Drugs and Biologicals Claim Edits – Tufts Health Public Plans

Policy	Description
Abatacept (Orencia®)	Tufts Health Plan limits J0129 to the following when billed by any provider: • 100 combined units per DOS if the diagnosis is juvenile idiopathic arthritis or psoriatic arthritis • 13 combined units per DOS by any provider and the diagnosis on the claim is polyarticular juvenile idiopathic arthritis, psoriatic arthritis, or rheumatoid arthritis if billed with subcutaneous administration codes (96372, 96377) and no other drug administered by non-chemotherapy subcutaneous technique has been billed for the same DOS
	Tufts Health Plan does not routinely compensate J0129 when billed by any provider in the following circumstances: • More than one unique visit per week if the diagnosis is juvenile idiopathic arthritis, psoriatic arthritis, or rheumatoid arthritis, except when the IV loading dose of J0129 is administered the previous day • 96374-96376 (non-chemotherapy IV administration) if billed with J0129 and no other drug administered by non-chemotherapy IV push technique has been billed for the same DOS.
Adalimumab	Tufts Health Plan does not routinely compensate J0135 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units exceed one.
Adenosine	Tufts Health Plan does not routinely compensate J0153 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 60.
Ado-Trastuzumab Emtansine (Kadcyla)®	Tufts Health Plan limits J9354 to 490 combined units per DOS by any provider and the diagnosis on the claim is HER2-positive breast cancer or non-small cell lung cancer.
	Tufts Health Plan will deny J9354 when billed by any provider more than once every three weeks and the diagnosis on the claim is HER2-positive breast cancer or non-small cell lung cancer.
	Tufts Health Plan will deny 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J9354 and no other drug administered by intravenous push technique has been billed for the same DOS by any provider.
	Tufts Health Plan will deny J9354 when billed and HER2 testing has not been previously billed in the patient's lifetime, or J9354, or trastuzumab (J9355, Q5112, Q5113, Q5114, Q5116, Q5117) has not been billed within the previous year by any provider.
	Tufts Health Plan will deny J9354 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.
Aflibercept (Eylea®)	Tufts Health Plan does not routinely compensate for J0178 unless billed with intravitreal injection of a pharmacologic agent (67028).
	Tufts Health Plan does not routinely compensate for the intravitreal injection of a pharmacologic agent, separate procedure (67028) when billed with aflibercept (J0178) if modifier LT (left side), RT (right side) or 50 (bilateral procedure) is not appended to the procedure code
	Tufts Health Plan will limit compensation for J0178 to four combined units per month (billed by any provider) when billed with an FDA-approved indication or an approved off-labeled indication.
	Tufts Health Plan will limit J0178 to four units per DOS when billed by any provider and the diagnosis on the claim is branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal neovascularization due to ocular histoplasmosis syndrome, diabetic macular edema, diabetic retinopathy, or neovascular (wet) age-related macular degeneration.
	Tufts Health Plan will not routinely compensate J0178 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Policy	Description
	Tufts Health Plan will deny J0178 when billed by any provider more than two visits per month and the diagnosis on the claim is branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal neovascularization due to ocular histoplasmosis syndrome, diabetic macular edema, diabetic retinopathy, or neovascular (wet) age-related macular degeneration.
Agalsidase beta (Fabrazyme®)	Tufts Health Plan does not routinely compensate J0180 when billed more than once every two weeks by any provider and the diagnosis is Fabry (-Anderson) disease.
Alglucerase	Tufts Health Plan does not routinely compensate J0205 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 40.
Alglucosidase alfa (Myozyme®, Lumizyme®)	Tufts Health Plan does not routinely compensate J0220 or J0221 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J0220 or J0221 to 272 combined units per DOS by any provider and the diagnosis on the claim is Pompe disease.
Alemtuzumab	Tufts Health Plan limits J0202 to 12 combined units per DOS by any provider and the diagnosis on the claim is multiple sclerosis.
Alpha-1 proteinase inhibitors (Aralast®, Glassia®, Prolastin®, Zemaira®)	Tufts Health Plan does not routinely compensate J0256 or J0257 when billed and the diagnosis on the claim is alpha-1 proteinase inhibitor deficiency with clinically evident emphysema and a diagnosis for panacinar emphysema is not also present on the claim.
	Tufts Health Plan does not routinely compensate J0256 or J0257 when billed by any provider more than one visit per week and the diagnosis on the claim is alpha-1 proteinase inhibitor deficiency with clinically evident emphysema.
	Tufts Health Plan does not routinely compensate J0256 or J0257 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Amphotericin B liposome (AmBisome®)	Tufts Health Plan will not routinely compensate for amphotericin B liposome (J0289) if an approved indication or approved off-label indication is not also billed on the same claim.
Antihemophilic Factor IX (IDELVION®)	Tufts Health Plan will limit J7202 to 10,462 units per DOS by any provider other than a specialty of Home Infusion Therapy or Pharmacy when billed and the diagnosis is congenital Factor IX deficiency.
Antihemophilic Factor VIII (XYNTHA®)	Tufts Health Plan will limit J7185 to 20,400 units per DOS by any provider and the diagnosis is hemophilia A.
Antihemophilic Factor VIII (Advate, Helixate FS, Kogenate FS, Recombinate)	Tufts Health Plan will limit J7192 to 27,200 units per DOS by any provider and the diagnosis is hemophilia A.
Antihemophilic Factor XIII (Corifact)	Tufts Health Plan does not routinely compensate J7180 when billed with modifier JW Drug amount discarded/not administered to any patient) and the units equal or exceed 1600.
Aprepitant	Tufts Health Plan will not routinely compensate J0185 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will not routinely compensate J0185 when billed and a highly or moderately emetogenic chemotherapy agent has not been billed for the same DOS by any provider.
