedule (Provider's Administered Drug List) | FLUPHENAZINE HCL 2.5MG/ML Solution | Injection, fluphenazine HCl, 1.25 mg | Inj fluphenazine hcl 1.25 mg | |
| J2680 | No Prior Authorization Required | Prolixin | Injection, fluphenazine decanoate, up to 25 mg | Fluphenazine decanoate 25 mg | |
| J2690 | No Prior Authorization Required | Procainamide | Injection, procainamide hcl, up to 1 gm | Procainamide hcl injection | |
| J2700 | No Prior Authorization Required | Oxacillin | Injection, oxacillin sodium, up to 250 mg | Oxacillin sodium injecton | |
| J2704 | No Prior Authorization Required | Diprivan | Injection, propofol, 10 mg | Inj, propofol, 10 mg | |

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| J2710 | No Prior Authorization Required | Bloxiverz | Injection, neostigmine methylsulfate, up to 0.5 mg | Neostigmine methylsulfate inj | |
| J2720 | No Prior Authorization Required | Protamine | Injection, protamine sulfate, per 10 mg | Inj protamine sulfate/10 mg | |
| J2724 | Prior Authorization Required | Ceprozin | Injection, protein c concentrate, intravenous, human, 10 iu | Protein c concentrate | |
| J2730 | No Prior Authorization Required | Protopam | Injection, pralidoxime chloride, up to 1 gm | Pralidoxime chloride inj | |
| J2760 | No Prior Authorization Required | Regitine | Injection, phentolamine mesylate, up to 5 mg | Phentolamine mesylate inj | |
| J2765 | No Prior Authorization Required | Reglan | Injection, metoclopramide hcl, up to 10 mg | Metoclopramide hcl injection | |
| J2770 | No Prior Authorization Required | Synercid | Injection, quinupristin/dalfopristin, 500 mg (150/350) | Quinupristin/dalfopristin | |
| J2777 | Prior Authorization Required | Vabysmo | Injection, faricimab-svoa, 0.1 mg | Inj, faricimab-svoa, 0.1mg | |
| J2778 | Prior Authorization Required | Lucentis | Injection, ranibizumab, 0.1 mg | Ranibizumab injection | |
| J2779 | Prior Authorization Required | Suvismo | Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg | | |
| J2781 | Prior Authorization Required | Syfovre | Injection, pegcetacoplan, intravitreal, 1 mg | Inj, pegcetacoplan, 1mg | |
| J2782 | Prior Authorization Required | Izervay | Injection, avacincaptad pegol, 0.1 mg | Inj avacincaptad pegol 0.1mg | |
| J2783 | No Prior Authorization Required | Elitek | Injection, rasburicase, 0.5 mg | Rasburicase | |
| J2785 | No Prior Authorization Required | Lexiscan | Injection, regadenoson, 0.1 mg | Regadenoson injection | |
| J2786 | Prior Authorization Required | Cinqair | Injection, reslizumab, 1 mg | Injection, reslizumab, 1mg | |
| J2787 | Prior Authorization Required | Photrexa | Riboflavin 5'-phosphate, ophthalmic solution, up to 3 ml | Riboflavin 5'phos ophth<=3ml | |
| J2788 | No Prior Authorization Required | HyperRho S/D, Micrhogam Ultra-Filtered Plus | Injection, rho d immune globulin, human, minidose, 50 micrograms (250 i.u.) | Rho d immune globulin 50 mcg | |
| J2790 | No Prior Authorization Required | HyperRho S/D, Rhogam Ultra-Filtered Plus | Injection, rho d immune globulin, human, full dose, 300 micrograms (1500 i.u.) | Rho d immune globulin inj | |
| J2791 | No Prior Authorization Required | Rhophylac | Injection, rho(d) immune globulin (human), (rhophylac), intramuscular or intravenous, 100 iu | Rhophylac injection | |
| J2792 | No Prior Authorization Required | WinRho | Injection, rho d immune globulin, intravenous, human, solvent detergent, 100 iu | Rho(d) immune globulin h, sd | |
| J2793 | Prior Authorization Required | Arcalyst | Injection, rilonacet, 1 mg | Rilonacet injection | |
| J2794 | No Prior Authorization Required | Risperdal Consta | Injection, risperidone (risperdal consta), 0.5 mg | Inj risperdal consta, 0.5 mg | |
| J2795 | No Prior Authorization Required | Naropin | Injection, ropivacaine hydrochloride, 1 mg | Ropivacaine hcl injection | |
| J2797 | Prior Authorization Required | VARUBI | Injection, rolapitant, 0.5 mg | Inj., rolapitant, 0.5 mg | |
| J2798 | Prior Authorization Required | Perseris | Injection, risperidone, (perseris), 0.5 mg | Inj., perseris, 0.5 mg | |
| J2799 | Prior Authorization Required | UZEDY 25MG/0.07ML Suspension, Extended Release | Injection, risperidone (Uzedy), 1 mg | Inj, uzedy, 1 mg | |
| J2800 | No Prior Authorization Required | Robaxin | Injection, methocarbamol, up to 10 ml | Methocarbamol injection | |
| J2801 | Not Covered on state fee schedule (Provider's Administered Drug List) | Rykindo | Injection, risperidone (Rykindo), 0.5 mg | Inj, rykindo, 0.5 mg | |
| J2802 | Prior Authorization Required | Nplate | Injection, romiplostim, 1 microgram | Inj, romiplostim 1 microgram | |
| J2805 | No Prior Authorization Required | Kinevac | Injection, sincalide, 5 micrograms | Sincalide injection | |
| J2810 | No Prior Authorization Required | Theophylline | Injection, theophylline, per 40 mg | Inj theophylline per 40 mg | |
| J2820 | Prior Authorization Required | Leukine | Injection, sargramostim (gm-csf), 50 mcg | Sargramostim injection | |
| J2840 | Prior Authorization Required | Kanuma | Injection, sebelipase alfa, 1 mg | Inj sebelipase alfa 1 mg | |
| J2850 | No Prior Authorization Required | Chirhostim | Injection, secretin, synthetic, human, 1 microgram | Inj secretin synthetic human | |
| J2860 | Prior Authorization Required | Sylvant | Injection, siltuximab, 10 mg | Injection, siltuximab | |
| J2916 | No Prior Authorization Required | Ferlecit | Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg | Na ferric gluconate complex | |
| J2919 | No Prior Authorization Required | Solu-Medrol | Injection, methylprednisolone sodium succinate, 5 mg | Inj, methylpred sod succ 5mg | |
| J2941 | Pharmacy Benefit | Humatrope, Genotropin, Genotropin Miniquick, Norditropin, Omnitrope, Serostim, Saizen, Zorbitive, Nutropin AQ Nuspin, Zomacton | Injection, somatotropin, 1 mg | Somatropin injection | |
| J2993 | No Prior Authorization Required | Retavase | Injection, reteplase, 18.1 mg | Retepase injection | |
| J2997 | No Prior Authorization Required | Cathflo | Injection, alteplase recombinant, 1 mg | Alteplase recombinant | |
| J3000 | No Prior Authorization Required | Streptomycin | Injection, streptomycin, up to 1 gm | Streptomycin injection | |
| J3010 | No Prior Authorization Required | Fentanyl | Injection, fentanyl citrate, 0.1 mg | Fentanyl citrate injection | |
| J3030 | No Prior Authorization Required | Imitrex | Injection, sumatriptan succinate, 6 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | Sumatriptan succinate / 6 mg | |
| J3031 | Prior Authorization Required | Ajovy | Injection, fremanezumab-vfrm, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered) | Inj., fremanezumab-vfrm 1 mg | |
| J3032 | Prior Authorization Required | Vyepti | Injection, eptinezumab-jjmr, 1 mg | Inj. eptinezumab-jjmr 1 mg | |

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| J3055 | Prior Authorization Required | Talvey | Injection, talquetamab-tgvs, 0.25 mg | Inj talquetamab-tgvs 0.25 mg | |
| J3060 | Prior Authorization Required | Elelyso | Injection, taliglucerase alfa, 10 units | Inj, taliglucerase alfa 10 u | |
| J3090 | Prior Authorization Required | Sivextro | Injection, tedizolid phosphate, 1 mg | Inj tedizolid phosphate | |
| J3095 | No Prior Authorization Required | Vibativ | Injection, telavancin, 10 mg | Telavancin injection | |
| J3101 | No Prior Authorization Required | Tnkase | Injection, tenecteplase, 1 mg | Tenecteplase injection | |
| J3105 | No Prior Authorization Required | Brethine | Injection, terbutaline sulfate, up to 1 mg | Terbutaline sulfate inj | |
| J3110 | Prior Authorization Required | Forteo | Injection, teriparatide, 10 mcg | Teriparatide injection | |
| J3111 | Prior Authorization Required | Evenity | Injection, romosozumab-aqqg, 1 mg | Inj. romosozumab-aqqg 1 mg | |
| J3121 | No Prior Authorization Required | Testosterone Enanthate | Injection, testosterone enanthate, 1 mg | Inj testostero enanthate 1mg | |
| J3145 | No Prior Authorization Required | Aveed | Injection, testosterone undecanoate, 1 mg | Testosterone undecanoate 1mg | |
| J3230 | No Prior Authorization Required | Thorazine | Injection, chlorpromazine hcl, up to 50 mg | Chlorpromazine hcl injection | |
| J3240 | No Prior Authorization Required | Thyrogen | Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial | Thyrotropin injection | |
| J3241 | Prior Authorization Required | Tepezza | Injection, teprotumumab-trbw, 10 mg | Inj. teprotumumab-trbw 10 mg | |
| J3243 | No Prior Authorization Required | Tygacil | Injection, tigecycline, 1 mg | Tigecycline injection | |
| J3244 | Prior Authorization Required | Tigecycline | Injection, tigecycline (Accord) not therapeutically equivalent to J3243, 1 mg | | |
| J3245 | Prior Authorization Required | Ilumya | Injection, tildrakizumab, 1 mg | Inj., tildrakizumab, 1 mg | |
| J3246 | No Prior Authorization Required | Aggrastat | Injection, tirofiban hcl, 0.25 mg | Tirofiban hcl | |
| J3247 | Prior Authorization Required | Cosentyx | Injection, secukinumab, intravenous, 1 mg | Inj secukinumab intrav 1mg | |
| J3250 | No Prior Authorization Required | Tigan | Injection, trimethobenzamide hcl, up to 200 mg | Trimethobenzamide hcl inj | |
| J3260 | No Prior Authorization Required | Tobramycin | Injection, tobramycin sulfate, up to 80 mg | Tobramycin sulfate injection | |
| J3262 | Prior Authorization Required | Actemra | Injection, tocilizumab, 1 mg | Tocilizumab injection | 3200 units per 28 days |
| J3263 | Prior Authorization Required | Loqtorzi | Injection, toripalimab-tpzi, 1 mg | Inj, toripalimab-tpzi, 1 mg | |
| J3285 | Pharmacy Benefit | Remodulin | Injection, treprostinil, 1 mg | Treprostinil injection | |
| J3299 | Prior Authorization Required | Xipere | Injection, triamcinolone acetonide, suprachoroidal (Xipere), 1 mg | | |
| J3300 | No Prior Authorization Required | Triesence | Injection, triamcinolone acetonide, preservative free, 1 mg | Triamcinolone a inj prs-free | |
| J3301 | No Prior Authorization Required | Kenalog | Injection, triamcinolone acetonide, not otherwise specified, 10 mg | Triamcinolone acet inj nos | |
| J3304 | Prior Authorization Required | Zilretta | Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg | Inj triamcinolone ace xr 1mg | |
| J3315 | Prior Authorization Required | Trelstar | Injection, triptorelin pamoate, 3.75 mg | Triptorelin pamoate | |
| J3316 | Prior Authorization Required | Triptodur | Injection, triptorelin, extended-release, 3.75 mg | Inj., triptorelin xr 3.75 mg | |
| J3355 | Prior Authorization Required | BRAVELLE | Injection, urofollitropin, 75 iu | Urofollitropin, 75 iu | |
| J3357 | Prior Authorization Required | Stelara | Ustekinumab, for subcutaneous injection, 1 mg | Ustekinumab sub cu inj, 1 mg | 90 units per 56 days after loading dose Subcutaneous Administration |
| J3358 | Prior Authorization Required | Stelara | Ustekinumab, for intravenous injection, 1 mg | Ustekinumab, iv inject, 1 mg | IV administration |
| J3360 | No Prior Authorization Required | Valium | Injection, diazepam, up to 5 mg | Diazepam injection | |
| J3371 | Prior Authorization Required | | Injection, vancomycin HCl (Mylan) not therapeutically equivalent to J3370, 500 mg | | |
| J3372 | Prior Authorization Required | | Injection, vancomycin HCl (Xellia) not therapeutically equivalent to J3370, 500 mg | | |
| J3380 | Prior Authorization Required | Entyvio | Injection, vedolizumab, 1 mg | Injection, vedolizumab | 300mg per infusion |
| J3385 | Prior Authorization Required | Vpriv | Injection, velaglucerase alfa, 100 units | Velaglucerase alfa | |
| J3392 | Prior Authorization Required | Casgevvy | Injection, exagamglogene autotemcel, per treatment | Inj, exagamglogene autotem | |
| J3393 | Prior Authorization Required | Zynteglo | Injection, betibeglogene autotemcel, per treatment | Inj, betibeglogene autotemce | |
| J3394 | Prior Authorization Required | Lyfgenia | Injection, lovitibeglogene autotemcel, per treatment | Inj, lovitibeglogene autotem | |
| J3396 | Prior Authorization Required | Visudyne | Injection, verteporfin, 0.1 mg | Verteporfin injection | |
| J3397 | Prior Authorization Required | Mepsevii | Injection, vestronidase alfa-vjvk, 1 mg | Inj., vestronidase alfa-vjvk | |
| J3398 | Prior Authorization Required | Luxturna | Injection, voretigene neparvovec-rzyl, 1 billion vector genomes | Inj luxturna 1 billion vec g | |
| J3399 | Prior Authorization Required | Zolgensma | Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10 ¹⁵ vector genomes | Inj onase abepar-xioi treat | |
| J3401 | Prior Authorization Required | VYJUVEK Gel | Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 ⁹ PFU/ml vector genomes, per 0.1 ml | Vyjuvek 5x10 ⁹ pfu/ml, 0.1 ml | |
| J3410 | No Prior Authorization Required | Vistaril | Injection, hydroxyzine hcl, up to 25 mg | Hydroxyzine hcl injection | |
| J3411 | No Prior Authorization Required | Thiamine | Injection, thiamine hcl, 100 mg | Thiamine hcl 100 mg | |