Aripiprazole Extended Release	Tufts Health Plan will not routinely compensate J0401 when billed without an FDA-approved indication or an approved off-labeled indication.
	Tufts Health Plan does not routinely compensate J0401 when billed by any provider more than one unique visit every 26 days and the diagnosis on the claim is schizophrenia or bipolar I disorder.
Aripiprazole Lauroxil	Tufts Health Plan does not routinely compensate J1943 or J1944 when billed and an FDA approved indication or an approved off labeled indication is not present on the claim.
Arsenic Trioxide	Tufts Health Plan will not routinely compensate J9017 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Policy	Description
	Tufts Health Plan will limit J9017 to 21 units per DOS by any provider and the diagnosis is acute promyelocytic leukemia (APL).
	Tufts Health Plan will not routinely compensate J9017 when billed by any provider more than 60 visits in 12 weeks and the diagnosis is acute promyelocytic leukemia (APL) or multiple myeloma.
Asparaginase Erwinaze®	Tufts Health Plan will not routinely compensate J9019 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will not routinely compensate J9019 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
Atezolizumab	Tufts Health Plan will not routinely compensate J9022 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim. Tufts Health Plan will not routinely compensate J9022 when billed by any provider more than one visit every three weeks and the diagnosis on the claim is renal cell carcinoma.
	Tufts Health Plan will not routinely compensate 96409, 96411 (Intravenous push chemotherapy administration) when billed with J9022 and no other drug administered by intravenous push technique has been billed for the same DOS by any provider.
	Tufts Health Plan will limit J9022 to 84 combined units per DOS by any provider and the diagnosis on the claim is breast cancer.
	Tufts Health Plan will limit J9022 to 1176 combined units in 26 weeks by any provider and the diagnosis on the claim is hepatocellular carcinoma, non-small cell lung cancer, small cell lung cancer, or urothelial carcinoma.
	Tufts Health Plan will not routinely compensate J9022 when billed with a diagnosis of breast cancer and testing for PD-L1 (88360) has not been billed by any provider in the patient's lifetime.
	Tufts Health Plan will not routinely compensate J9022 when billed and the diagnosis on the claim is renal cell carcinoma and bevacizumab (J9035, Q5107, Q5118) has not been billed for the same DOS by any provider.
Autologous Cultured Chondrocytes, Implant	Tufts Health Plan does not routinely compensate 27412 (Autologous chondrocyte implantation, knee) when billed and J7330 (Autologous cultured chondrocytes, implant) has not been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J7330 when billed and autologous chondrocyte implantation of knee has not been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J7330 when billed and arthroscopy of knee has not been billed by any provider within the previous six weeks.
Avelumab	Tufts Health Plan does not routinely compensate J9023 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Azacitidine	Tufts Health Plan will limit J9025 to 260 combined units per DOS by any provider when the diagnosis is myelofibrosis.
	Tufts Health Plan will not routinely compensate J9025 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.
Basiliximab Simulect®	Tufts Health Plan does not compensate for J0480 unless a kidney or liver transplantation has been billed and paid for on the same DOS or in the previous 5 days by any provider.
BCG (Intravesical)	Tufts Health Plan limits J9030 to 1 unit per DOS or one visit per week by any provider if the diagnosis is urothelial carcinoma.
	Tufts Health Plan does not routinely compensate J9030 if billed and 50391 or 51720 (bladder installation administration) has not been billed for the same DOS.
	Tufts Health Plan limits J9030 to 50 combined units per DOS by any provider and the diagnosis on the claim is urothelial carcinoma.
	Tufts Health Plan does not routinely compensate J9030 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J9030 to one visit per week by any provider when the diagnosis is urothelial carcinoma.

Policy	Description
	Tufts Health Plan does not routinely compensate J9030 when billed and 50391 or 51720 (Bladder installation therapy) has not been billed for the same DOS.
Belatacept (Nulojix)	Tufts Health Plan will limit J0485 to 1,360 combined units per DOS by any provider and the diagnosis is kidney transplant rejection prophylaxis.
Belimumab (Benlysta®)	Tufts Health Plan does not routinely compensate J0490 when billed by any provider more than one visit per week when the diagnosis on the claim is systemic lupus erythematosus.
	Tufts Health Plan limits J0490 to 136 combined units per DOS by any provider when the diagnosis is systemic lupus erythematosus and a nonchemotherapy or chemotherapy intravenous infusion code (96365-96368, 96413, 96415, or 96417) is also present on the same claim.
	Tufts Health Plan does not routinely compensate J0490 when billed with modifier JW and the units equal or exceed 12 and a nonchemotherapy or chemotherapy intravenous infusion code (96365-96368, 96413, 96415, or 96417) is also present.
	Tufts Health Plan does not routinely compensate 96374-97376, 96409, 96411 (Nonchemotherapy or chemotherapy administration intravenous push technique) when billed with J0490 and no other drug administered by an intravenous push technique has been billed for the same DOS by any provider.
Bendamustine HCl (Bendeka)	Tufts Health Plan does not routinely compensate J9034 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Bendamustine HCl (Treanda®)	Tufts Health Plan does not compensate for J9033 or J9036 if an approved indication or approved off-label indication is not also billed.
	Tufts Health Plan limits coverage of J9033 or J9036 to 1,326 combined units within a 12-week period by any provider if the diagnosis is Waldenstrom's macroglobulinemia or lymphoplasmacytic lymphoma or mantle cell lymphoma diagnosis.