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| J3415 | Not Covered on state fee schedule (Provider's Administered Drug List) | Pyridoxine | Injection, pyridoxine hcl, 100 mg | Pyridoxine hcl 100 mg | |
| J3420 | No Prior Authorization Required | Cyanocobalamine | Injection, vitamin b-12 cyanocobalamin, up to 1000 mcg | Vitamin b12 injection | |
| J3424 | Not Covered on state fee schedule (Provider's Administered Drug List) | Cyanokit | Injection, hydroxocobalamin, IV, 25 mg | Inj hydroxocobalamin iv 25mg | |
| J3425 | Not Covered on state fee schedule (Provider's Administered Drug List) | HYDROXOCOBALAMIN 1000MCG/ML Solution | Injection, hydroxocobalamin, 10 mcg | Inj, hydroxocobalamin | |
| J3430 | No Prior Authorization Required | Mephyton | Injection, phytonadione (vitamin k), per 1 mg | Vitamin k phytonadione inj | |
| J3465 | No Prior Authorization Required | Vfend | Injection, voriconazole, 10 mg | Injection, voriconazole | |
| J3470 | No Prior Authorization Required | Amphadase | Injection, hyaluronidase, up to 150 units | Hyaluronidase injection | |
| J3471 | No Prior Authorization Required | Vitrase | Injection, hyaluronidase, ovine, preservative free, per 1 usp unit (up to 999 usp units) | Ovine, up to 999 usp units | |
| J3473 | No Prior Authorization Required | Hylenex | Injection, hyaluronidase, recombinant, 1 usp unit | Hyaluronidase recombinant | |
| J3475 | No Prior Authorization Required | Magnesium Sulfate | Injection, magnesium sulfate, per 500 mg | Inj magnesium sulfate | |
| J3480 | No Prior Authorization Required | Potassium Chloride | Injection, potassium chloride, per 2 meq | Inj potassium chloride | |
| J3485 | No Prior Authorization Required | Retrovir | Injection, zidovudine, 10 mg | Zidovudine | |
| J3486 | No Prior Authorization Required | Geodan | Injection, ziprasidone mesylate, 10 mg | Ziprasidone mesylate | |
| J3489 | No Prior Authorization Required | Reclast / Zometa | Injection, zoledronic acid, 1 mg | Zoledronic acid 1mg | |
| J3490 | No Prior Authorization Required | Unclassified code | Unclassified drugs | Drugs unclassified injection | |
| J3490 | Prior Authorization Required | Unclassified code | Exparel 1.3% Susp | Exparel | |
| J3535 | No Prior Authorization Required | Unclassified code | Drug administered through a metered dose inhaler | Metered dose inhaler drug | |
| J3590 | Prior Authorization Required (Avastin (J3590) for EYE INJECTIONS ONLY is No PA Required) | Unclassified code | Unclassified biologics | Unclassified biologics | |
| J3590 | Prior Authorization Required | Unclassified code | betibeglogene autotemcel | | |
| J3590 | Prior Authorization Required | Unclassified code | elivaldogene autotemcel | | |
| J3590 | Prior Authorization Required | Unclassified code | Exagamglogene autotemcel | Exagamglogene autotemcel | |
| J3590 | Prior Authorization Required | Unclassified code | lovo-cel | lovo-cel | |
| J3591 | No Prior Authorization Required | Unclassified code | Unclassified drug or biological used for esrd on dialysis | Esrd on dialysi drug/bio noc | |
| J7030 | No Prior Authorization Required | Sodium Chloride 0.9% | Infusion, normal saline solution , 1000 cc | Normal saline solution infus | |
| J7040 | No Prior Authorization Required | Sodium Chloride 0.9% | Infusion, normal saline solution, sterile (500 ml = 1 unit) | Normal saline solution infus | |
| J7042 | No Prior Authorization Required | Dextrose Sodium Chloride 5%-0.9% | 5% dextrose/normal saline (500 ml = 1 unit) | 5% dextrose/normal saline | |
| J7050 | No Prior Authorization Required | Sodium Chloride 0.9% | Infusion, normal saline solution, 250 cc | Normal saline solution infus | |
| J7060 | No Prior Authorization Required | Dextrose 5% | 5% dextrose/water (500 ml = 1 unit) | 5% dextrose/water | |
| J7070 | No Prior Authorization Required | Dextrose 5% | Infusion, d5w, 1000 cc | D5w infusion | |
| J7100 | No Prior Authorization Required | LMD in D5W 10% | Infusion, dextran 40, 500 ml | Dextran 40 infusion | |
| J7120 | No Prior Authorization Required | Lactated Ringers | Ringers lactate infusion, up to 1000 cc | Ringers lactate infusion | |
| J7121 | No Prior Authorization Required | Dextrose in Lactated Ringers 5% | 5% dextrose in lactated ringers infusion, up to 1000 cc | 5% dextrose in lac ringers | |
| J7131 | No Prior Authorization Required | Sodium Chloride | Hypertonic saline solution, 1 ml | Hypertonic saline sol | |
| J7165 | Not Covered on state fee schedule (Provider's Administered Drug List) | Balfaxar | Injection, prothrombin complex concentrate, human-lans, per IU of Factor IX activity | Inj, human-lans, per i.u | |
| J7168 | Not Covered on state fee schedule (Provider's Administered Drug List) | Kcentra | Prothrombin complex concentrate (human), Kcentra, per IU of Factor IX activity | Prothrombin complex kcentra | |
| J7169 | Prior Authorization Required | Andexxa | Injection, coagulation factor xa (recombinant), inactivated-zhzo (andexxa), 10 mg | Inj andexxa, 10 mg | |
| J7170 | Prior Authorization Required | Hemlibra | Injection, emicizumab-kxwh, 0.5 mg | Inj., emicizumab-kxwh 0.5 mg | |
| J7171 | Prior Authorization Required | Adzynma | Injection, adams13, recombinant-krhn, 10 iu | Inj, adzynma, 10 iu | |
| J7175 | Prior Authorization Required | Coagadex | Injection, factor x, (human), 1 i.u. | Inj, factor x, (human), 1iu | |
| J7177 | Prior Authorization Required | Fibryga | Injection, human fibrinogen concentrate (fibryga), 1 mg | Inj., fibryga, 1 mg | |
| J7178 | Prior Authorization Required | RiaStap | Injection, human fibrinogen concentrate, not otherwise specified, 1 mg | Inj human fibrinogen con nos | |
| J7179 | Prior Authorization Required | Vonvendi | Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rc | Vonvendi inj 1 iu vwf:rc | |
| J7180 | Prior Authorization Required | Corifact | Injection, factor xiii (antihemophilic factor, human), 1 i.u. | Factor xiii anti-hem factor | |
| J7181 | Prior Authorization Required | Tretten | Injection, factor xiii a-subunit, (recombinant), per iu | Factor xiii recomb a-subunit | |

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| J7182 | Prior Authorization Required | Novoeight | Injection, factor viii, (antihemophilic factor, recombinant), (novoeight), per iu | Factor viii recomb novoeight | |
| J7183 | Prior Authorization Required | Wilate | Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rho | Wilate injection | |
| J7185 | Prior Authorization Required | Xyntha | Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u. | Xyntha inj | |
| J7186 | Prior Authorization Required | Alphanate | Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u. | Antihemophilic viii/vwf comp | |
| J7187 | Prior Authorization Required | Humate P | Injection, von willebrand factor complex (humate-p), per iu vwf:rho | Humate-p, inj | |
| J7188 | Prior Authorization Required | Obizur | Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u. | Factor viii recomb obizur | |
| J7189 | Prior Authorization Required | Novoseven | Factor viia (antihemophilic factor, recombinant), per 1 microgram | Factor viia | |
| J7190 | Prior Authorization Required | Hemophil M Koate Monoclate | Factor viii (antihemophilic factor, human) per i.u. | Factor viii | |
| J7192 | Prior Authorization Required | Advate Kogenate FS Recombinate | Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified | Factor viii recombinant nos | |
| J7193 | Prior Authorization Required | Alphanine SD Mononine | Factor ix (antihemophilic factor, purified, non-recombinant) per i.u. | Factor ix non-recombinant | |
| J7194 | Prior Authorization Required | Profilnine | Factor ix, complex, per i.u. | Factor ix complex | |
| J7195 | Prior Authorization Required | Ixinity Benefix | Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified | Factor ix recombinant nos | |
| J7196 | Prior Authorization Required | Atryn | Injection, antithrombin recombinant, 50 i.u. | Antithrombin recombinant | |
| J7196 | Prior Authorization Required | Atryn | Injection, antithrombin recombinant, 50 i.u. | Antithrombin recombinant | |
| J7197 | Prior Authorization Required | Thrombate III | Antithrombin iii (human), per i.u. | Antithrombin iii injection | |
| J7198 | Prior Authorization Required | Feiba NF | Anti-inhibitor, per i.u. | Anti-inhibitor | |
| J7199 | Prior Authorization Required | Unclassified code | Hemophilia clotting factor, not otherwise classified | Hemophilia clot factor noc | |
| J7200 | Prior Authorization Required | Rixubis | Injection, factor ix, (antihemophilic factor, recombinant), rixubis, per iu | Factor ix recombinan rixubis | |
| J7201 | Prior Authorization Required | Alprolix | Injection, factor ix, fc fusion protein, (recombinant), alprolix, 1 i.u. | Factor ix alprolix recomb | |
| J7202 | Prior Authorization Required | Idelvion | Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u. | Factor ix idelvion inj | |
| J7203 | Prior Authorization Required | Rebinyn | Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu | Factor ix recomb gly rebinyn | |
| J7204 | Prior Authorization Required | Esperocet | Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu | Inj recomb esperoct per iu | |
| J7205 | Prior Authorization Required | Eloctate | Injection, factor viii fc fusion protein (recombinant), per iu | Factor viii fc fusion recomb | |
| J7207 | Prior Authorization Required | Adynovate | Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u. | Factor viii pegylated recomb | |
| J7208 | Prior Authorization Required | Jivi | Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u. | Inj. jivi 1 iu | |
| J7209 | Prior Authorization Required | Nuwiq | Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u. | Factor viii nuwiq recomb 1iu | |
| J7210 | Prior Authorization Required | Afstyla | Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u. | Inj, afstyla, 1 i.u. | |
| J7211 | Prior Authorization Required | Kovaltry | Injection, factor viii, (antihemophilic factor, recombinant), (koyaltry), 1 i.u. | Inj, koyaltry, 1 i.u. | |
| J7212 | Prior Authorization Required | Sevenfact | Factor viia recomb sevenfact | Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram | |
| J7213 | Prior Authorization Required | Ixinity | Injection, coagulation factor IX (recombinant), ixinity, 1 IU | Inj, ixinity, 1 i.u. | |
| J7214 | Prior Authorization Required | Altuviio | Injection, Factor VIII/von Willebrand factor complex, recombinant (Altuviio), per Factor VIII IU | Altuviio per factor viii iu | |
| J7294 | Pharmacy Benefit | Annovera | Segesterone acetate and ethinyl estradiol 0.15 mg, 0.013 mg per 24 hours; yearly vaginal system, ea | Seg acet and eth estr yearly | |
| J7295 | Pharmacy Benefit | Nuvaring EluRyng | Ethinyl estradiol and etonogestrel 0.015 mg, 0.12 mg per 24 hours; monthly vaginal ring, ea | Eth estr and eton monthly | |
| J7296 | No Prior Authorization Required | Kyleena | Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg | Kyleena, 19.5 mg | |
| J7297 | No Prior Authorization Required | Liletta | Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg | Liletta, 52 mg | |
| J7298 | No Prior Authorization Required | Mirena | Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg | Mirena, 52 mg | |
| J7300 | No Prior Authorization Required | Paragard | Intrauterine copper contraceptive | Intraut copper contraceptive | |
| J7301 | No Prior Authorization Required | Skyla | Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg | Skyla, 13.5 mg | |
| J7304 | No Prior Authorization Required | Xulane | Contraceptive supply, hormone containing patch, each | Contraceptive hormone patch | |
| J7307 | No Prior Authorization Required | Nexplanon | Etonogestrel (contraceptive) implant system, including implant and supplies | Etonogestrel implant system | |
| J7308 | No Prior Authorization Required | Levulan Kerastick | Aminolevulinic acid hcl for topical administration, 20%, single unit dosage form (354 mg) | Aminolevulinic acid hcl top | |
| J7311 | Prior Authorization Required | Retisert | Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg | Inj., retisert, 0.01 mg | |
| J7312 | Prior Authorization Required | Ozurdex | Injection, dexamethasone, intravitreal implant, 0.1 mg | Dexamethasone intra implant | |

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| J7313 | Prior Authorization Required | Iluvien | Injection, fluocinolone acetonide, intravitreal implant (iluvien), 0.01 mg | Inj., iluvien, 0.01 mg | |
| J7314 | Prior Authorization Required | Yutiq | Injection, fluocinolone acetonide, intravitreal implant (yutiq), 0.01 mg | Inj., yutiq, 0.01 mg | |
| J7315 | No Prior Authorization Required | Mitosol | Mitomycin, ophthalmic, 0.2 mg | Ophthalmic mitomycin | |
| J7316 | Prior Authorization Required | Jetrea | Injection, ocriplasmin, 0.125 mg | Inj, ocriplasmin, 0.125 mg | |
| J7318 | Prior Authorization Required | Durolane | Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg | Inj, durolane 1 mg | 1 Injection |
| J7320 | Prior Authorization Required | GenVisc | Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg | Genvisc 850, inj, 1mg | |
| J7321 | Prior Authorization Required | Hyalgan Supartz | Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose | Hyalgan supartz visco-3 dose | 5 injections |
| J7322 | Prior Authorization Required | Hymovis | Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg | Hymovis injection 1 mg | 2 injections |
| J7323 | Prior Authorization Required | Euflexxa | Hyaluronan or derivative, euflexxa, for intra-articular injection, per dose | Euflexxa inj per dose | 3 injections |
| J7324 | Prior Authorization Required | Orthovisc | Hyaluronan or derivative, orthovisc, for intra-articular injection, per dose | Orthovisc inj per dose | 4 injections |
| J7325 | Prior Authorization Required | Synvisc Synvisc-One | Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg | Synvisc or synvisc-one | Synvisc: 3 injections Synvisc-One: 1 injection |
| J7326 | Prior Authorization Required | Gel-One | Hyaluronan or derivative, gel-one, for intra-articular injection, per dose | Gel-one | 1 injection |
| J7327 | Prior Authorization Required | Monovisc | Hyaluronan or derivative, monovisc, for intra-articular injection, per dose | Monovisc inj per dose | 1 injection |
| J7328 | Prior Authorization Required | Gelsyn-3 | Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg | Gelsyn-3 injection 0.1 mg | 3 injections |
| J7329 | Prior Authorization Required | Trivisc | Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg | Inj, trivisc 1 mg | |
| J7330 | Prior Authorization Required | MACI | Autologous cultured chondrocytes, implant | Cultured chondrocytes implnt | |
| J7331 | Prior Authorization Required | Synjoynt | Hyaluronan or derivative, synjoynt, for intra-articular injection, 1 mg | Synjoynt, inj., 1 mg | |
| J7332 | Prior Authorization Required | Triluron | Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg | Inj., triluron, 1 mg | 3 injections |
| J7336 | Prior Authorization Required | Qutenza | Capsaicin 8% patch, per square centimeter | Capsaicin 8% patch | |
| J7340 | Prior Authorization Required | Duopa | Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml | Carbidopa levodopa ent 100ml | |
| J7340 | Prior Authorization Required | Duopa | Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml | Carbidopa levodopa ent 100ml | |
| J7342 | Prior Authorization Required | Otiprio | Instillation, ciprofloxacin otic suspension, 6 mg | Ciprofloxacin otic susp 6 mg | |
| J7345 | Prior Authorization Required | Ameluz | Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg | Aminolevulinic acid, 10% gel | |
| J7351 | Prior Authorization Required | Durysta | Injection, bimatoprost, intracameral implant, 1 microgram | Inj bimatoprost itc imp1mcg | |
| J7352 | Prior Authorization Required | Scenesse | Afamelanotide implant, 1 mg | Afamelanotide implant, 1 mg | |
| J7353 | Prior Authorization Required | Nexobrid | Anacaulase-bcdb, 8.8% gel, 1 gm | Anacaulase-bcdb 8.8% gel 1 g | |
| J7354 | Not Covered on state fee schedule (Provider's Administered Drug List) | Ycanth | Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg) | Cantharidin top, applicator | |
| J7355 | Prior Authorization Required | iDose TR | Injection, travoprost, intracameral implant, 1 microgram | Inj travoprost intra impl | |
| J7500 | Pharmacy Benefit | Imuran | Azathioprine, oral, 50 mg | Azathioprine oral 50mg | |
| J7501 | No Prior Authorization Required | Azathioprine | Azathioprine, parenteral, 100 mg | Azathioprine parenteral | |
| J7502 | Pharmacy Benefit | Neoral Sandimmune | Cyclosporine, oral, 100 mg | Cyclosporine oral 100 mg | |
| J7503 | Pharmacy Benefit | Envarsus Rx | Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg | Tacrol envarsus ex rel oral | |
| J7504 | Prior Authorization Required | Atgam | Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg | Lymphocyte immune globulin | |
| J7507 | Pharmacy Benefit | Prograf | Tacrolimus, immediate release, oral, 1 mg | Tacrolimus imme rel oral 1mg | |
| J7508 | Pharmacy Benefit | Astagraf XL | Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg | Tacrol astagraf ex rel oral | |
| J7509 | Pharmacy Benefit | Medrol | Methylprednisolone oral, per 4 mg | Methylprednisolone oral | |
| J7510 | Pharmacy Benefit | Orapred Pediapred | Prednisolone oral, per 5 mg | Prednisolone oral per 5 mg | |
| J7511 | No Prior Authorization Required | Thymoglobulin | Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral, 25 mg | Antithymocyte globuln rabbit | |
| J7512 | Pharmacy Benefit | Prednisone | Prednisone, immediate release or delayed release, oral, 1 mg | Prednisone ir or dr oral 1mg | |
| J7514 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Mycophenolate mofetil (myhibbin), oral suspension, 100 mg | Mycophenol (myhibbin) 100 mg | |
| J7515 | Pharmacy Benefit | Neoral Sandimmune | Cyclosporine, oral, 25 mg | Cyclosporine oral 25 mg | |
| J7516 | No Prior Authorization Required | Sandimmune | Cyclosporin, parenteral, 250 mg | Cyclosporin parenteral 250mg | |
| J7517 | No Prior Authorization Required | Cellcept | Mycophenolate mofetil, oral, 250 mg | Mycophenolate mofetil oral | |
| J7518 | Pharmacy Benefit | Myfortic | Mycophenolic acid, oral, 180 mg | Mycophenolic acid | |
| J7519 | No Prior Authorization Required | Cellcept | Injection, mycophenolate mofetil, 10 mg | Inj. mycophenolate mofetil | |
| J7520 | Pharmacy Benefit | Rapamune | Sirolimus, oral, 1 mg | Sirolimus, oral | |
| J7525 | No Prior Authorization Required | Prograf | Tacrolimus, parenteral, 5 mg | Tacrolimus injection | |
| J7527 | Pharmacy Benefit | Zortress | Everolimus, oral, 0.25 mg | Oral everolimus | |
| J7599 | No Prior Authorization Required | Unclassified code | Immunosuppressive drug, not otherwise classified | Immunosuppressive drug noc | |
| J7601 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg | Ensifentrine inh 3 mg | |