	Tufts Health Plan will limit J9033 to 2,336 combined units within a 12-week period by any provider if the diagnosis is breast cancer
	Tufts Health Plan will limit J9033 or J9036 to 312 combined units per DOS by any provider and the diagnosis on the claim is adult T-cell leukemia/lymphoma, B-cell lymphoma (except mantle cell lymphoma), hepatosplenic gamma-delta T-cell lymphoma, Hodgkin's lymphoma (classic), mycosis fungoides/Sezary syndrome, peripheral T-cell lymphoma, or primary cutaneous CD30+ lymphoproliferative disorder.
	Tufts Health Plan will limit J9033 or J9036 to 260 combined units per DOS by any provider and the diagnosis on the claim is chronic lymphocytic leukemia/small lymphocytic lymphoma.
	Tufts Health Plan will limit J9033 or J9036 to 234 combined units per DOS by any provider and the diagnosis on the claim is mantle cell lymphoma or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
	Tufts Health Plan will limit J9033 or J9036 to 2080 combined units within a 12-week period by any provider and the diagnosis on the claim is chronic lymphocytic leukemia/small lymphocytic lymphoma.
	Tufts Health Plan will limit J9033 or J9036 to 3120 combined units within a 12-week period by any provider and the diagnosis on the claim is breast cancer.
	Tufts Health Plan will not routinely compensate J9033 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.
Bevacizumab (Avastin®)	Tufts Health Plan limits coverage of J9035 to the following when billed by any provider- two units per DOS if the diagnosis is for ophthalmic indications
	Tufts Health Plan does not routinely compensate for J9035, Q5107, or Q5118 when billed and an FDA-approved or an off-label indication is not present on the claim.
	Tufts Health Plan does not routinely compensate for J9035, Q5107, or Q5118 if billed more than twice per month by any provider and the diagnosis on the claim is an ophthalmologic indication.
	Tufts Health Plan does not routinely compensate for 67028 (Intravitreal injection of a pharmacologic agent (separate procedure) when billed with J9035, Q5107, or Q5118 and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.

Policy	Description
Bevacizumab (Avastin®)	Tufts Health Plan will limit C9257 to 10 combined units per DOS by any provider when the diagnosis is angioid streaks of the choroid, branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal retinal neovascularization associated with age-related macular degeneration, choroidal retinal neovascularization associated with angioid streaks, cystoid macular degeneration, degenerative myopia, diabetic macular edema, histoplasmosis retinitis, neovascular glaucoma, nondiabetic proliferative retinopathy, proliferative diabetic retinopathy, retinal edema, retinal ischemia, retinal neovascularization, retinal telangiectasia, or rubeosis iridis.
	Tufts Health Plan will limit J9035,Q5107, , or Q5118 to 68 combined units per DOS by any provider when the diagnosis is hereditary hemorrhagic telangiectasia.
	Tufts Health Plan will limit J9035,Q5107,or Q5118 to 544 combined units within a 26-week period by any provider when the diagnosis is hereditary hemorrhagic telangiectasia.
	Tufts Health Plan will not routinely compensate C9257 and 67028 (Intravitreal injection of a pharmacologic agent) when the diagnosis is an ophthalmologic indication and C9257 has been billed with 67028 in the previous month.
	Tufts Health Plan will limit C9257 to 20 combined units per DOS by any provider when the diagnosis is neovascular [wet] age-related macular degeneration [AMD].
	Tufts Health Plan will not routinely compensate C9257 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will not routinely compensate C9257 when billed by any provider more than two times per month and the diagnosis is an ophthalmologic indication.
	Tufts Health Plan will limit J9035, Q5107, or Q5118 to 136 combined units per DOS by any provider when the diagnosis is colorectal cancer or renal cell carcinoma.
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed by any provider more than once every two weeks and the diagnosis is anaplastic glioma, breast cancer, colorectal cancer, glioblastoma multiforme, hereditary hemorrhagic telangiectasia, intracranial and spinal ependymoma, meningioma, ovarian cancer, post-radiation necrosis of the central nervous system, or renal cell carcinoma.
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed by any provider more than once every three weeks and the diagnosis is cervical cancer, endometrial carcinoma, malignant mesothelioma, non-small cell lung cancer, soft tissue sarcoma (angiosarcoma, solitary fibrous tumor/hemangiopericytoma), or vulvar cancer.
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed and the patient is less than 18 years of age and the diagnosis is not post-radiation necrosis of the central nervous system, or retinopathy of prematurity (stage 3+).
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed with greater than two units by any provider one month before a major surgery.
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed with greater than two units by any provider less than one month following a major surgery.
	Tufts Health Plan will limit J9035, Q5107, or Q5118 to 204 combined units per DOS by any provider and the diagnosis is anaplastic glioma, breast cancer, cervical cancer, endometrial carcinoma, glioblastoma multiforme, intracranial and spinal ependymoma, malignant mesothelioma, meningioma, non-small cell lung cancer, ovarian cancer, post-radiation necrosis of the central nervous system, or soft tissue sarcoma (angiosarcoma, solitary fibrous tumor/hemangiopericytoma), or vulvar cancer.
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
	Tufts Health Plan will not routinely compensate J9035, Q5107, or Q5118 when billed by any provider more than two times per month and the diagnosis on the claim is an ophthalmologic indication.

Policy	Description
	Tufts Health Plan will not routinely compensate 67028 (Intravitreal injection of a pharmacologic agent (separate procedure)) when billed with J9035, Q5107, or Q5118 and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.
	Tufts Health Plan will limit J9035, Q5107, or Q5118 to 68 combined units per DOS by any provider when the diagnosis is hereditary hemorrhagic telangiectasia.
Bezlotoxumab	Tufts Health Plan will not routinely compensate J0565 when billed with a diagnosis on the claim of clostridioides difficile infection (CDI), and a a clostridioides difficile toxin(s) detection technique (0107U, 87230, 87324, 87493) has not been billed in the previous week by any provider.