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| J7604 | No Prior Authorization Required | Compounded | Acetylcysteine, inhalation solution, compounded product, administered through dme, unit dose form, per gram | Acetylcysteine comp unit | |
| J7605 | No Prior Authorization Required | Brovana | Arformoterol, inhalation solution, fda approved final product, non-compounded, administered through dme, unit dose form, 15 micrograms | Arformoterol non-comp unit | |
| J7606 | No Prior Authorization Required | Perforomist | Formoterol fumarate, inhalation solution, fda approved final product, non-compounded, administered through dme, unit dose form, 20 micrograms | Formoterol fumarate, inh | |
| J7607 | No Prior Authorization Required | Compounded | Levalbuterol, inhalation solution, compounded product, administered through dme, concentrated form, 0.5 mg | Levalbuterol comp con | |
| J7608 | No Prior Authorization Required | Acetylcysteine | Acetylcysteine, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per gram | Acetylcysteine non-comp unit | |
| J7609 | No Prior Authorization Required | Albuterol Sulfate | Albuterol, inhalation solution, compounded product, administered through dme, unit dose, 1 mg | Albuterol comp unit | |
| J7610 | No Prior Authorization Required | Albuterol Sulfate | Albuterol, inhalation solution, compounded product, administered through dme, concentrated form, 1 mg | Albuterol comp con | |
| J7611 | No Prior Authorization Required | Ventolin Proventil | Albuterol, inhalation solution, fda-approved final product, non-compounded, administered through dme, concentrated form, 1 mg | Albuterol non-comp con | |
| J7612 | No Prior Authorization Required | compounded | Levalbuterol, inhalation solution, fda-approved final product, non-compounded, administered through dme, concentrated form, 0.5 mg | Levalbuterol non-comp con | |
| J7613 | No Prior Authorization Required | Ventolin Proventil | Albuterol, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose, 1 mg | Albuterol non-comp unit | |
| J7614 | No Prior Authorization Required | Levalbuterol | Levalbuterol, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose, 0.5 mg | Levalbuterol non-comp unit | |
| J7615 | No Prior Authorization Required | Levalbuterol | Levalbuterol, inhalation solution, compounded product, administered through dme, unit dose, 0.5 mg | Levalbuterol comp unit | |
| J7620 | No Prior Authorization Required | Ipratropium Albuterol | Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, fda-approved final product, non-compounded, administered through dme | Albuterol ipratrop non-comp | |
| J7622 | No Prior Authorization Required | Beclomethasone | Beclomethasone, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Beclomethasone comp unit | |
| J7624 | No Prior Authorization Required | Compounded | Betamethasone, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Betamethasone comp unit | |
| J7626 | No Prior Authorization Required | Pulmicort | Budesonide, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, up to 0.5 mg | Budesonide non-comp unit | |
| J7627 | No Prior Authorization Required | Compounded | Budesonide, inhalation solution, compounded product, administered through dme, unit dose form, up to 0.5 mg | Budesonide comp unit | |
| J7628 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Bitolterol mesylate, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Bitolterol mesylate comp con | |
| J7629 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Bitolterol mesylate, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Bitolterol mesylate comp unit | |
| J7631 | No Prior Authorization Required | Compounded | Cromolyn sodium, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per 10 milligrams | Cromolyn sodium noncomp unit | |
| J7632 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Cromolyn sodium, inhalation solution, compounded product, administered through dme, unit dose form, per 10 milligrams | Cromolyn sodium comp unit | |
| J7633 | No Prior Authorization Required | Pulmicort | Budesonide, inhalation solution, fda-approved final product, non-compounded, administered through dme, concentrated form, per 0.25 milligram | Budesonide non-comp con | |
| J7634 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Budesonide, inhalation solution, compounded product, administered through dme, concentrated form, per 0.25 milligram | Budesonide comp con | |
| J7635 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Atropine, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Atropine comp con | |
| J7636 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Atropine, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Atropine comp unit | |
| J7637 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Dexamethasone, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Dexamethasone comp con | |

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| J7638 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Dexamethasone, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Dexamethasone comp unit | |
| J7639 | Prior Authorization Required | Pulmozyme | Dornase alfa, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per milligram | Dornase alfa non-comp unit | |
| J7640 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Formoterol, inhalation solution, compounded product, administered through dme, unit dose form, 12 micrograms | Formoterol comp unit | |
| J7641 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Flunisolide, inhalation solution, compounded product, administered through dme, unit dose, per milligram | Flunisolide comp unit | |
| J7642 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Glycopyrrolate, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Glycopyrrolate comp con | |
| J7643 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Glycopyrrolate, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Glycopyrrolate comp unit | |
| J7644 | No Prior Authorization Required | Ipratropium Bromide | Ipratropium bromide, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per milligram | Ipratropium bromide non-comp | |
| J7645 | Not Covered on state fee schedule (Provider's Administered Drug List) | Atrovent | Ipratropium bromide, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Ipratropium bromide comp | |
| J7647 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Isoetharine hcl, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Isoetharine comp con | |
| J7648 | No Prior Authorization Required | | Isoetharine hcl, inhalation solution, fda-approved final product, non-compounded, administered through dme, concentrated form, per milligram | Isoetharine non-comp con | |
| J7649 | No Prior Authorization Required | | Isoetharine hcl, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per milligram | Isoetharine non-comp unit | |
| J7650 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Isoetharine hcl, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Isoetharine comp unit | |
| J7657 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Isoproterenol hcl, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Isoproterenol comp con | |
| J7658 | No Prior Authorization Required | | Isoproterenol hcl, inhalation solution, fda-approved final product, non-compounded, administered through dme, concentrated form, per milligram | Isoproterenol non-comp con | |
| J7659 | No Prior Authorization Required | | Isoproterenol hcl, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per milligram | Isoproterenol non-comp unit | |
| J7660 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Isoproterenol hcl, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Isoproterenol comp unit | |
| J7665 | No Prior Authorization Required | Mannitol | Mannitol, administered through an inhaler, 5 mg | Mannitol for inhaler | |
| J7667 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Metaproterenol sulfate, inhalation solution, compounded product, concentrated form, per 10 milligrams | Metaproterenol comp con | |
| J7668 | No Prior Authorization Required | Alupent | Metaproterenol sulfate, inhalation solution, fda-approved final product, non-compounded, administered through dme, concentrated form, per 10 milligrams | Metaproterenol non-comp con | |
| J7669 | No Prior Authorization Required | Compounded | Metaproterenol sulfate, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per 10 milligrams | Metaproterenol non-comp unit | |
| J7670 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Metaproterenol sulfate, inhalation solution, compounded product, administered through dme, unit dose form, per 10 milligrams | Metaproterenol comp unit | |
| J7674 | No Prior Authorization Required | Provocholine | Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg | Methacholine chloride, neb | |
| J7676 | Not Covered on state fee schedule (Provider's Administered Drug List) | Pentam | Pentamidine isethionate, inhalation solution, compounded product, administered through dme, unit dose form, per 300 mg | Pentamidine comp unit dose | |
| J7677 | Prior Authorization Required | Yupelri | Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through dme, 1 microgram | Revefenacin inh non-com 1mcg | |
| J7680 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Terbutaline sulfate, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Terbutaline sulf comp con | |
| J7681 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Terbutaline sulfate, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Terbutaline sulf comp unit | |

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| J7682 | Prior Authorization Required | Tobi | Tobramycin, inhalation solution, fda-approved final product, non-compounded, unit dose form, administered through dme, per 300 milligrams | Tobramycin non-comp unit | |
| J7683 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Triamcinolone, inhalation solution, compounded product, administered through dme, concentrated form, per milligram | Triamcinolone comp con | |
| J7684 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Triamcinolone, inhalation solution, compounded product, administered through dme, unit dose form, per milligram | Triamcinolone comp unit | |
| J7685 | Not Covered on state fee schedule (Provider's Administered Drug List) | Compounded | Tobramycin, inhalation solution, compounded product, administered through dme, unit dose form, per 300 milligrams | Tobramycin comp unit | |
| J7686 | Prior Authorization Required | Tyvaso | Treprostinil, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, 1.74 mg | Treprostinil, non-comp unit | |
| J7699 | Prior Authorization Required | Unclassified code | Noc drugs, inhalation solution administered through dme | Inhalation solution for dme | |
| J7799 | No Prior Authorization Required | Unclassified code | Noc drugs, other than inhalation drugs, administered through dme | Non-inhalation drug for dme | |
| J7999 | Not Covered on state fee schedule (Provider's Administered Drug List) | Unclassified code | Compounded drug, not otherwise classified | Compounded drug, noc | |
| J8498 | No Prior Authorization Required | Unclassified code | Antiemetic drug, rectal/suppository, not otherwise specified | Antiemetic rectal/supp nos | |
| J8499 | Prior Authorization Required | Unclassified code | Prescription drug, oral, non chemotherapeutic, nos | Oral prescrip drug non chemo | |
| J8501 | Pharmacy Benefit | Emend | Aprepitant, oral, 5 mg | Oral aprepitant | |
| J8510 | Pharmacy Benefit | Myleran | Busulfan; oral, 2 mg | Oral busulfan | |
| J8515 | Pharmacy Benefit | Dostinex | Cabergoline, oral, 0.25 mg | Cabergoline, oral 0.25mg | |
| J8522 | Not Covered on state fee schedule (Provider's Administered Drug List) | XELODA 150MG Tablet | Capecitabine, oral, 50 mg | Capecitabine, oral, 50 mg | |
| J8530 | Pharmacy Benefit | Cytosan | Cyclophosphamide; oral, 25 mg | Cyclophosphamide oral 25 mg | |
| J8540 | Pharmacy Benefit | Decadron | Dexamethasone, oral, 0.25 mg | Oral dexamethasone | |
| J8541 | Not Covered on state fee schedule (Provider's Administered Drug List) | HEMADY 20MG Tablet | Dexamethasone (hemady), oral, 0.25 mg | Oral, hemady, 0.25 mg | |
| J8560 | Pharmacy Benefit | Vpesid | Etoposide; oral, 50 mg | Etoposide oral 50 mg | |
| J8565 | Pharmacy Benefit | Iressa | Gefitinib, oral, 250 mg | Gefitinib oral | |
| J8597 | Pharmacy Benefit | Unclassified code | Antiemetic drug, oral, not otherwise specified | Antiemetic drug oral nos | |
| J8600 | Pharmacy Benefit | Alkeran | Melphalan; oral, 2 mg | Melphalan oral 2 mg | |
| J8610 | Pharmacy Benefit | Rheumatrex | Methotrexate; oral, 2.5 mg | Methotrexate oral 2.5 mg | |
| J8611 | Prior Authorization Required | JYLAMVO 2MG/ML Solution | Methotrexate (jylamvo), oral, 2.5 mg | Oral methotrexate (jylamvo) | |
| J8612 | Prior Authorization Required | XATMEP 2.5MG/ML Solution | Methotrexate (xatmep), oral, 2.5 mg | Oral methotrexate (xatmep) | |
| J8650 | Prior Authorization Required | CESAMET | Nabilone, oral, 1 mg | Nabilone oral | |
| J8655 | Pharmacy Benefit | Akynzeo | Netupitant 300 mg and palonosetron 0.5 mg, oral | Oral netupitant, palonosetron | |
| J8670 | No Prior Authorization Required | Varubi | Rolapitant, oral, 1 mg | Varubi | |
| J8700 | Pharmacy Benefit | Temodar | Temozolomide, oral, 5 mg | Temozolomide | |
| J8705 | Pharmacy Benefit | Hycamtin | Topotecan, oral, 0.25 mg | Topotecan oral | |
| J8999 | Pharmacy Benefit | Unclassified code | Prescription drug, oral, chemotherapeutic, nos | Oral prescription drug chemo | |
| J9000 | No Prior Authorization Required | Adriamycin | Injection, doxorubicin hydrochloride, 10 mg | Doxorubicin hcl injection | |
| J9015 | Prior Authorization Required | Proleukin | Injection, aldesleukin, per single use vial | Aldesleukin injection | |
| J9017 | No Prior Authorization Required | Trisenox | Injection, arsenic trioxide, 1 mg | Arsenic trioxide injection | |
| J9019 | No Prior Authorization Required | Erwinaze | Injection, asparaginase (erwinaze), 1,000 iu | Erwinaze injection | |
| J9021 | Prior Authorization Required | Rylaze | Injection, asparaginase, recombinant, (Rylaze), 0.1 mg | Inj, aspara, rylaze, 0.1 mg | |
| J9022 | Prior Authorization Required | Tecentriq | Injection, atezolizumab, 10 mg | Inj, atezolizumab, 10 mg | |
| J9023 | Prior Authorization Required | Bavencio | Injection, avelumab, 10 mg | Injection, avelumab, 10 mg | |
| J9025 | Prior Authorization Required | Vidaza | Injection, azacitidine, 1 mg | Azacitidine injection | |
| J9026 | Prior Authorization Required | Imdelltra | Injection, tarlatamab-dlle, 1 mg | Inj, tarlatamab-dlle, 1 mg | |
| J9027 | No Prior Authorization Required | Clolar | Injection, clofarabine, 1 mg | Clofarabine injection | |
| J9028 | Prior Authorization Required | | Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram | Inj, nogapendekin pmln, 1mcg | |
| J9029 | Prior Authorization Required | Adstiladrin | Injection, nadofaragene firadenovec-vncg, per therapeutic dose | Inj, adstiladrin, per tx dos | |
| J9030 | Prior Authorization Required | Tice BCG | Bcg live intravesical instillation, 1 mg | Bcg live intravesical 1mg | |
| J9032 | Prior Authorization Required | Beleodaq | Injection, belinostat, 10 mg | Injection, belinostat, 10mg | |
| J9033 | No Prior Authorization Required | Treanda | Injection, bendamustine hcl (treanda), 1 mg | Inj., treanda 1 mg | |
| J9034 | Prior Authorization Required | Bendeka | Injection, bendamustine hcl (bendeka), 1 mg | Inj., bendeka 1 mg | |
| J9035 | Prior Authorization Required | Avastin | Injection, bevacizumab, 10 mg | Bevacizumab injection | |
| J9036 | Prior Authorization Required | Belrapzo | Injection, bendamustine hydrochloride, (belrapzo/bendamustine), 1 mg | Inj. belrapzo/bendamustine | |
| J9039 | Prior Authorization Required | Blinicyto | Injection, blinatumomab, 1 microgram | Injection, blinatumomab | |
| J9040 | No Prior Authorization Required | Bleomycin | Injection, bleomycin sulfate, 15 units | Bleomycin sulfate injection | |
| J9041 | No Prior Authorization Required | Velcade | Injection, bortezomib (velcade), 0.1 mg | Inj., velcade 0.1 mg | |
| J9042 | Prior Authorization Required | Adcetris | Injection, brentuximab vedotin, 1 mg | Brentuximab vedotin inj | |

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| J9043 | No Prior Authorization Required | Jevtana | Injection, cabazitaxel, 1 mg | Cabazitaxel injection | |
| J9045 | No Prior Authorization Required | Paraplatin | Injection, carboplatin, 50 mg | Carboplatin injection | |
| J9046 | Not Covered on state fee schedule (Provider's Administered Drug List) | Bortezomib | Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg | | |
| J9047 | Prior Authorization Required | Kyprolis | Injection, carfilzomib, 1 mg | Injection, carfilzomib, 1 mg | |
| J9048 | Not Covered on state fee schedule (Provider's Administered Drug List) | Brotezomib | Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg | | |
| J9049 | Prior Authorization Required | Brotezomib | Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg | | |
| J9050 | No Prior Authorization Required | BICNU | Injection, carmustine, 100 mg | Carmustine injection | |
| J9051 | Prior Authorization Required | Brotezomib | Injection, bortezomib (MAIA), not therapeutically equivalent to J9041, 0.1 mg | Inj, bortezomib (maia) | |
| J9052 | No Prior Authorization Required | CARMUSTINE 50MG Solution Reconstituted | Injection, carmustine (Accord), not therapeutically equivalent to J9050, 100 mg | Inj, carmustine (accord) | |
| J9055 | Prior Authorization Required | Erbitux | Injection, cetuximab, 10 mg | Cetuximab injection | |
| J9056 | Not Covered on state fee schedule (Provider's Administered Drug List) | Vivimusta | Injection, bendamustine HCl (Vivimusta), 1 mg | Inj, bendamustine, 1 mg | |
| J9057 | Not Covered | Aliqopa | Injection, copanlisib, 1 mg | Inj., copanlisib, 1 mg | |
| J9060 | No Prior Authorization Required | Platinol | Injection, cisplatin, powder or solution, 10 mg | Cisplatin 10 mg injection | |
| J9061 | Prior Authorization Required | Rybrevant | Injection, amivantamab-vmjw, 2 mg | Inj, amivantamab-vmjw | |
| J9063 | Prior Authorization Required | Elahere | Injection, mirvetuximab soravtansine-gynx, 1 mg | Inj, elahere, 1 mg | |
| J9064 | Prior Authorization Required | | Injection, cabazitaxel (Sandoz), not therapeutically equivalent to J9043, 1 mg | Inj, cabazitaxel (sandoz) | |
| J9065 | No Prior Authorization Required | Mavenclad | Injection, cladribine, per 1 mg | Inj cladribine per 1 mg | |
| J9071 | Not Covered on state fee schedule (Provider's Administered Drug List) | cyclophosphamide | Injection, cyclophosphamide, (AuroMedics), 5 mg | | |
| J9072 | No Prior Authorization Required | CYCLOPHOSPHAMIDE 500MG/ML Solution | Injection, cyclophosphamide, (Dr. Reddys), 5 mg | Inj cyclophos dr.reddy's 5mg | |
| J9073 | Not Covered on state fee schedule (Provider's Administered Drug List) | Cyclophosphamide | Injection, cyclophosphamide (Ingenus), 5 mg | Inj cyclophosphamd (ingenus) | |
| J9074 | No Prior Authorization Required | Cyclophosphamide | Injection, cyclophosphamide (Sandoz), 5 mg | Inj, cyclophosphamd, sandoz | |
| J9075 | No Prior Authorization Required | Cyclophosphamide | Injection, cyclophosphamide, not otherwise specified, 5 mg | Inj, cyclophosphamide, nos | |
| J9076 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, cyclophosphamide (baxter), 5 mg | Inj, cyclophos (baxter) 5mg | |
| J9100 | No Prior Authorization Required | Cytosar | Injection, cytarabine, 100 mg | Cytarabine hcl 100 mg inj | |
| J9118 | Prior Authorization Required | Asparlas | Injection, calaspargase pegol-mknl, 10 units | Inj. calaspargase pegol-mknl | |
| J9119 | No Prior Authorization Required | Libtayo | Injection, cemiplimab-rwlc, 1 mg | Inj., cemiplimab-rwlc, 1 mg | |
| J9120 | No Prior Authorization Required | Cosmegen | Injection, dactinomycin, 0.5 mg | Dactinomycin injection | |
| J9130 | No Prior Authorization Required | DTIC-Dome | Dacarbazine, 100 mg | Dacarbazine 100 mg inj | |
| J9144 | Prior Authorization Required | Darzalex | Daratumumab, hyaluronidase | Injection, daratumumab, 10 mg and hyaluronidase-fihj | |
| J9145 | Prior Authorization Required | Darzalex | Injection, daratumumab, 10 mg | Injection, daratumumab 10 mg | |
| J9150 | No Prior Authorization Required | Daunorubicin | Injection, daunorubicin, 10 mg | Daunorubicin injection | |
| J9153 | Prior Authorization Required | Vyxeos | Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine | Inj daunorubicin, cytarabine | |
| J9155 | Prior Authorization Required | Firmagon | Injection, degarelix, 1 mg | Degarelix injection | |
| J9165 | No Prior Authorization Required | Not available in the US | Injection, diethylstilbestrol diphosphate, 250 mg | Diethylstilbestrol injection | |
| J9171 | No Prior Authorization Required | Taxotere | Injection, docetaxel, 1 mg | Docetaxel injection | |
| J9172 | Prior Authorization Required | Docivyx | Injection, docetaxel (Ingenus), not therapeutically equivalent to J9171, 1 mg | Docetaxel (ingenus), 1 mg | |
| J9173 | Prior Authorization Required | Imfinzi | Injection, durvalumab, 10 mg | Inj., durvalumab, 10 mg | |
| J9175 | No Prior Authorization Required | Elliotts B Solution | Injection, eliotts' b solution, 1 ml | Elliotts b solution per ml | |
| J9176 | Prior Authorization Required | Empliciti | Injection, elotuzumab, 1 mg | Injection, elotuzumab, 1mg | |
| J9177 | Prior Authorization Required | Padvec | Injection, enfortumab vedotin-efv, 0.25 mg | Inj enfort vedo-efv 0.25mg | |
| J9178 | No Prior Authorization Required | Ellence | Injection, epirubicin hcl, 2 mg | Inj, epirubicin hcl, 2 mg | |

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| J9179 | No Prior Authorization Required | Halaven | Injection, eribulin mesylate, 0.1 mg | Eribulin mesylate injection | |
| J9181 | No Prior Authorization Required | Etopophos | Injection, etoposide, 10 mg | Etoposide injection | |
| J9185 | No Prior Authorization Required | Fludara | Injection, fludarabine phosphate, 50 mg | Fludarabine phosphate inj | |
| J9190 | No Prior Authorization Required | Adrucil | Injection, fluorouracil, 500 mg | Fluorouracil injection | |
| J9196 | Not Covered on state fee schedule (Provider's Administered Drug List) | Gemcitabine | Injection, gemcitabine hydrochloride (Accord), not therapeutically equivalent to J9201, 200 mg | Inj gemcitabine hcl (accord) | |
| J9198 | Prior Authorization Required | Infugem | Injection, gemcitabine hydrochloride, (infugem), 100 mg | Inj. infugem, 100 mg | |
| J9200 | No Prior Authorization Required | FUDR | Injection, floxuridine, 500 mg | Floxuridine injection | |
| J9201 | No Prior Authorization Required | Gemzar | Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg | In gemcitabine hcl nos 200mg | |
| J9202 | Prior Authorization Required | Zoladex | Goserelin acetate implant, per 3.6 mg | Goserelin acetate implant | |
| J9203 | Prior Authorization Required | Mylotarg | Injection, gemtuzumab ozogamicin, 0.1 mg | Gemtuzumab ozogamicin 0.1 mg | |
| J9204 | Prior Authorization Required | Poteligeo | Injection, mogamulizumab-kpkc, 1 mg | Inj mogamulizumab-kpkc, 1 mg | |
| J9205 | Prior Authorization Required | Onivyde | Injection, irinotecan liposome, 1 mg | Inj irinotecan liposome 1 mg | |
| J9206 | No Prior Authorization Required | Camptosar | Injection, irinotecan, 20 mg | Irinotecan injection | |
| J9207 | No Prior Authorization Required | Ixempra | Injection, ixabepilone, 1 mg | Ixabepilone injection | |
| J9208 | No Prior Authorization Required | Ifex | Injection, ifosfamide, 1 gram | Ifosfamide injection | |
| J9209 | No Prior Authorization Required | Mesnex | Injection, mesna, 200 mg | Mesna injection | |
| J9210 | Prior Authorization Required | Gamifant | Injection, emapalumab-lzsg, 1 mg | Inj., emapalumab-lzsg, 1 mg | |
| J9211 | No Prior Authorization Required | Idamycin | Injection, idarubicin hydrochloride, 5 mg | Idarubicin hcl injection | |
| J9214 | Prior Authorization Required | Intron A | Injection, interferon, alfa-2b, recombinant, 1 million units | Interferon alfa-2b inj | |
| J9215 | Prior Authorization Required | Alferon N | Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 iu | Interferon alfa-n3 inj | |
| J9216 | Prior Authorization Required | Actimmune | Injection, interferon, gamma 1-b, 3 million units | Interferon gamma 1-b inj | |
| J9217 | Prior Authorization Required | Eligard | Leuprolide acetate (for subcutaneous inj kit), 7.5 mg | Leuprolide acetate suspension | Endometriosis: -every 84 days -only 1 reauth permitted Uterine Fibroids/Leiomyoma: every 84 days |
| J9218 | Prior Authorization Required | Leuprolide | Leuprolide acetate, per 1 mg | Leuprolide acetate injection | Endometriosis: -every 84 days -only 1 reauth permitted Uterine Fibroids/Leiomyoma: every 84 days |
| J9223 | Prior Authorization Required | Zepzelca | Inj. lurbinectedin, 0.1 mg | Injection, lurbinectedin, 0.1 mg | |
| J9225 | Prior Authorization Required | Vantas | Histrelin implant (vantas), 50 mg | Vantas implant | |
| J9226 | Prior Authorization Required | Supprelin LA | Histrelin implant (supprelin la), 50 mg | Supprelin la implant | |
| J9227 | Prior Authorization Required | Sarclisa | Injection, isatuximab-irfc, 10 mg | Inj. isatuximab-irfc 10 mg | |
| J9228 | Prior Authorization Required | Yervoy | Injection, ipilimumab, 1 mg | Ipilimumab injection | |
| J9229 | Prior Authorization Required | Besponsa | Injection, inotuzumab ozogamicin, 0.1 mg | Inj inotuzumab ozogam 0.1 mg | |
| J9230 | No Prior Authorization Required | Mustargen | Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg | Mechlorethamine hcl inj | |
| J9245 | No Prior Authorization Required | Alkeran | Injection, melphalan hydrochloride, 50 mg | Inj melphalan hydrochl 50 mg | |
| J9246 | Prior Authorization Required | Evomela | Injection, melphalan (evomela), 1 mg | Inj., evomela, 1 mg | |
| J9247 | Not Covered on state fee schedule (Provider's Administered Drug List) | Alkeran, Evomela | Injection, melphalan flufenamide, 1 mg | Inj, melphalan flufenami 1mg | |
| J9248 | Not Covered on state fee schedule (Provider's Administered Drug List) | Hepzato | Injection, melphalan (Hepzato), 1 mg | Inj melphalan (hepzato) 1 mg | |
| J9249 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, melphalan (Apotex), 1 mg | Inj, melphalan (apotex) 1 mg | |
| J9255 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, methotrexate (Accord), not therapeutically equivalent to J9250 and J9260, 50 mg | Inj. methotrexate (accord) | |
| J9260 | No Prior Authorization Required | Methotrexate | Methotrexate sodium, 50 mg | Methotrexate sodium inj | |
| J9261 | No Prior Authorization Required | Arranon | Injection, nelarabine, 50 mg | Nelarabine injection | |
| J9262 | Prior Authorization Required | Synribo | Injection, omacetaxine mepesuccinate, 0.01 mg | Inj, omacetaxine mep, 0.01mg | |
| J9263 | No Prior Authorization Required | Eloxatin | Injection, oxaliplatin, 0.5 mg | Oxaliplatin | |
| J9264 | No Prior Authorization Required | Abraxane | Injection, paclitaxel protein-bound particles, 1 mg | Paclitaxel protein bound | |
| J9266 | Prior Authorization Required | Oncaspar | Injection, pegaspargase, per single dose vial | Pegaspargase injection | Dosing every 2 weeks; 1 billing unit= up to 3750IU |
| J9267 | No Prior Authorization Required | Taxol | Injection, paclitaxel, 1 mg | Paclitaxel injection | |
| J9268 | No Prior Authorization Required | Nipent | Injection, pentostatin, 10 mg | Pentostatin injection | |