Biosimilar Drugs	Tufts Health Plan does not routinely compensate J9355 (Injection, trastuzumab, excludes biosimilar, 10 mg) when billed and Q5112 (Injection, trastuzumab-dttb, biosimilar, [Ontruzant], 10 mg), Q5113 (Injection, trastuzumab-pkrb, biosimilar, [Herzuma], 10 mg), Q5114 (Injection, trastuzumab-dkst, biosimilar, [Ogivri], 10 mg), Q5116 (Injection, trastuzumab-qyyp, biosimilar, [Trazimera], 10 mg), Q5117 (Injection, trastuzumab-anns, biosimilar, [Kanjinti], 10 mg) has been billed by any provider on the same DOS.
	Tufts Health Plan does not routinely compensate Q5106 (Injection, epoetin alfa, biosimilar, (Retacrit) (for non-ESRD use), 1000 units) when billed and Q5105 (Injection, epoetin alfa, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units), J0885 (Injection, epoetin alfa, (for non-ESRD use), 1000 units)), Q4081 (Injection, epoetin alfa, 100 units (for ESRD on dialysis)), or has been billed by any provider on the same date service.
Bortezomib (Velcade®)	Tufts Health Plan does not compensate for chemotherapy administration by other than subcutaneous or intravenous push technique when billed with bortezomib (J9041 or J9044) if no other drug administered via chemotherapy administration is billed for the same DOS.
	Tufts Health Plan does not routinely compensate J9041 or J9044 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 35.
	Tufts Health Plan does not routinely compensate J9041 or J9044 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J9041 or J9044 when billed by any provider more than one visit every three days and the diagnosis on the claim is adult T-cell leukemia/lymphoma, Castleman's disease, mantle cell lymphoma, multiple myeloma, non-Hodgkin's lymphoma (B-cell lymphomas other than mantle cell lymphoma), pediatric acute lymphoblastic leukemia, systemic light-chain amyloidosis, or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
	Tufts Health Plan limits J9041 or J9044 to 34 combined units per DOS by any provider when billed and the diagnosis on the claim is adult T-cell leukemia/lymphoma, Castleman's disease, or pediatric acute lymphoblastic leukemia.
	Tufts Health Plan limits J0585 to 100 combined units per DOS by any provider and the diagnosis on the claim is achalasia, dysphagia, essential tremor, pharyngoesophageal segment spasm after total laryngectomy, voice failure after tracheoesophageal puncture or total laryngectomy, or whiplash injury [headache].
Botulinum Toxin A and B (Botox®, Dysport™ Myobloc®)	Tufts Health Plan limits coverage of J0585 to the following: 30 combined units per DOS for the diagnosis of hemifacial spasm or pelvic floor dyssynergia (anismus) 400 units within three months
	Tufts Health Plan limits coverage of J0585 to 100 combined units per DOS by any provider when: The diagnosis is anal fissure (chronic) A diagnosis of tension-type headache and a diagnosis of chronic migraine headache is not also present on the claim
	Tufts Health Plan limits coverage of J0587 to the following: 100 combined units per DOS if billed with a diagnosis of cervical dystonia (spasmodic torticollis) or migraine headache prophylaxis

Policy	Description
	Tufts Health Plan limits coverage of J0585 to the following: 80 combined units per DOS when the diagnosis is tardive dyskinesia
	Tufts Health Plan limits J0585 to 20 combined units per DOS if the diagnosis is oculomotor injury (acute) or vocal cord granuloma.
	Tufts Health Plan will limit J0586 to 44 combined units per DOS by any provider and the diagnosis on the claim is hemifacial spasm.
	Tufts Health Plan will limit J0586 to 300 combined units in three months by any provider.
	Tufts Health Plan will limit J0587 to 20 combined units per DOS when billed by any provider and the diagnosis on the claim is sialorrhea associated with neurological conditions.
	Tufts Health Plan will limit J0588 to 120 combined units per DOS by any provider and the diagnosis is cervical dystonia [spasmodic torticollis].
	Tufts Health Plan will not routinely compensate J0588 when billed and J0585, J0586, or J0587 (Botulinum toxin) has been billed in the previous three months by any provider.
	Tufts Health Plan limits J0585 to 100 combined units per DOS by any provider and the diagnosis on the claim is achalasia, dysphagia, essential tremor, pharyngoesophageal segment spasm after total laryngectomy, voice failure after tracheoesophageal puncture or total laryngectomy, or whiplash injury [headache].
	Tufts Health Plan limits J0585 to 200 combined units per month by any provider and the diagnosis on the claim is blepharospasm.
	Tufts Health Plan limits J0585 to 300 combined units per DOS by any provider and the diagnosis on the claim is benign prostatic hypertrophy, cervical dystonia (spasmodic torticollis), detrusor overactivity associated with neurologic conditions, neurogenic bladder, or overactive bladder.
	Tufts Health Plan does not routinely compensate J0585 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.
	Tufts Health Plan limits J0585 to 400 combined units per DOS by any provider and the diagnosis on the claim is axillary hyperhidrosis, spasticity (cerebral palsy) , spasticity (lower limb, post stroke), spasticity (lower limb), spasticity (upper limb, post stroke), or spasticity (upper limb).
	Tufts Health Plan limits J0586 to 200 combined units per DOS by any provider and the diagnosis on the claim is cervical dystonia.
	Tufts Health Plan does not routinely compensate J0586 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 60.
	Tufts Health Plan does not routinely compensate J0588 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.
	Tufts Health Plan does not routinely compensate J0587 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.
Brentuximab Vedotin (Adcetris®)	Tufts Health Plan will not routinely compensate J9042 when billed and the patient is less than 18 years of age and an FDA approved or an approved off-labeled indication is present.
	Tufts Health Plan does not routinely compensate J9042 when billed by any provider more than one visit every three weeks and the diagnosis on the claim is adult T-cell leukemia/lymphoma, AIDS-related B-cell lymphoma, B-cell lymphoma, CD30-expressing mycosis fungoides, peripheral T-cell lymphoma, post-transplant lymphoproliferative disorders, primary cutaneous anaplastic large cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorder, Sezary syndrome, systemic anaplastic large cell lymphoma, or T-cell lymphoma.
	Tufts Health Plan does not routinely compensate J9042 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.
	Tufts Health Plan does not routinely compensate J9042 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Policy	Description
	Tufts Health Plan limits J9042 to 180 combined units per DOS by any provider and the diagnosis on the claim is adult T-cell leukemia/lymphoma, AIDS-related B-cell lymphomas, B-cell lymphoma, CD30-expressing mycosis fungoides, Hodgkin's lymphoma [classical], Hodgkin's lymphoma [classical] as post-autologous hematopoietic stem cell transplantation [auto-HSCT] consolidation, peripheral T-cell lymphoma, post-transplant lymphoproliferative disorders, primary cutaneous anaplastic large cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorder, Sezary syndrome, systemic anaplastic large cell lymphoma, or T-cell lymphoma.
Cabazitaxel	Tufts Health Plan does not routinely compensate J9043 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 60.
Canakinumab Ilaris®	Tufts Health Plan limits coverage of J0638 when billed by any provider: 150 combined units per DOS if billed with a diagnosis of acute gouty arthritis or cryopyrin-associated periodic syndrome (CAPS)
	Tufts Health Plan limits J0638 to 300 combined units per DOS by any provider and the diagnosis on the claim is adult-onset Still's disease, familiar Mediterranean fever (FMF), hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD), systemic juvenile idiopathic arthritis, or tumor necrosis factor receptor associated periodic syndrome (TRAPS).
	Tufts Health Plan does not routinely compensate J0638 when billed by any provider more than one visit every four weeks and the diagnosis on the claim is adult-onset Still's disease, familiar Mediterranean fever (FMF), hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD), systemic juvenile idiopathic arthritis, or tumor necrosis factor receptor associated periodic syndrome (TRAPS).
Carfilzomib (Kyprolis®)	Tufts Health Plan does not routinely compensate for J9047 if billed without a diagnosis for an FDA-approved indication or an off-labeled indication.
	Tufts Health Plan limits J9047 to 154 combined units per DOS by any provider and the diagnosis on the claim is multiple myeloma.
	Tufts Health Plan does not routinely compensate J9047 when billed for more than six visits per month by any provider and the diagnosis on the claim is multiple myeloma.
	Tufts Health Plan does not routinely compensate J9047 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
Cemiplimab	Tufts Health Plan limits J9119 to 350 combined units per DOS by any provider and the diagnosis is squamous cell skin cancer.
	Tufts Health Plan does not routinely compensate J9119 when billed more than one unique visit every three weeks by any provider and the diagnosis on the claim is squamous cell skin cancer.
Cetuximab (Erbitux®)	Tufts Health Plan does not routinely compensate 96409, 96411 (IV push chemotherapy administration) if billed with J9055 and no other drug administered by chemotherapy administration has been billed for the same DOS.
	Tufts Health Plan does not routinely cover J9055 when billed more than once a week by any provider and the diagnosis is colorectal cancer, esophagogastric junction cancer, gastric cancer, head and neck cancer, non-small cell lung cancer, penile cancer, or squamous cell skin cancer.
	Tufts Health Plan does not routinely cover J9055 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
Cinacalcet	Tufts Health Plan will not routinely compensate J0604 when billed and the diagnosis is secondary hyperparathyroidism in adult patients with chronic kidney disease on hemodialysis and serum calcium testing has not been billed by any provider in the previous month.

Policy	Description
Collagenase clostridium histolyticum (Xiaflex®)	Tufts Health Plan does not routinely compensate J0775 if billed under the following circumstances: If billed with a diagnosis of Peyronie's disease and 54200 (administration) has not been billed for the same DOS If billed without 20527 (injection, enzyme, palmar fascial cord) and the diagnosis is Dupuytren's contracture If 26341 (manipulation, palmar fascial cord, post enzyme injection, single cord) is billed with a diagnosis of Dupuytren's contracture, and administration code 20527 or J0775 has not been billed for the same DOS or in the previous three days.
Corticotropin	Tufts Health Plan does not routinely compensate IV infusion (96365-96371, 96373-96379) if billed with J0800 and no other drug administered by nonchemotherapy IV administration has been billed for the same DOS by any provider.
Cosyntropin (Cortrosyn™)	Tufts Health Plan does not routinely compensate J0834 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
C1 esterase Inhibitor (Berinert®)	Tufts Health Plan does not routinely compensate J0597 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Daratumumab (Darzalex®)	Tufts Health Plan does not routinely compensate J9145 if billed with modifier JW and the units equal or exceed 10
	Tufts Health Plan will limit J9145 to 218 combined units per DOS by any provider and the diagnosis on the claim is multiple myeloma or systemic light chain amyloidosis.
Darbepoetin alfa (Aranesp®)	Tufts Health Plan does not compensate for J0881 if a diagnosis of chronic renal failure is billed on the claim but a diagnosis for anemia in chronic kidney disease is not also present on the claim.