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| J9269 | Prior Authorization Required | Elzonris | Injection, tagraxofusp-erzs, 10 micrograms | Inj. tagraxofusp-erzs 10 mcg | |
| J9271 | Prior Authorization Required | Keytruda | Injection, pembrolizumab, 1 mg | Inj pembrolizumab | |
| J9272 | Prior Authorization Required | Jemperli | Injection, dostarlimab-gxly, 10 mg | Inj, dostarlimab-gxly, 10 mg | |
| J9273 | Prior Authorization Required | Tivdak | Injection, tisotumab vedotin-tftv, 1 mg | | |
| J9274 | Prior Authorization Required | Kimtrak | Injection, tebentafusp-tebn, 1 microgram | Inj, tebentafusp-tebn, 1 mcg | |
| J9280 | No Prior Authorization Required | Mutamycin | Injection, mitomycin, 5 mg | Mitomycin injection | |
| J9281 | Prior Authorization Required | Jemlyto | Mitomycin instillation | Mitomycin pyelocalyceal instillation, 1 mg | |
| J9285 | Prior Authorization Required | Lartruvo | Injection, olaratumab, 10 mg | Inj, olaratumab, 10 mg | |
| J9286 | Prior Authorization Required | COLUMVI 2.5MG/2.5ML Solution | Injection, glofitamab-gxbm, 2.5 mg | Inj glofitamab gxbm, 2.5 mg | |
| J9292 | Not Covered on state fee schedule (Provider's Administered Drug List) | Avyxa | Injection, pemetrexed (avyxa), not therapeutically equivalent to J9305, 10 mg | Inj, pemetrexed (avyxa) 10mg | |
| J9293 | Prior Authorization Required | Novantrone | Injection, mitoxantrone hydrochloride, per 5 mg | Mitoxantrone hydrochl / 5 mg | |
| J9294 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, pemetrexed (Hospira), not therapeutically equivalent to J9305, 10 mg | Inj pemetrexed, hospira 10mg | |
| J9295 | Prior Authorization Required | Portrazza | Injection, necitumumab, 1 mg | Injection, necitumumab, 1 mg | |
| J9296 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, pemetrexed (Accord), not therapeutically equivalent to J9305, 10 mg | Inj pemetrexed (accord) 10mg | |
| J9297 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, pemetrexed (Sandoz), not therapeutically equivalent to J9305, 10 mg | Inj pemetrexed (sandoz) 10mg | |
| J9298 | Prior Authorization Required | Opdualag | Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg | Inj nivolumab relatlimab 3mg/1mg | |
| J9299 | Prior Authorization Required | Opdivo | Injection, nivolumab, 1 mg | Injection, nivolumab | |
| J9301 | Prior Authorization Required | Gazyva | Injection, obinutuzumab, 10 mg | Obinutuzumab inj | |
| J9302 | Prior Authorization Required | Arzerra | Injection, ofatumumab, 10 mg | Ofatumumab injection | |
| J9303 | No Prior Authorization Required | Vectibix | Injection, panitumumab, 10 mg | Panitumumab injection | |
| J9304 | Prior Authorization Required | Pemfexy | Injection, pemetrexed (pemfexy), 10 mg | Inj. pemetrexed, 10 mg | |
| J9305 | No Prior Authorization Required | Alimta | Injection, pemetrexed, 10 mg | Pemetrexed injection | |
| J9306 | Prior Authorization Required | Perjeta | Injection, pertuzumab, 1 mg | Injection, pertuzumab, 1 mg | |
| J9307 | No Prior Authorization Required | Folotyn | Injection, pralatrexate, 1 mg | Pralatrexate injection | |
| J9308 | Prior Authorization Required | Cyramza | Injection, ramucirumab, 5 mg | Injection, ramucirumab | |
| J9309 | Prior Authorization Required | Polivy | Injection, polatuzumab vedotin-piiq, 1 mg | Inj, polatuzumab vedotin 1mg | |
| J9309 | Prior Authorization Required | Polivy | Injection, polatuzumab vedotin-piiq, 1 mg | Inj, polatuzumab vedotin 1mg | |
| J9311 | Prior Authorization Required | Rituxan Hycela | Injection, rituximab 10 mg and hyaluronidase | Inj rituximab, hyaluronidase | Hycela is only covered for the oncology diagnoses. |
| J9312 | Prior Authorization Required | Rituxan | Injection, rituximab, 10 mg | Inj., rituximab, 10 mg | |
| J9313 | Prior Authorization Required | Lumoxiti | Injection, moxetumomab pasudotox-tdfk, 0.01 mg | Inj., lumoxiti, 0.01 mg | |
| J9314 | Prior Authorization Required | | Injection, pemetrexed (Teva) not therapeutically equivalent to J9305, 10 mg | | |
| J9316 | Prior Authorization Required | Phesgo | Pertuzu, trastuzu, 10 mg | Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg | |
| J9317 | Prior Authorization Required | Trodelvy | Sacituzumab govitecan-hziy | Injection, sacituzumab govitecan-hziy, 2.5 mg | |
| J9318 | Not Covered on state fee schedule (Provider's Administered Drug List) | Istodax | Injection, romidepsin, nonlyophilized, 0.1 mg | Inj romidepsin non-lyo 0.1mg | |
| J9319 | Prior Authorization Required | Istodax | Injection, romidepsin, lyophilized, 0.1 mg | Inj romidepsin lyophil 0.1mg | |
| J9320 | No Prior Authorization Required | Zanosar | Injection, streptozocin, 1 gram | Streptozocin injection | |
| J9321 | Prior Authorization Required | Epkinly | Injection, epcoritamab-bysp, 0.16 mg | Inj epcoritamab-bysp,0.16 mg | |
| J9322 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, pemetrexed (BluePoint) not therapeutically equivalent to J9305, 10 mg | Inj pemetrexed (bluepoint) | |
| J9323 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, pemetrexed (Hospira) not therapeutically equivalent to J9305, 10 mg | Inj pemetrexed ditromethamin | |
| J9324 | Not Covered on state fee schedule (Provider's Administered Drug List) | Pemrydi RTU | Injection, pemetrexed (Pemrydi RTU), 10 mg | Inj, pemrydi rtu, 10 mg | |
| J9325 | Prior Authorization Required | Imlygic | Injection, talimogene laherparepvec, per 1 million plaque forming units | Inj talimogene laherparepvec | |
| J9328 | Prior Authorization Required | Temodar | Injection, temozolomide, 1 mg | Temozolomide injection | |
| J9329 | Prior Authorization Required | TEVIMBRA 100MG/10ML Solution | Injection, tislelizumab-jsgr, 1mg | Inj, tislelizumab-jsgr | |
| J9330 | Prior Authorization Required | Torisel | Injection, temsirolimus, 1 mg | Temsirolimus injection | |

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| J9332 | Prior Authorization Required | Vyvgart | Injection, efgartigimod alfa-fcab, 2mg | | |
| J9333 | Prior Authorization Required | RYSTIGGO 140MG/ML Solution | Injection, rozanolixizumab-noli, 1 mg | Inj ronzanolixizum-noli 1 mg | |
| J9334 | Prior Authorization Required | Vyvgart Hytrulo | Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc | Inj efgart-alfa 2mg hya-qvfc | |
| J9340 | No Prior Authorization Required | Tepadina | Injection, thiotepa, 15 mg | Thiotepa injection | |
| J9345 | Prior Authorization Required | Zynyz | Injection, retifanlimab-dlwr, 1 mg | Inj, retifanlimab-dlwr, 1 mg | |
| J9347 | Prior Authorization Required | Imjudo | Injection, tremelimumab-actl, 1 mg | Inj, tremelimumab-actl, 1 mg | |
| J9348 | Prior Authorization Required | Danyelza | Injection, naxitamab-gqgk, 1 mg | Inj. naxitamab-gqgk, 1 mg | |
| J9350 | Prior Authorization Required | | Injection, mosunetuzumab-axgb, 1 mg | Inj mosunetuzumab-axgb, 1 mg | |
| J9351 | No Prior Authorization Required | Hycamtin | Injection, topotecan, 0.1 mg | Topotecan injection | |
| J9352 | Prior Authorization Required | Yondelis | Injection, trabectedin, 0.1 mg | Injection trabectedin 0.1mg | |
| J9353 | Prior Authorization Required | Margenza | Injection, margetuximab-cmkb, 5 mg | Inj. margetuximab-cmkb, 5 mg | |
| J9354 | Prior Authorization Required | Kadcyla | Injection, ado-trastuzumab emtansine, 1 mg | Inj, ado-trastuzumab emt 1mg | |
| J9355 | Prior Authorization Required | Herceptin | Injection, trastuzumab, excludes biosimilar, 10 mg | Inj trastuzumab excl biosimi | |
| J9356 | Prior Authorization Required | Herceptin Hylecta | Injection, trastuzumab, 10 mg and hyaluronidase-oysk | Inj. herceptin hylecta, 10mg | |
| J9357 | No Prior Authorization Required | Valstar | Injection, valrubicin, intravesical, 200 mg | Valrubicin injection | |
| J9358 | Prior Authorization Required | Enhertu | Injection, fam-trastuzumab deruxtecan-nxki, 1 mg | Inj fam-trastu deru-nxki 1mg | |
| J9359 | Prior Authorization Required | Zynlonta | Injection, loncastuximab tesirine-lpyl, 0.075 mg | | |
| J9360 | No Prior Authorization Required | Velban | Injection, vinblastine sulfate, 1 mg | Vinblastine sulfate inj | |
| J9361 | Prior Authorization Required | | Injection, efbemalenograstim alfa-vuxw, 0.5 mg | Inj, efbemalenograstim alfa- | |
| J9370 | No Prior Authorization Required | Vincasar PFS | Vincristine sulfate, 1 mg | Vincristine sulfate 1 mg inj | |
| J9376 | Not Covered on state fee schedule (Provider's Administered Drug List) | Veopoz | Injection, pozelimab-bbfg, 1 mg | Inj pozelimab-bbfg, 1 mg | |
| J9380 | Not Covered | Tecvayli | Injection, teclistamab-cqyv, 0.5 mg | Inj teclistamab cqyv 0.5 mg | |
| J9381 | Prior Authorization Required | Tzielid | Injection, teplizumab-mzww, 5 mcg | Inj teplizumab mzww 5 mcg | |
| J9390 | No Prior Authorization Required | Navelbine | Injection, vinorelbine tartrate, 10 mg | Vinorelbine tartrate inj | |
| J9393 | Not Covered on state fee schedule (Provider's Administered Drug List) | Fulvestrant | Injection, fulvestrant (Teva) not therapeutically equivalent to J9395, 25 mg | | |
| J9394 | Prior Authorization Required | Fulvestrant | Injection, fulvestrant (Fresenius Kabi) not therapeutically equivalent to J9395, 25 mg | | |
| J9395 | No Prior Authorization Required | Faslodex | Injection, fulvestrant, 25 mg | Injection, fulvestrant | |
| J9400 | Prior Authorization Required | Zaltrap | Injection, ziv-aflibercept, 1 mg | Inj, ziv-aflibercept, 1mg | |
| J9600 | No Prior Authorization Required | Photofrin | Injection, porfimer sodium, 75 mg | Porfimer sodium injection | |
| J9999 | Prior Authorization Required | Unclassified code | Not otherwise classified, antineoplastic drugs | Chemotherapy drug | |
| M0201 | No Prior Authorization Required | Home vaccine admin | Covid-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only covid-19 vaccine administration is performed at the patient's home | Covid-19 vaccine home admin | |
| M0224 | Prior Authorization Required | Pengarda | Intravenous infusion, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known sars-cov-2 exposure, who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, includes infusion and post administration monitoring | Pemivibart infusion | |
| M0249 | No Prior Authorization Required | Genentech | Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose | Adm Tocilizu COVID-19 1st | |
| M0250 | No Prior Authorization Required | Genentech | Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose | Adm Tocilizu COVID-19 2nd | |

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| P9012 | No Prior Authorization Required | | Cryoprecipitate, each unit | Cryoprecipitate each unit | |
| P9041 | No Prior Authorization Required | | Infusion, albumin (human), 5%, 50 ml | Albumin (human),5%, 50ml | |
| P9043 | No Prior Authorization Required | | Infusion, plasma protein fraction (human), 5%, 50 ml | Plasma protein fract,5%,50ml | |
| P9045 | No Prior Authorization Required | | Infusion, albumin (human), 5%, 250 ml | Albumin (human), 5%, 250 ml | |
| P9046 | No Prior Authorization Required | | Infusion, albumin (human), 25%, 20 ml | Albumin (human), 25%, 20 ml | |
| P9047 | No Prior Authorization Required | | Infusion, albumin (human), 25%, 50 ml | Albumin (human), 25%, 50ml | |
| P9048 | No Prior Authorization Required | | Infusion, plasma protein fraction (human), 5%, 250 ml | Plasmaprotein fract,5%,250ml | |
| P9050 | No Prior Authorization Required | | Granulocytes, pheresis, each unit | Granulocytes, pheresis unit | |
| Q0112 | No Prior Authorization Required | | All potassium hydroxide (koh) preparations | Potassium hydroxide preps | |
| Q0138 | Prior Authorization Required | Feraheme | Injection, ferumoxylol, for treatment of iron deficiency anemia, 1 mg (non-esrd use) | Ferumoxylol, non-esrd | |
| Q0139 | Prior Authorization Required | Feraheme | Injection, ferumoxylol, for treatment of iron deficiency anemia, 1 mg (for esrd on dialysis) | Ferumoxylol, esrd use | |
| Q0155 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Dronabinol (syndros), 0.1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Dronabinol (syndros) 0.1 mg | |
| Q0161 | No Prior Authorization Required | Thorazine | Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Chlorpromazine hcl 5mg oral | |
| Q0162 | No Prior Authorization Required | Zofran | Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Ondansetron oral | |
| Q0163 | No Prior Authorization Required | Benadryl | Diphenhydramine hydrochloride, 50 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen | Diphenhydramine hcl 50mg | |
| Q0164 | No Prior Authorization Required | Compazine | Prochlorperazine maleate, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Prochlorperazine maleate 5mg | |
| Q0166 | No Prior Authorization Required | Kytril | Granisetron hydrochloride, 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen | Granisetron hcl 1 mg oral | |
| Q0167 | Prior Authorization Required | Inapsine | Dronabinol, 2.5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Dronabinol 2.5mg oral | |
| Q0169 | No Prior Authorization Required | Phenergan | Promethazine hydrochloride, 12.5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Promethazine hcl 12.5mg oral | |
| Q0175 | No Prior Authorization Required | Trilafon | Perphenazine, 4 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Perphenazine 4mg oral | |

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| Q0177 | Not Covered on state fee schedule (Provider's Administered Drug List) | Vistaril | Hydroxyzine pamoate, 25 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Hydroxyzine pamoate 25mg | |
| Q0180 | Prior Authorization Required | Anzemet | Dolasetron mesylate, 100 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen | Dolasetron mesylate oral | |
| Q0181 | No Prior Authorization Required | | Unspecified oral dosage form, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for a iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen | Unspecified oral anti-emetic | |
| Q0224 | Prior Authorization Required | Pemgarda | Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known sars-cov-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to covid-19 vaccination, 4500 mg | Inj, pemivibart, 4500 mg | |
| Q0249 | No Prior Authorization Required | Genentech | Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg | Tocilizumab for COVID-19 | |
| Q0510 | No Prior Authorization Required | | Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant | Dispens fee immunosuppressive | |
| Q0511 | No Prior Authorization Required | | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30-day period | Sup fee antiem,antica,immuno | |
| Q0513 | No Prior Authorization Required | | Pharmacy dispensing fee for inhalation drug(s); per 30 days | Disp fee inhal drugs/30 days | |
| Q0514 | No Prior Authorization Required | | Pharmacy dispensing fee for inhalation drug(s); per 90 days | Disp fee inhal drugs/90 days | |
| Q0521 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription | Supply fee hiv prep fda appr | |
| Q2009 | No Prior Authorization Required | Cerebyx | Injection, fosphenytoin, 50 mg phenytoin equivalent | Fosphenytoin inj pe | |
| Q2017 | Prior Authorization Required | Teniposide | Injection, teniposide, 50 mg | Teniposide, 50 mg | |
| Q2039 | No Prior Authorization Required | | Influenza virus vaccine, not otherwise specified | Influenza virus vaccine, nos | |
| Q2041 | Prior Authorization Required | Yescarta | Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Axicabtagene ciloleucel car+ | |
| Q2042 | Prior Authorization Required | Kymriah | Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Tisagenlecleucel car-pos t | |
| Q2043 | Prior Authorization Required | Provenge | Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion | Sipuleucel-t auto cd54+ | |
| Q2050 | Prior Authorization Required | Doxil | Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg | Doxorubicin inj 10mg | |
| Q2053 | Prior Authorization Required | Tecartus | Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Brexucabtagene car pos t | |
| Q2054 | Prior Authorization Required | Breyanzi | Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Lisocabtagene mara car pos t | |
| Q2055 | Prior Authorization Required | Abecma | Idecabtagene vicleucel, up to 460 million autologous B-cell maturation antigen (BCMA) directed CAR-positive T cells, including leukapheresis and dose preparation procedures, p | Idecabtagene vicleucel car | |
| Q2056 | Prior Authorization Required | Carvykti | Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Ciltacabtagene car-pos t | |
| Q3027 | Prior Authorization Required | Avonex | Injection, interferon beta-1a, 1 mcg for intramuscular use | Inj beta interferon im 1 mcg | |
| Q3028 | Prior Authorization Required | Rebif | Injection, interferon beta-1a, 1 mcg for subcutaneous use | Inj beta interferon sq 1 mcg | |
| Q4074 | Prior Authorization Required | Ventavis | Iloprost, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, up to 20 micrograms | Iloprost non-comp unit dose | |