	Tufts Health Plan does not compensate for J0881 if any of the following have not been billed on the same day or within the last 7 days by any provider: 80050 (general health panel) 80055 (obstetrical panel) 85025 (CBC, automated with WBC) 85027 (CBC, automated) 85013 (hematocrit, spun) 85014 (hematocrit) 85018 (hemoglobin) G0306 (CBC, automated with WBC) G0307 (CBC, automated)
	Tufts Health Plan does not routinely compensate J0882 unless 82728 (ferritin), 83540 (iron), 83550 (iron binding capacity), or 84466 (transferrin) have also been billed for the same DOS or within the past three months.3
	Tufts Health Plan will not routinely compensate J0881 when billed and a diagnosis for anemia in neoplastic disease is present and a diagnosis of neoplasm is not also present.
	Tufts Health Plan will not routinely compensate J0881 when billed and hemoglobin studies (80050, 80055, 80081, 85013, 85014, 85018, 85025, 85027, G0306, or G0307) has not been billed by any provider on the same day, or within the past month.
	Tufts Health Plan will not routinely compensate J0882 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Darbepoetin alfa (Aranesp®)	Tufts Health Plan will not routinely compensate J0882 when billed and the diagnosis is end stage renal disease, and a diagnosis for anemia in chronic kidney disease is not also present.
	Initial Non-EPO Conversion Dose: Tufts Health Plan limits J0882 to 52 combined units per DOS when the diagnosis is anemia in patients with chronic kidney disease on dialysis and the patient is between one month and 18 years of age, and J0882 has not been billed in the previous month by any provider, and Q4081 or Q5105 has not been billed in the previous two weeks by any provider.
	Initial Non-EPO Conversion Dose (Adult): Tufts Health Plan limits J0881 to 62 combined units per DOS when the diagnosis is anemia in patients with chronic kidney disease not on dialysis and the patient is greater than 18 years of age, and J0881 has not been billed in the previous month, and J0885, Q4081, Q5105, or Q5106 has not been billed in the previous two weeks by any provider.

Policy	Description
Darbepoetin alfa (Aranesp®)	Tufts Health Plan limits J0881 to 300 combined units per DOS by any provider and the diagnosis is anemia of chronic inflammatory disease.
	Tufts Health Plan does not routinely compensate J0881 when billed and hemoglobin studies (80050, 80055, 80081, 85013, 85014, 85018, 85025, 85027, G0306, or G0307) has not been billed by any provider on the same day, or within the past month.
Darbepoetin alfa (Aranesp®)	Tufts Health Plan does not routinely compensate J0881 when billed and iron status studies (82728, 83540, or 84466) has not been billed by any provider on the same day or within the past three months.
	Tufts Health Plan does not routinely compensate J0881 when billed by any provider more than one unique visit per week and the diagnosis is anemia in patients with chronic kidney disease not on dialysis, anemia of chronic inflammatory disease, anemia of prematurity, cancer-induced anemia, chemotherapy-induced anemia, myelodysplastic syndrome, myelofibrosis, or preoperative use for the reduction of allogenic blood transfusions.
	Tufts Health Plan does not routinely compensate J0881 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J0881 when billed and a diagnosis for anemia due to antineoplastic chemotherapy is present and a diagnosis for neoplasm is not also present.
	Tufts Health Plan does not routinely compensate J0881 when billed and a diagnosis for anemia in chronic kidney disease is present and a diagnosis for chronic kidney disease is not also present.
	Initial Non-EPO Conversion Dose (Pediatric/Adolescent): Tufts Health Plan limits J0881 to 102 combined units per DOS when the diagnosis is anemia in patients with chronic kidney disease not on dialysis and the patient is between one month and 18 years of age, and J0881 has not been billed in the previous month, and J0885, Q4081, Q5105, or Q5106 has not been billed in the previous two weeks by any provider.
	Tufts Health Plan does not routinely compensate J0881 when billed and the diagnosis is neoplasm, encounter for antineoplastic chemotherapy or immunotherapy, or personal history of antineoplastic chemotherapy, and a claim for either chemotherapy administration or a chemotherapy drug has not been billed for the same DOS or in the previous four months by any provider.
	Tufts Health Plan does not routinely compensate J0881 when billed more often than once every two weeks by any provider and the diagnosis is anemia related to hepatis C treatment with ribavirin, or anemia related to treatment with zidovudine for HIV.
	Tufts Health Plan does not routinely compensate J0881 when billed and a diagnosis for anemia in other chronic diseases classified elsewhere is present and a diagnosis of an underlying condition is not also present.
	Tufts Health Plan does not routinely compensate J0881 when billed and a diagnosis for encounter for other preprocedural examination or encounter for other procedures for purposes other than remedying health state is present and a diagnosis of anemia is not also present.
Decitabine	Tufts Health Plan will not routinely compensate J0894 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.
	Tufts Health Plan will not routinely compensate J0894 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J0894 to 52 combined units per DOS when billed by any provider and the diagnosis on the claim is blastic plasmacytoid dendritic cell neoplasm or myelofibrosis.
Denosumab (Prolia®, Xgeva®)	Tufts Health Plan limits J0897 to 120 combined units per DOS by any provider if the diagnosis is bone metastases, giant cell tumor of bone, hypercalcemia of malignancy or multiple myeloma.

Policy	Description
	Tufts Health Plan limits J0897 to 60 combined units per DOS by any provider when the diagnosis on the claim is glucocorticoid-induced osteoporosis, intolerance to other available osteoporosis therapy, osteoporosis in men, postmenopausal osteoporosis prophylaxis, postmenopausal osteoporosis treatment, postmenopausal women receiving aromatase inhibitors for early breast cancer, prostate cancer patients receiving androgen deprivation therapy, or systemic mastocytosis
	Tufts Health Plan does not routinely compensate J0897 when billed by any provider more than one visit per week and the diagnosis on the claim is giant cell tumor of bone or hypercalcemia of malignancy.
	Tufts Health Plan does not routinely compensate J0897 when billed by any provider more than one visit per month and the diagnosis on the claim is bone metastases or multiple myeloma.
	Tufts Health Plan does not routinely compensate J0897 when billed by any provider more than one visit every six months and the diagnosis on the claim is glucocorticoid-induced osteoporosis, intolerance to other available osteoporosis therapy, osteoporosis in men, postmenopausal osteoporosis prophylaxis, postmenopausal osteoporosis treatment, postmenopausal women receiving aromatase inhibitors for early breast cancer, prostate cancer patients receiving androgen deprivation therapy, or systemic mastocytosis.
Dexamethasone, Intravitreal Implant (Ozurdex®)	Tufts Health Plan does not compensate dexamethasone (J7312) when billed without intravitreal injection of a pharmacologic agent (67028).
	Tufts Health Plan does not routinely compensate 67028 (Intravitreal injection of a pharmacologic agent [separate procedure]) when billed with dexamethasone (J7312) and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.
	Tufts Health Plan does not routinely compensate J7312 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J7312 to 14 combined units per DOS by any provider and the diagnosis is diabetic macular edema, macular edema following branch retinal vein occlusion, macular edema following central retinal vein occlusion, or non-infectious uveitis affecting the posterior segment.
Docetaxel (Taxotere®)	Tufts Health Plan does not compensate for J9171 for the diagnosis of occult primary unless carboplatin, cisplatin, fluorouracil or gemcitabine have been billed for the same DOS.
	Tufts Health Plan does not routinely compensate for J9171 if billed without an FDA-approved indication or an off-labeled indication on the claim.
	Tufts Health Plan limits J9171 to 156 units per DOS if billed by any provider with a diagnosis of thyroid carcinoma or anaplastic carcinoma.
	Tufts Health Plan limits J9171 to 325 combined units per DOS by any provider and the diagnosis on the claim is Ewing's sarcoma or osteosarcoma
Doxorubicin HCl liposome (Doxil®)	Tufts Health Plan does not routinely compensate J9002, Q2049 or Q2050 if billed without an FDA-approved indication or an off-label indication.
	Tufts Health Plan will not routinely compensate for 96401-96411, 96420-96450, 96542, or Q0083 if billed with Q2049 or Q2050 and another drug administered by chemotherapy administration has not been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate Q2049 or Q2050 if billed with a diagnosis of Kaposi's sarcoma unless a diagnosis of human immunodeficiency virus (HIV) disease is present.
	Tufts Health Plan limits Q2049 or Q2050 to the following: • 5 units per DOS if the diagnosis is AIDS-related Kaposi's sarcoma or Castleman's disease • 13 units per DOS if billed with a diagnosis of breast cancer, fallopian tube cancer, endometrial carcinoma, ovarian cancer/primary peritoneal cancer, soft tissue sarcoma or uterine sarcoma
	Tufts Health Plan will not routinely compensate Q2049 or Q2050 when billed more than once every four weeks by any provider and the diagnosis is breast cancer, endometrial carcinoma, or uterine sarcoma.

Policy	Description
	Tufts Health Plan will not routinely compensate Q2049 or Q2050 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 2.
Drug Administration for Drugs and Biologicals	Tufts Health Plan does not routinely compensate chemotherapy drug administration code (96401-96450, 96542-96549, G0498, Q0083-Q0085) when billed with a drug that is administered using non-chemotherapy administration codes and a drug that is administered using chemotherapy codes has not been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate chemotherapy drug administration code (96401-96450, 96542-96549, G0498, Q0083-Q0085) when billed and a drug that is administered using a chemotherapy code has not also been billed by any provider for the same DOS.
Drug Wastage	Tufts Health Plan does not routinely compensate any code other than a drug code when billed with modifier JW (Drug amount discarded/not administered to any patient).
	Tufts Health Plan does not routinely compensate a drug when billed with modifier JW (Drug amount discarded/not administered to any patient) and another claim line does not exist for the same drug on the same DOS.
Durvalumab	Tufts Health Plan will not routinely compensate J9173 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J9173 to 150 units per DOS by any provider when billed and the diagnosis on the claim is non-small cell lung cancer or small cell lung cancer.
	Tufts Health Plan will not routinely compensate J9173 when billed by any provider more than one visit every two weeks and the diagnosis is non-small cell lung cancer or urothelial carcinoma.
	Tufts Health Plan will not routinely compensate J9173 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 12.
Ecallantide (Kalbitor®)	Tufts Health Plan does not routinely compensate J1290 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Eculizumab (Soliris®)	Tufts Health Plan limits J1300 to 90 combined units per DOS or 600 combined units in 12 weeks if a diagnosis of paroxysmal nocturnal hemoglobinuria is billed.
Epoetin alfa (Procrit®, Epogen®)	Tufts Health Plan does not routinely compensate J0885 if billed with a diagnosis of anemia due to neoplastic disease or anemia in members receiving immunosuppressive chemotherapy with at least two additional months of planned chemotherapy, unless a laboratory service that includes hemoglobin testing has been billed for the same DOS or in the previous two weeks by any provider.