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| Q4081 | No Prior Authorization Required | Epoen Procrit | Injection, epoetin alfa, 100 units (for ESRD on dialysis) (for renal dialysis facilities and hospital use) | Epoetin alfa, 100 units esrd | |
| Q5101 | Prior Authorization Required | Zarxio | Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram | Injection, zarxio 1mcg | |
| Q5103 | Prior Authorization Required | Inflectra | Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg | Injection, inflectra 10mg | |
| Q5104 | Prior Authorization Required | Renflexis | Injection, infliximab-abda, biosimilar, (renflexis), 10 mg | Injection, renflexis 10mg | |
| Q5105 | Prior Authorization Required | Retacrit | Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for esrd on dialysis), 100 units | Inj retacrit esrd on dialysi | |
| Q5106 | Prior Authorization Required | Retacrit | Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units | Inj retacrit non-esrd use | |
| Q5107 | Prior Authorization Required | Mvasi | Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg | Inj mvasi 10 mg | |
| Q5108 | Prior Authorization Required | Fulphila | Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg | Injection, fulphila 0.5mg | |
| Q5109 | Prior Authorization Required | Ixifi | Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg | Injection, ixifi, 10 mg | |
| Q5110 | Prior Authorization Required | Nivestym | Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram | Injection, Nivestym 1mcg | |
| Q5111 | Prior Authorization Required | Udenyca | Injection, pegfilgrastim-cbqv, biosimilar, (udenyca), 0.5 mg | Injection, udenyca 0.5 mg | |
| Q5112 | Prior Authorization Required | Ontruzant | Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg | Inj ontruzant 10 mg | |
| Q5113 | Prior Authorization Required | Herzuma | Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg | Inj herzuma 10 mg | |
| Q5114 | Prior Authorization Required | Ogivri | Injection, trastuzumab-dkst, biosimilar, (ogivri), 10 mg | Inj ogivri 10 mg | |
| Q5115 | Prior Authorization Required | Truxima | Injection, rituximab-abbs, biosimilar, (truxima), 10 mg | Inj truxima 10 mg | |
| Q5116 | Prior Authorization Required | Trazimera | Injection, trastuzumab-anns, biosimilar, (kanjinti), 10mg | Inj, Trazimera 10mg | |
| Q5117 | Prior Authorization Required | Kanjinti | Injection, trastuzumab-anns, biosimilar, (trazimera), 10mg | Inj, Kanjinti, 10mg | |
| Q5118 | Prior Authorization Required | Zirabev | Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10mg | Inj, Zirabev, 10mg | |
| Q5119 | Prior Authorization Required | Ruxience | Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg | Inj ruxience, 10 mg | |
| Q5120 | Prior Authorization Required | Ziextenzo | Injection, pegfilgrastim-bmez, biosimilar, (ziextenzo), 0.5 mg | Inj pegfilgrastim-bmez 0.5mg | |
| Q5121 | Prior Authorization Required | Avsola | Injection, infliximab-axxq, biosimilar, (avsola), 10 mg | Inj. avsola, 10 mg | |
| Q5122 | Prior Authorization Required | Nyvepria | Inj, nyvepria | Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg | |
| Q5123 | Prior Authorization Required | Riabni | Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg | Inj. riabni, 10 mg | |
| Q5124 | Prior Authorization Required | Byooviz | Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg | | |
| Q5125 | Prior Authorization Required | Releuko | Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram | Inj, releuko 1 mcg | |
| Q5126 | Prior Authorization Required | Alymsys | Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg | | |
| Q5127 | Prior Authorization Required | Stimufend | Injection, pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg | Inj, stimufend, 0.5 mg | |
| Q5128 | Prior Authorization Required | Cimerli | Injection, ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg | Inj, cimerli, 0.1 mg | |
| Q5129 | Prior Authorization Required | Vegzelma | Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg | Inj, vegzelma, 10 mg | |
| Q5130 | Prior Authorization Required | Fylnetra | Injection, pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg | Inj, fylnetra, 0.5 mg | |
| Q5133 | Not Covered on state fee schedule (Provider's Administered Drug List) | Tofidence | Injection, tocilizumab-bavi (Tofidence), biosimilar, 1 mg | Inj, tofidence, 1 mg | |
| Q5134 | Not Covered on state fee schedule (Provider's Administered Drug List) | Tyruko | Injection, natalizumab-sztn (Tyruko), biosimilar, 1 mg | Inj, tyruko, 1 mg | |
| Q5135 | Not Covered on state fee schedule (Provider's Administered Drug List) | TYENNE 162MG/0.9ML Solution Auto-injector | Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg | Inj, tyenne, 1 mg | |
| Q5136 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg | Inj. denosumab-bbdz, 1 mg | |
| Q5137 | Prior Authorization Required | Wezlana | Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg | Inj, wezlana, sub cu, 1 mg | |
| Q5138 | Prior Authorization Required | Wezlana | Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg | Inj, wezlana, iv, 1 mg | |
| Q5139 | Not Covered on state fee schedule (Provider's Administered Drug List) | Bkemv | Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg | Inj, eculizumab-aeeb, 10 mg | |
| Q5140 | Prior Authorization Required | | Injection, adalimumab-fkjp, biosimilar, 1 mg | Inj adalimumab-fkjp, 1 mg | |
| Q5141 | Prior Authorization Required | | Injection, adalimumab-aaty, biosimilar, 1 mg | Inj adalimumab-aaty, 1 mg | |
| Q5142 | Prior Authorization Required | | Injection, adalimumab-ryvk biosimilar, 1 mg | Inj adalimumab-ryvk, 1 mg | |
| Q5143 | Prior Authorization Required | | Injection, adalimumab-adbm, biosimilar, 1 mg | Inj adalimumab-adbm, 1 mg | |

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| Q5144 | Not Covered on state fee schedule (Provider's Administered Drug List) | Idacio | Injection, adalimumab-aacf (idacio), biosimilar, 1 mg | Inj, idacio, 1 mg | |
| Q5145 | Prior Authorization Required | Abrilada | Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg | Inj, abrilada, 1 mg | |
| Q5146 | Prior Authorization Required | Hercessi | Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg | Inj, hercessi, 10 mg | |
| Q9950 | No Prior Authorization Required | Lumason | Injection, sulfur hexafluoride lipid microspheres, per ml | Inj sulf hexa lipid microsph | |
| Q9969 | No Prior Authorization Required | | Tc-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose | Non-heu tc-99m add-on/dose | |
| Q9991 | Prior Authorization Required | Sublocade | Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg | Buprenorph xr 100 mg or less | |
| Q9992 | Prior Authorization Required | Sublocade | Injection, buprenorphine extended-release (sublocade), greater than 100 mg | Buprenorphine xr over 100 mg | |
| Q9996 | Not Covered on state fee schedule (Provider's Administered Drug List) | Pyzchiva | Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg | Ustekinumab- ttwe sub cu inj | |
| Q9997 | Not Covered on state fee schedule (Provider's Administered Drug List) | Pyzchiva | Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg | Ustekinumab-ttwe iv inj 1 mg | |
| Q9998 | Not Covered on state fee schedule (Provider's Administered Drug List) | Selarsdi | Injection, ustekinumab-aekn (selarsdi), 1 mg | Ustekinumab-aekn inj | |
| S0012 | No Prior Authorization Required | Stadol Nasal | Butorphanol tartrate, nasal spray, 25 mg | Butorphanol tartrate, nasal | |
| S0013 | Prior Authorization Required | Spravato | Esketamine, nasal spray | Esketamine, nasal spray, 1 mg | |
| S0017 | No Prior Authorization Required | Amicar | Injection, aminocaproic acid, 5 grams | Injection, aminocaproic acid | |
| S0028 | No Prior Authorization Required | Pepcid | Injection, famotidine, 20 mg | Injection, famotidine, 20 mg | |
| S0032 | No Prior Authorization Required | Nafcillin | Injection, nafcillin sodium, 2 grams | Injection, nafcillin sodium | |
| S0039 | No Prior Authorization Required | Septra | Injection, sulfamethoxazole and trimethoprim, 10 ml | Injection, sulfamethoxazole | |
| S0074 | No Prior Authorization Required | Cefotan | Injection, cefotetan disodium, 500 mg | Injection, cefotetan disodiu | |
| S0078 | No Prior Authorization Required | Cerebyx | Injection, fosphenytoin sodium, 750 mg | Injection, fosphenytoin sodi | |
| S0080 | No Prior Authorization Required | Pentam | Injection, pentamidine isethionate, 300 mg | Injection, pentamidine iseth | |
| S0088 | No Prior Authorization Required | Gleevec | Imatinib, 100 mg | Imatinib 100 mg | |
| S0090 | No Prior Authorization Required | Viagra | Sildenafil citrate, 25 mg | Sildenafil citrate, 25 mg | |
| S0091 | No Prior Authorization Required | Kytril | Granisetron hydrochloride, 1 mg (for circumstances falling under the medicare statute, use q0166) | Granisetron 1mg | |
| S0092 | No Prior Authorization Required | Dilaudid | Injection, hydromorphone hydrochloride, 250 mg (loading dose for infusion pump) | Hydromorphone 250 mg | |
| S0093 | No Prior Authorization Required | Morphine | Injection, morphine sulfate, 500 mg (loading dose for infusion pump) | Morphine 500 mg | |
| S0104 | No Prior Authorization Required | Retrovir | Zidovudine, oral, 100 mg | Zidovudine, oral, 100 mg | |
| S0106 | No Prior Authorization Required | Wellbutrin SR | Bupropion hcl sustained release tablet, 150 mg, per bottle of 60 tablets | Bupropion hcl sr 60 tablets | |
| S0108 | No Prior Authorization Required | Purixan | Mercaptopurine, oral, 50 mg | Mercaptopurine 50 mg | |
| S0109 | No Prior Authorization Required | Dolophine | Methadone, oral, 5 mg | Methadone oral 5mg | |
| S0117 | No Prior Authorization Required | Retin A | Tretinoin, topical, 5 grams | Tretinoin topical 5 g | |
| S0119 | No Prior Authorization Required | Zofran | Ondansetron, oral, 4 mg (for circumstances falling under the medicare statute, use hcpcs q code) | Ondansetron 4 mg | |
| S0122 | No Prior Authorization Required | Menopur | Injection, menopins, 75 iu | Inj menopins 75 iu | |
| S0126 | No Prior Authorization Required | Gonal F | Injection, follitropin alfa, 75 iu | Inj follitropin alfa 75 iu | |
| S0128 | No Prior Authorization Required | Follistim AQ | Injection, follitropin beta, 75 iu | Inj follitropin beta 75 iu | |
| S0132 | Not Covered on state fee schedule (Provider's Administered Drug List) | Ganirelix Acetate | Injection, ganirelix acetate, 250 mcg | Inj ganirelix acetat 250 mcg | |
| S0136 | No Prior Authorization Required | Clozaril | Clozapine, 25 mg | Clozapine, 25 mg | |
| S0137 | No Prior Authorization Required | Videx EC | Didanosine (ddi), 25 mg | Didanosine, 25 mg | |
| S0138 | No Prior Authorization Required | Proscar | Finasteride, 5 mg | Finasteride, 5 mg | |
| S0139 | No Prior Authorization Required | Minoxidil | Minoxidil, 10 mg | Minoxidil, 10 mg | |
| S0145 | No Prior Authorization Required | Pegasys | Injection, pegylated interferon alfa-2a, 180 mcg per ml | Peg interferon alfa-2a/180 | |
| S0148 | No Prior Authorization Required | Peg-Intron | Injection, pegylated interferon alfa-2b, 10 mcg | Peg interferon alfa-2b/10 | |
| S0155 | No Prior Authorization Required | Folan Diluent | Sterile dilutant for epoprostenol, 50 ml | Epoprostenol dilutant | |
| S0156 | No Prior Authorization Required | Aromasin | Exemestane, 25 mg | Exemestane, 25 mg | |
| S0157 | No Prior Authorization Required | Regranex | Becaplermin gel 0.01%, 0.5 gm | Becaplermin gel 1%, 0.5 gm | |
| S0160 | No Prior Authorization Required | Zenedi | Dextroamphetamine sulfate, 5 mg | Dextroamphetamine | |
| S0169 | No Prior Authorization Required | Rocaltrol | Calcitrol, 0.25 microgram | Calcitrol | |

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|-------|---------------------------------|-------------------|--|---------------------------------|--|
| S0170 | No Prior Authorization Required | Arimidex | Anastrozole, oral, 1 mg | Anastrozole 1 mg | |
| S0172 | No Prior Authorization Required | Leukeran | Chlorambucil, oral, 2 mg | Chlorambucil 2 mg | |
| S0174 | No Prior Authorization Required | Anzemet | Dolasetron mesylate, oral 50 mg (for circumstances falling under the medicare statute, use q0180) | Dolasetron 50 mg | |
| S0175 | No Prior Authorization Required | Flutamide | Flutamide, oral, 125 mg | Flutamide 125 mg | |
| S0176 | No Prior Authorization Required | Hydrea | Hydroxyurea, oral, 500 mg | Hydroxyurea 500 mg | |
| S0178 | No Prior Authorization Required | Gleostine | Lomustine, oral, 10 mg | Lomustine 10 mg | |
| S0179 | No Prior Authorization Required | Megace | Megestrol acetate, oral, 20 mg | Megestrol 20 mg | |
| S0182 | No Prior Authorization Required | Matulane | Procarbazine hydrochloride, oral, 50 mg | Procarbazine, oral | |
| S0183 | No Prior Authorization Required | Compazine | Prochlorperazine maleate, oral, 5 mg (for circumstances falling under the medicare statute, use q0164) | Prochlorperazine 5 mg | |
| S0187 | No Prior Authorization Required | Nolvadex | Tamoxifen citrate, oral, 10 mg | Tamoxifen 10 mg | |
| S0189 | No Prior Authorization Required | Testopel | Testosterone pellet, 75 mg | Testosterone pellet 75 mg | |
| S0190 | No Prior Authorization Required | Mifeprex | Mifepristone, oral, 200 mg | Mifepristone, oral, 200 mg | |
| S0191 | No Prior Authorization Required | Cytotec | Misoprostol, oral, 200 mcg | Misoprostol, oral, 200 mcg | |
| S0194 | No Prior Authorization Required | Renal Caps | Dialysis/stress vitamin supplement, oral, 100 capsules | Vitamin suppl 100 caps | |
| S0197 | No Prior Authorization Required | Prenatal Vitamins | Prenatal vitamins, 30-day supply | Prenatal vitamins 30 day | |
| S0316 | No Prior Authorization Required | | Disease management program, follow-up/reassessment | Follow-up/reassessment | |
| S4990 | No Prior Authorization Required | | Nicotine patches, legend | Nicotine patch legend | |
| S4991 | No Prior Authorization Required | | Nicotine patches, non-legend | Nicotine patch nonlegend | |
| S4993 | No Prior Authorization Required | | Contraceptive pills for birth control | Contraceptive pills for bc | |
| S5000 | No Prior Authorization Required | | Prescription drug, generic | Prescription drug, generic | |
| S5001 | No Prior Authorization Required | | Prescription drug, brand name | Prescription drug, brand name | |
| S5010 | No Prior Authorization Required | | 5% dextrose and 0.45% normal saline, 1000 ml | 5% dextrose and 0.45% saline | |
| S5012 | No Prior Authorization Required | | 5% dextrose with potassium chloride, 1000 ml | 5% dextrose with potassium | |
| S5013 | No Prior Authorization Required | | 5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1000 ml | 5% dextrose/0.45% saline 1000ml | |
| S5014 | No Prior Authorization Required | | 5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1500 ml | D5w/0.45ns w kcl and mgs04 | |
| S5497 | Prior Authorization Required | | Home infusion therapy, catheter care / maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit cath care noc | |
| S5498 | Prior Authorization Required | | Home infusion therapy, catheter care / maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem | Hit simple cath care | |
| S5501 | Prior Authorization Required | | Home infusion therapy, catheter care / maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit complex cath care | |
| S5502 | Prior Authorization Required | | Home infusion therapy, catheter care / maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use) | Hit interim cath care | |
| S5517 | Prior Authorization Required | | Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting | Hit declotting kit | |
| S5518 | No Prior Authorization Required | | Home infusion therapy, all supplies necessary for catheter repair | Hit cath repair kit | |
| S5521 | No Prior Authorization Required | | Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion | Hit midline cath insert kit | |
| S5550 | No Prior Authorization Required | | Insulin, rapid onset, 5 units | Insulin rapid 5 u | |
| S5551 | No Prior Authorization Required | | Insulin, most rapid onset (lispro or aspart); 5 units | Insulin most rapid 5 u | |
| S5552 | No Prior Authorization Required | | Insulin, intermediate acting (nph or lente); 5 units | Insulin intermed 5 u | |
| S5553 | No Prior Authorization Required | | Insulin, long acting; 5 units | Insulin long acting 5 u | |

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| S5560 | No Prior Authorization Required | | Insulin delivery device, reusable pen; 1.5 ml size | Insulin reuse pen 1.5 ml | |
| S5561 | No Prior Authorization Required | | Insulin delivery device, reusable pen; 3 ml size | Insulin reuse pen 3 ml | |
| S5565 | No Prior Authorization Required | | Insulin cartridge for use in insulin delivery device other than pump; 150 units | Insulin cartridge 150 u | |
| S5566 | No Prior Authorization Required | | Insulin cartridge for use in insulin delivery device other than pump; 300 units | Insulin cartridge 300 u | |
| S5570 | No Prior Authorization Required | | Insulin delivery device, disposable pen (including insulin); 1.5 ml size | Insulin dispos pen 1.5 ml | |
| S5571 | No Prior Authorization Required | | Insulin delivery device, disposable pen (including insulin); 3 ml size | Insulin dispos pen 3 ml | |
| S8490 | No Prior Authorization Required | | Insulin syringes (100 syringes, any size) | 100 insulin syringes | |
| S9061 | Prior Authorization Required | | Home administration of aerosolized drug therapy (e.g., pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Medical supplies and equipme | |
| S9325 | No Prior Authorization Required | | Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with s9326, s9327 or s9328) | Hit pain mgmt per diem | |
| S9326 | Prior Authorization Required | | Home infusion therapy, continuous (twenty-four hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit cont pain per diem | |
| S9327 | No Prior Authorization Required | | Home infusion therapy, intermittent (less than twenty-four hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit int pain per diem | |
| S9328 | Prior Authorization Required | | Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit pain imp pump diem | |
| S9329 | No Prior Authorization Required | | Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with s9330 or s9331) | Hit chemo per diem | |
| S9330 | Prior Authorization Required | | Home infusion therapy, continuous (twenty-four hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit cont chem diem | |
| S9331 | Prior Authorization Required | | Home infusion therapy, intermittent (less than twenty-four hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit intermit chemo diem | |
| S9335 | No Prior Authorization Required | | Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem | Ht hemodialysis diem | |
| S9336 | No Prior Authorization Required | | Home infusion therapy, continuous anticoagulant infusion therapy (e.g., heparin), administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit cont anticoag diem | |
| S9338 | No Prior Authorization Required | | Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit immunotherapy diem | |
| S9339 | No Prior Authorization Required | | Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit periton dialysis diem | |

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| S9345 | Prior Authorization Required | | Home infusion therapy, anti-hemophilic agent infusion therapy (e.g., factor viii); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit anti-hemophil diem | |
| S9346 | Prior Authorization Required | | Home infusion therapy, alpha-1-proteinase inhibitor (e.g., prolactin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit alpha-1-proteinase diem | |
| S9347 | Prior Authorization Required | | Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit longterm infusion diem | |
| S9348 | Prior Authorization Required | | Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g., dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit sympathomim diem | |
| S9349 | No Prior Authorization Required | | Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit tocolysis diem | |
| S9351 | Prior Authorization Required | | Home infusion therapy, continuous or intermittent anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately), per diem | Hit cont antiemetic diem | |
| S9353 | Prior Authorization Required | | Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit cont insulin diem | |
| S9355 | No Prior Authorization Required | | Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit chelation diem | |
| S9357 | Prior Authorization Required | | Home infusion therapy, enzyme replacement intravenous therapy; (e.g., imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit enzyme replace diem | |
| S9359 | Prior Authorization Required | | Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e.g., infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit anti-tnf per diem | |
| S9361 | No Prior Authorization Required | | Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit diuretic infus diem | |
| S9363 | No Prior Authorization Required | | Home infusion therapy, anti-spasmodic therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit anti-spasmodic diem | |
| S9364 | Prior Authorization Required | | Home infusion therapy, total parenteral nutrition (tpn); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes s9365-s9368 using daily volume scales) | Hit tpn total diem | |
| S9365 | Prior Authorization Required | | Home infusion therapy, total parenteral nutrition (tpn); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | Hit tpn 1 liter diem | |

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| S9366 | Prior Authorization Required | | Home infusion therapy, total parenteral nutrition (tpn); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | Hit tpn 2 liter diem | |
| S9367 | Prior Authorization Required | | Home infusion therapy, total parenteral nutrition (tpn); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | Hit tpn 3 liter diem | |
| S9368 | Prior Authorization Required | | Home infusion therapy, total parenteral nutrition (tpn); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | Hit tpn over 3l diem | |
| S9370 | Prior Authorization Required | | Home therapy, intermittent anti-emetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht inj antiemetic diem | |
| S9372 | Prior Authorization Required | | Home therapy; intermittent anticoagulant injection therapy (e.g., heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code for flushing of infusion devices with heparin to maintain patency) | Ht inj anticoag diem | |
| S9373 | No Prior Authorization Required | | Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use with hydration therapy codes s9374-s9377 using daily volume scales) | Hit hydra total diem | |
| S9374 | Prior Authorization Required | | Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit hydra 1 liter diem | |
| S9375 | Prior Authorization Required | | Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit hydra 2 liter diem | |
| S9376 | Prior Authorization Required | | Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit hydra 3 liter diem | |
| S9377 | No Prior Authorization Required | | Home infusion therapy, hydration therapy; more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem | Hit hydra over 3l diem | |
| S9379 | No Prior Authorization Required | | Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit noc per diem | |
| S9430 | No Prior Authorization Required | | Pharmacy compounding and dispensing services | Pharmacy comp/disp serv | |
| S9490 | No Prior Authorization Required | | Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit corticosteroid/diem | |

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| S9494 | Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with home infusion codes for hourly dosing schedules s9497-s9504) | Hit antibiotic total diem | |
| S9497 | No Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit antibiotic q3h diem | |
| S9500 | Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit antibiotic q24h diem | |
| S9501 | Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit antibiotic q12h diem | |
| S9502 | Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit antibiotic q8h diem | |
| S9503 | Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit antibiotic q6h diem | |
| S9504 | Prior Authorization Required | | Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit antibiotic q4h diem | |
| S9537 | Prior Authorization Required | | Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, g-csf, gm-csf); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht hem horm inj diem | |
| S9538 | No Prior Authorization Required | | Home transfusion of blood product(s); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (blood products, drugs, and nursing visits coded separately), per diem | Hit blood products diem | |
| S9542 | Prior Authorization Required | | Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht inj noc per diem | |
| S9558 | No Prior Authorization Required | | Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht inj growth horm diem | |
| S9559 | No Prior Authorization Required | | Home injectable therapy, interferon, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Hit inj interferon diem | |
| S9560 | No Prior Authorization Required | | Home injectable therapy; hormonal therapy (e.g.; leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht inj hormone diem | |
| S9562 | No Prior Authorization Required | | Home injectable therapy, palivizumab, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht inj palivizumab diem | |

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| S9590 | Prior Authorization Required | | Home therapy, irrigation therapy (e.g., sterile irrigation of an organ or anatomical cavity); including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Ht irrigation diem | |
| C9301 | Not Covered on state fee schedule (Provider's Administered Drug List) | AUCATZYL | Obecabtagene autoleucel, up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Obecabtagene car pos t | |
| C9302 | Prior Authorization Required | ZIIHERA 300MG | Injection, zanidatamab-hrii, 2 mg | Inj zanidatamab, 2 mg | |
| C9303 | Prior Authorization Required | VYLOY 100MG | Injection, zolbetuximab-clzb, 1 mg | Inj zolbetuximab, 1 mg | |
| C9304 | Prior Authorization Required | HYMPAVZI PFS | Injection, marstacimab-hncq, 0.5 mg | Inj marstacimab, 0.5 mg | |
| J0281 | Not Covered on state fee schedule (Provider's Administered Drug List) | AMINOCAPROIC ACID | Injection, aminocaproic acid, 1 gram | Inj aminocaproic acid 1 gram | |
| J1072 | No Prior Authorization Required | AZMIRO 200MG/ML | Injection, testosterone cypionate (azmiro), 1 mg | Inj, testosterone, azmiro | |
| J1271 | Not Covered on state fee schedule (Provider's Administered Drug List) | DOXYCYCLINE HYCLATE | Injection, doxycycline hyclate, 1 mg | Inj doxycycline hyclate 1 mg | |
| J1299 | Not Covered on state fee schedule (Provider's Administered Drug List) | SOLIRIS | Injection, eculizumab, 2 mg | Inj, eculizumab, 2 mg | |
| J1308 | Not Covered on state fee schedule (Provider's Administered Drug List) | FAMOTIDINE | Injection, famotidine, 0.25 mg | Inj, famotidine, 0.25 mg | |
| J1808 | Not Covered on state fee schedule (Provider's Administered Drug List) | FOLIC ACID | Injection, folic acid, 0.1 mg | Inj, folic acid, 0.1 mg | |
| J1938 | Not Covered on state fee schedule (Provider's Administered Drug List) | FUROSEMIDE | Injection, furosemide, 1 mg | Inj, furosemide, 1 mg | |
| J2351 | Prior Authorization Required | OCREVUS | Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq | Inj ocrelizumab 1mg hya-ocsq | |
| J2428 | Not Covered on state fee schedule (Provider's Administered Drug List) | ERZOFRI | Injection, paliperidone palmitate extended release (erzofri), 1 mg | Inj, erzofri, 1 mg | |
| J2804 | Not Covered on state fee schedule (Provider's Administered Drug List) | RIFADIN | Injection, rifampin, 1 mg | Inj, rifampin, 1 mg | |
| J2865 | Not Covered on state fee schedule (Provider's Administered Drug List) | SULFAMETHOXAZOLE-TRIMETHOPRIM | Injection, sulfamethoxazole 5 mg and trimethoprim 1 mg | Inj sulfameth/trim 5 mg/1 mg | |
| J7521 | Not Covered on state fee schedule (Provider's Administered Drug List) | PROGRAF | Tacrolimus, granules, oral suspension, 0.1 mg | Tacrolim granules oral susp | |
| J9024 | Prior Authorization Required | TECENTRIQ HYBREZA | Injection, atezolizumab, 5 mg and hyaluronidase-tqjs | Inj atezolizumb 5mg hya-tqjs | |
| J9038 | Not Covered on state fee schedule (Provider's Administered Drug List) | NIKTIMVO | Injection, axatilimab-csfr, 0.1 mg | Inj axatilimab-csfr 0.1 mg | |
| J9054 | Prior Authorization Required | BORUZU | Injection, bortezomib (boruzu), 0.1 mg | Inj bortezomib boruzu 0.1 mg | |
| J9161 | Not Covered on state fee schedule (Provider's Administered Drug List) | LYMPHIR | Injection, denileukin diftitox-cxdl, 1 mcg | Inj denileuk difti-cxdl 1mcg | |
| Q5147 | Prior Authorization Required | PAVBLU | Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg | Inj, aflibercept-ayyh, 1 mg | |
| Q5148 | Not Covered on state fee schedule (Provider's Administered Drug List) | NYPOZI | Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram | Inj, nyposi 1 mcg | |
| Q5149 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg | Inj, aflibercept-abzv, 1 mg | |
| Q5150 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg | Inj, aflibercept-mrbb, 1 mg | |
| Q5151 | Not Covered on state fee schedule (Provider's Administered Drug List) | EPYSQLI | Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg | Inj, eculizumab-aagh, 2 mg | |
| Q5152 | Not Covered on state fee schedule (Provider's Administered Drug List) | BKEMV | Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg | Inj, eculizumab-aeeb, 2 mg | |
| Q2057 | Prior Authorization Required | TECELRA | Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose | Afamitresgene autoleucel | |
| A9607 | Prior Authorization Required | Pluvicto | Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie | Lutetium lu 177 vipivotide | |
| 90382 | Not Covered on state fee schedule (Provider's Administered Drug List) | Enflonsia | Respiratory syncytial virus, monoclonal antibody, seasonal dose, 0.7 mL, for intramuscular use | clesrovimab-cfor | |
| 91323 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 10 mcg/0.2 mL dosage, for intramuscular use | | |
| C9174 | Not Covered on state fee schedule (Provider's Administered Drug List) | Datroway | Injection, datopotamab deruxtecan-dlnk, 1 mg | Datopotamab deruxtecan, 1 mg | |
| C9175 | Not Covered on state fee schedule (Provider's Administered Drug List) | Grafapex | Injection, treosulfan, 50 mg | Inj, treosulfan, 50 mg | |
| J0165 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, epinephrine, not otherwise specified, 0.1 mg | Inj epinephrine nos 0.1 mg | |

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| J0166 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, epinephrine (BPI), not therapeutically equivalent to J0165, 0.1 mg | Inj epinephrine (bpi) | |
| J0167 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, epinephrine (Hospira), not therapeutically equivalent to J0165, 0.1 mg | Inj epinephrine (hospira) | |
| J0168 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, epinephrine (International Medication Systems), not therapeutically equivalent to J0165, 0.1 mg | Epinephrine (intl med sys) | |
| J0169 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, epinephrine (adrenalin), not therapeutically equivalent to J0165, 0.1 mg | Inj epinephrine (adrenalin) | |
| J0616 | Not Covered on state fee schedule (Provider's Administered Drug List) | Lopressor | Injection, metoprolol tartrate, 1 mg | Inj metoprolol tartrate 1 mg | |
| J0618 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, calcium chloride, 2 mg | Inj, calcium chloride, 2 mg | |
| J1163 | Not Covered on state fee schedule (Provider's Administered Drug List) | Cardizem | Injection, diltiazem HCl, 0.5 mg | Inj, diltiazem hcl, 0.5 mg | |
| J1326 | Prior Authorization Required | Vyloy | Injection, zolbetuximab-clzb, 2 mg ² | Inj, zolbetuximab-clzb, 2 mg | |
| J2312 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, naloxone HCl, not otherwise specified, 0.01 mg | Inj naloxone hcl nos, 0.01mg | |
| J2313 | Pharmacy Benefit | Zimhi | Injection, naloxone HCl (Zimhi), 0.01 mg | Inj, naloxone (zimhi) 0.01mg | |
| J3373 | Not Covered on state fee schedule (Provider's Administered Drug List) | Vancocin | Injection, vancomycin HCl, 10 mg | Inj, vancomycin hcl, 10 mg | |
| J3374 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, vancomycin HCl (Mylan) not therapeutically equivalent to J3373, 10 mg | Inj, vancomycin (mylan) 10mg | |
| J3375 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, vancomycin HCl (Xellia), not therapeutically equivalent to J3373, 10 mg | Inj vancomycin (xellia) 10mg | |
| J3391 | Not Covered on state fee schedule (Provider's Administered Drug List) | Lenmeldy | Injection, atidarsagene autotemcel, per treatment ² | Inj, atidarsagene autotemcel | |
| J7172 | Pharmacy Benefit | Hypavzi | Injection, marstacimab-hncq, 0.5 mg ² | Inj marstacim-hncq, 0.5 mg | |
| J7356 | Not Covered on state fee schedule (Provider's Administered Drug List) | Vyalev | Injection, foscarbidopa 0.25 mg/foslevodopa 5 mg | Inj foscarb/foslevodopa 5 mg | |
| J9174 | Not Covered on state fee schedule (Provider's Administered Drug List) | Beizray | Injection, docetaxel (Beizray), 1 mg ² | Inj, docetaxel (beizray) 1mg | |
| J9220 | Not Covered on state fee schedule (Provider's Administered Drug List) | Bludigo | Injection, indigotindisulfonate sodium, 1 mg ² | Indigotindisulfonate sod 1mg | |
| J9275 | Not Covered on state fee schedule (Provider's Administered Drug List) | Unloxyt | Injection, cosibelimab-ipdl, 2 mg | Inj cosibelimab-ipdl, 2 mg | |
| J9276 | Prior Authorization Required | Ziihera | Injection, zanidatamab-hrri, 2 mg ² | Inj zanidatamab-hrri, 2 mg | |
| J9289 | Not Covered on state fee schedule (Provider's Administered Drug List) | Opdivo Qvantig | Injection, nivolumab, 2 mg and hyaluronidase-nvhy ² | Inj nivolumab 2 mg hyaluron | |
| J9341 | Not Covered on state fee schedule (Provider's Administered Drug List) | Tepylute | Injection, thiotepa (Tepylute), 1 mg | Inj thiotepa (tepylute) 1 mg | |
| J9342 | Not Covered on state fee schedule (Provider's Administered Drug List) | Tepadina | Injection, thiotepa, not otherwise specified, 1 mg ² | Inj thiotepa nos 1 mg | |
| J9382 | Not Covered on state fee schedule (Provider's Administered Drug List) | Bizengri | Injection, zenocutuzumab-zbco, 1 mg ² | Inj zenocutuzumab-zbco 1 mg | |
| Q2058 | Not Covered on state fee schedule (Provider's Administered Drug List) | Aucatzyl | Obecabtagene autoleucel, 10 up to 400 million CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion | Obecbtge autol up to 400 mil | |
| Q5098 | Not Covered on state fee schedule (Provider's Administered Drug List) | Imuldosa | Injection, ustekinumab-srlf (Imuldosa), biosimilar, 1 mg | Inj ustekinumab-srlf, 1 mg | |
| Q5099 | Not Covered on state fee schedule (Provider's Administered Drug List) | Steqeyma | Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg | Inj ustekinumab-stba, 1 mg | |
| Q5100 | Not Covered on state fee schedule (Provider's Administered Drug List) | Yesintek | Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg | Inj ustekinumab-kfce, 1 mg | |
| Q5153 | Not Covered on state fee schedule (Provider's Administered Drug List) | Opuviz | Injection, aflibercept-yszy (Opuviz), biosimilar, 1 mg | Inj, aflibercept-yszy, 1 mg | |
| J1554 | Prior Authorization Required | Asceniv | Injection, immune globulin (Asceniv), 500 mg | Inj, immune globulin, 500 mg | |
| J2267 | Not Covered on state fee schedule (Provider's Administered Drug List) | Omvoh | Injection, mirikizumab-mrkz, 1 mg | Inj, mirikizumab-mrkz, 1 mg | |
| A9612 | Not Covered on state fee schedule (Provider's Administered Drug List) | AK-Fluor; Fluorescite | Injection, fluorescein, 1 mg | Inj, fluorescein, 1 mg | |
| C9305 | Prior Authorization Required | Imaavy | Injection, nipocalimab-aahu, 3 mg | Inj, nipocalimab-aahu, 3 mg | |
| C9306 | Prior Authorization Required | Emrelis | Injection, telisotuzumab vedotin-tllv, 1 mg | Inj, telisotuzumab vedotin-tllv, 1 mg | |
| J0163 | Not Covered on state fee schedule (Provider's Administered Drug List) | Endo 505(b)(2) epinephrine in sodium chloride | Injection, epinephrine in sodium chloride (Endo), 0.1 mg | Inj, epinephrine in sodium chloride | |

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| J0164 | Not Covered on state fee schedule (Provider's Administered Drug List) | Baxter 505(b)(2) epinephrine bitartrate in sodium chloride | Injection, epinephrine in sodium chloride (Baxter), 0.1 mg | Inj, epinephrine in sodium chloride (Baxter), 0.1 mg | |
| J0458 | No Prior Authorization Required | Emblaveo | Injection, aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg) | Inj, aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg) | |
| J0462 | Not Covered on state fee schedule (Provider's Administered Drug List) | Accord 505(b)(2) atropine sulfate | Injection, atropine sulfate, not therapeutically equivalent to J0461, 0.01 mg | Inj, atropine sulfate, not therapeutically equivalent to J0461, 0.01 mg | |
| J0525 | Not Covered on state fee schedule (Provider's Administered Drug List) | Cefotan | Injection, cefotetan disodium, 10 mg | Inj, cefotetan disodium, 10 mg | |
| J0582 | Not Covered on state fee schedule (Provider's Administered Drug List) | Endo 505(b)(2) bivalirudin | Injection, bivalirudin (Endo), not therapeutically equivalent to J0583, 1 mg | Injection, bivalirudin (Endo) | |
| J0614 | No Prior Authorization Required | Grafapex | Injection, treosulfan, 50 mg | Inj, treosulfan, 50 mg | |
| J0668 | No Prior Authorization Required | Zynrelief | Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg | Instill, bupivacaine and meloxicam, 1 mg/0.03 mg | |
| J0675 | Not Covered on state fee schedule (Provider's Administered Drug List) | Hemabate | Injection, carboprost tromethamine, 0.1 mg | Inj, carboprost tromethamine, 0.1 mg | |
| J0681 | Not Covered on state fee schedule (Provider's Administered Drug List) | Zevtera | Injection, ceftobiprole medocartil sodium, 3 mg | Inj, ceftobiprole medocartil sodium, 3 mg | |
| J0738 | Prior Authorization Required | Yeztugo | Injection, lenacapavir, 1 mg, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (PrEP) (not for use as treatment for HIV) | Inj, lenacapavir, 1 mg | |
| J0752 | Prior Authorization Required | Yeztugo | Oral, lenacapavir, 300 mg, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (PrEP) (not for use as treatment for HIV) | Oral, lenacapavir, 300 mg | |
| J0759 | Not Covered on state fee schedule (Provider's Administered Drug List) | Cleviprex | Injection, clevidipine butyrate, 1 mg | Inj, clevidipine butyrate, 1 mg | |
| J1370 | Not Covered on state fee schedule (Provider's Administered Drug List) | Nexium IV | Injection, esomeprazole sodium, 1 mg | Inj, esomeprazole sodium, 1 mg | |
| J1612 | No Prior Authorization Required | Gvoke Hypopen, Gvoke Pfs; Gvoke VialDX | Injection, glucagon (Gvoke), 0.01 mg | Inj, glucagon (Gvoke), 0.01 mg | |
| J1807 | Not Covered on state fee schedule (Provider's Administered Drug List) | Sodium Edecrin | Injection, ethacrynate sodium, 1 mg | Inj, ethacrynate sodium, 1 mg | |
| J1809 | Prior Authorization Required | Nulibry | Injection, fosdenopterin, 0.1 mg | Inj, fosdenopterin, 0.1 mg | |
| J1834 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, isoniazid, 1 mg | Inj, isoniazid, 1 mg | |
| J2151 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Injection, mannitol, 250 mg | Inj, mannitol, 250 mg | |
| J2291 | Not Covered on state fee schedule (Provider's Administered Drug List) | Baxter nafcillin sodium | Injection, nafcillin sodium (Baxter), 20 mg | Inj, nafcillin sodium (Baxter), 20 mg | |
| J3290 | Not Covered on state fee schedule (Provider's Administered Drug List) | Cyklokapron | Injection, tranexamic acid, 5 mg | Inj, tranexamic acid, 5 mg | |
| J3402 | Prior Authorization Required | Ryoncil | Injection, remestemcel-l-rknd, per therapeutic dose | Inj, remestemcel-l-rknd, per therapeutic dose | |
| J3403 | Not Covered on state fee schedule (Provider's Administered Drug List) | Encelto | Revakinagene taroretcel-lwey, per implant | Revakinagene taroretcel-lwey, per implant | |
| J7173 | Pharmacy Benefit | Alhemo | Injection, concizumab-mtci, 0.5 mg | Inj, concizumab-mtci, 0.5 mg | |
| J7174 | Prior Authorization Required | Qfitlia | Injection, fitusiran, 0.04 mg | Inj, fitusiran, 0.04 mg | |
| J9011 | Prior Authorization Required | Datroway | Injection, datopotamab deruxtecán-dlnk, 1 mg | Inj, datopotamab deruxtecán-dlnk, 1 mg | |
| M0235 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Intravenous infusion, monoclonal antibody products with an indication for postexposure prophylaxis or treatment of COVID-19, for hospitalized adults and/or pediatric patients who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, not otherwise classified, first dose | | |
| M0236 | Not Covered on state fee schedule (Provider's Administered Drug List) | | Intravenous infusion, monoclonal antibody products with an indication for postexposure prophylaxis or treatment of COVID-19, for hospitalized adults and/or pediatric patients who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, not otherwise classified, second dose | | |

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| M0237 | Not Covered on state fee schedule (Provider's Administered Drug List) | Avtozma 1st dose administration | Intravenous infusion, tocilizumab-anoh, for hospitalized adult patients with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose | | |
| M0238 | Not Covered on state fee schedule (Provider's Administered Drug List) | Avtozma 2nd dose administration | Intravenous infusion, tocilizumab-anoh, for hospitalized adult patients with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose | | |
| Q0235 | No Prior Authorization Required | | Injection, monoclonal antibody products with an indication for postexposure prophylaxis or treatment of COVID-19, for hospitalized adults and/or pediatric patients who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, not otherwise classified, 1 mg | | |
| Q0237 | Not Covered on state fee schedule (Provider's Administered Drug List) | Avtozma | Injection, tocilizumab-anoh, for hospitalized adult patients with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg | | |
| Q5154 | Not Covered on state fee schedule (Provider's Administered Drug List) | Omlyclo | Injection, omalizumab-igec (Omlyclo), biosimilar, 5 mg | Inj, omalizumab-igec (Omlyclo), biosimilar, 5 mg | |
| Q5155 | Not Covered on state fee schedule (Provider's Administered Drug List) | Yesafili | Injection, aflibercept-jbvf (Yesafili), biosimilar, 1 mg | Inj, aflibercept-jbvf (Yesafili), biosimilar, 1 mg | |
| Q5156 | Not Covered on state fee schedule (Provider's Administered Drug List) | Avtozma | Injection, tocilizumab-anoh (Avtozma), biosimilar, 1 mg | Inj, tocilizumab-anoh (Avtozma), biosimilar, 1 mg | |
| Q5157 | Not Covered on state fee schedule (Provider's Administered Drug List) | Osenvelt; Stoboclo | Injection, denosumab-bmwo (Stoboclo/Osenvelt), biosimilar, 1 mg | Inj, denosumab-bmwo (Stoboclo/Osenvelt), biosimilar, 1 mg | |
| Q5158 | Not Covered on state fee schedule (Provider's Administered Drug List) | Bomynta; Conexence | Injection, denosumab-bnht (Bomynta/Conexence), biosimilar, 1 mg | Inj, denosumab-bnht (Bomynta/Conexence), biosimilar, 1 mg | |
| Q5159 | Not Covered on state fee schedule (Provider's Administered Drug List) | Ospomyv; Xbryk | Injection, denosumab-dssb (Ospomyv/Xbryk), biosimilar, 1 mg | Inj, denosumab-dssb (Ospomyv/Xbryk), biosimilar, 1 mg | |
| J9331 | Prior Authorization Required | Fyarro | Injection, sirolimus protein-bound particles, 1 mg | Inj, sirolimus protein-bound particles, 1 mg | |
| 90377 | No Prior Authorization Required | | Rabies immune globulin, heat- and solvent/detergent-treated (Rig-HT S/D), human, for intramuscular and/or subcutaneous use | | |
| C9307 | Prior Authorization Required | Lynozytic | Injection, linvoseltamab-gcpt, 1 mg | Inj linvoseltamab-gcpt 1 mg | |
| C9308 | Prior Authorization Required | Avyxa | Injection, carboplatin (avyxa), 1 mg | Inj, carboplatin (avyxa) | |
| J0013 | Not Covered | Spravato | Esketamine, nasal spray, 1 mg | Esketamine, nasal spray, 1 mg | |
| J0162 | Not Covered | Fresenius Kabi | Injection, epinephrine (fresenius), not therapeutically equivalent to j0165, 0.1 mg | Inj epinephrine (fresenius) | |
| J0654 | Not Covered | Triostat | Injection, liothyronine, 1 mcg | Inj, liothyronine, 1 mcg | |
| J1073 | Not Covered | Testopel | Testosterone pellet, implant, 75 mg | Testosterone pellet 75 mg | |
| J1736 | Not Covered | Delova | Injection, meloxicam (delova), 1 mg | Inj meloxicam (delova) 1mg | |
| J1737 | Not Covered | Azurity | Injection, meloxicam (azurity), 1 mg | Inj meloxicam (azurity) 1mg | |
| J1837 | Not Covered | Noxafil | Injection, posaconazole, 1 mg | Inj, posaconazole, 1 mg | |
| J2516 | Not Covered | Pentam | Injection, pentamidine isethionate, 1 mg | Inj, pentamidine isethionate | |
| J2596 | Not Covered | Long Grove 505(b)(2) vasopressin | Injection, vasopressin (long grove), not therapeutically equivalent to j2598, 1 unit | Vasopressin (long grove) 1 u | |
| J2711 | Not Covered | Prevduo | Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg | Inj neostigmin/glycopyrrolat | |
| J3291 | Not Covered | | Injection, tranexamic acid in sodium chloride, 5 mg | Tranexamic acid in sod chlor | |
| J3376 | Not Covered | Hikma 505(b)(2) vancomycin | Injection, vancomycin hcl (hikma), not therapeutically equivalent to j3373, 10 mg | Inj vancomycin (hikma) 10mg | |
| J3379 | No Prior Authorization Required | Depacon | Injection, valproate sodium, 5 mg | Inj, valproate sod, 5 mg | |
| J3387 | Not Covered | Skysona | Injection, elivaldogene autotemcel, per treatment | Inj elivaldogene autotemcel | |
| J3389 | Not Covered | Zevaskyn | Topical administration, prademagene zamikeracel, per treatment | Topi adm prad zami per treat | |
| J7299 | Not Covered | Miudella | Intrauterine copper contraceptive (miudella) | Intraut copp cont (miudella) | |
| J7528 | Not Covered | CellCept | Mycophenolate mofetil, for suspension, oral, 100 mg | Mycophen mofetil for susp | |
| J9184 | Prior Authorization Required | Avyxa | Injection, gemcitabine hydrochloride (avyxa), 200 mg | Inj gemcitabin (avyxa) 200mg | |
| J9256 | Prior Authorization Required | Imaavy | Injection, nipocalimab-aahu, 3 mg | Inj, nipocalimab-aahu, 3 mg | |

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| J9282 | Prior Authorization Required | Zusduri | Mitomycin, intravesical instillation, 1 mg | Mitomycin intravesical inst | |
| J9326 | Prior Authorization Required | Emrelis | Injection, telisotuzumab vedotin-tllv, 1 mg | Telisotuzumab vedotin-tllv | |
| Q5160 | Not Covered | Jobevne | Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg | Inj, jobevne, 10 mg | |