	Tufts Health Plan does not routinely compensate J0885 if billed with a diagnosis of anemia in members with chronic kidney disease not on dialysis unless an iron status study (82728, 83540, 83550) has been billed on the same DOS or within the previous 12 weeks
	Tufts Health Plan limits J0885 to the following when billed by any provider: 14 combined units per DOS if the diagnosis is anemia in patients with chronic kidney disease not on dialysis and the member is 17 years of age or older on the DOS, and J0885 has not been billed in the previous week by any provider. 6 combined units per DOS if the diagnosis is anemia in members with congestive heart failure
	Tufts Health Plan does not routinely compensate subcutaneous or intramuscular injection (96372) if billed with J0885 and all of the following are met: The diagnosis is anemia in members receiving myelosuppressive chemotherapy with at least two additional months of planned chemotherapy The member is less than 18 years of age No other nonchemotherapy subcutaneous or intramuscular drug has been billed for the same DOS by any provider
	Tufts Health Plan does not routinely compensate for epoetin alfa HCl (Q4081 or Q5105) when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Policy	Description
	Tufts Health Plan does not routinely compensate Q4081 or Q5105 when billed with a diagnosis of anemia in chronic kidney disease and ESRD is not also present.
	Tufts Health Plan does not routinely compensate Q4081 or Q5105 when billed and the diagnosis is ESRD and a diagnosis of dependence on renal dialysis is not also present.
	Tufts Health Plan does not routinely compensate Q4081 or Q5105 when billed and an iron status study (82728, 83540, or 83550) has not been billed by any provider on the same day or within the past three months.
	Tufts Health Plan does not routinely compensate J0885 or Q5106 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J0885 or Q5106 when billed with a diagnosis for anemia in neoplastic disease and a diagnosis of malignancy is not also present.
	Tufts Health Plan does not routinely compensate J0885 or Q5106 when billed with a diagnosis for anemia in chronic kidney disease and a diagnosis for chronic kidney disease is not also present.
	Maintenance Dose – Tufts Health Plan limits J0885 or Q5106 to 27 combined units per DOS by any provider when the diagnosis is anemia in patients with chronic kidney disease not on dialysis, and J0885 or Q5106 has been billed in the previous week by any provider.
	Adult Dose – Tufts Health Plan limits J0885 or Q5106 to 120 combined units per DOS by any provider when the diagnosis is anemia in neoplastic disease or anemia due to antineoplastic chemotherapy, and the patient is 17 years of age or older.
	Tufts Health Plan limits J0885 or Q5106 to 80 combined units per DOS when the diagnosis is myelodysplastic syndrome.
	Tufts Health Plan limits J0885 or Q5106 to 20 combined units per DOS by any provider when the diagnosis is myelofibrosis.
	Tufts Health Plan does not routinely compensate J0885 or Q5106 when billed with a diagnosis of anemia in other chronic diseases classified elsewhere and a diagnosis of an underlying condition is not also present.
	Tufts Health Plan limits J0885 or Q5106 to 34 combined units per DOS by any provider and the diagnosis is multiple myeloma.
	Tufts Health Plan does not routinely compensate J0885 or Q5106 when billed and a laboratory service that includes hemoglobin testing is not billed for the same DOS or in the previous 12 weeks by any provider.
	Tufts Health Plan limits J0885 or Q5106 to six combined units per week by any provider and the diagnosis is anemia in patients with congestive heart failure.
Eribulin Mesylate (Halaven®)	Tufts Health Plan will not routinely compensate for 96401-96406, 96413-96450,96542 or 96549 (chemotherapy administration by other than intravenous push technique code) if billed with J9179 and no other drug administered via chemotherapy administration is billed for the same DOS by any provider.
	Tufts Health Plan will not routinely compensate J9179 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J9179 when billed by any provider more than twice within a three week period and the diagnosis on the claim is breast cancer or soft tissue sarcoma.
	Tufts Health Plan does not routinely compensate J9179 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
Etelcalcetide	Tufts Health Plan will not routinely compensate J0606 when billed with a diagnosis of ESRD and a diagnosis of dependence on renal dialysis is not also present on the claim.
Ferric Carboxymaltose	Tufts Health Plan will not routinely compensate J1439 when billed with a diagnosis of encounter for antineoplastic chemotherapy or encounter for other specified aftercare, and a diagnosis of anemia due to antineoplastic chemotherapy is not also present.
	Tufts Health Plan will not routinely compensate J1439 when billed with a diagnosis of encounter for antineoplastic chemotherapy or encounter for other specified aftercare, and a diagnosis of anemia due to antineoplastic chemotherapy is not also present.

Policy	Description
	Tufts Health Public Plans will not routinely compensate J1439 under the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim • If billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of chronic kidney disease is not also present • If billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present • If billed with a diagnosis of encounter for antineoplastic chemotherapy or encounter for other specified aftercare, and a diagnosis of anemia due to antineoplastic chemotherapy is not also present • If billed with a diagnosis of anemia in other chronic diseases and a diagnosis of one of the following: – Crohn's disease – Celiac disease – Chronic heart failure – Intestinal malabsorption unspecified – Other malabsorption due to intolerance – Excessive and frequent menstruation – Irregular menstruation – Ulcerative colitis – Adverse effect of iron and its compounds
	Tufts Health Plan will not routinely compensate J1439 when billed and the patient is less than 18 years of age and the diagnosis is cancer-induced anemia, chemotherapy-induced anemia, iron deficiency anemia, iron deficiency anemia in chronic kidney disease, iron deficiency anemia in end-stage renal disease on dialysis, iron deficiency anemia associated with heart failure, iron deficiency of pregnancy, or restless legs syndrome [Willis-Ekbom disease].
Ferumoxytol (Feraheme®)	Tufts Health Plan limits coverage of Q0138 or to 510 combined units per DOS when billed by any provider.
	Tufts Health Plan does not routinely compensate for Q0138 for non-ESRD use when billed with diagnosis of anemia in chronic kidney disease and a diagnosis of chronic kidney disease is not also present on the claim.
	Tufts Health Plan does not routinely compensate Q0139 if billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of ESRD is not present.
	Tufts Health Plan will not routinely compensate Q0138 when billed with a diagnosis of intolerance to oral iron, unsatisfactory or impossible oral administration, or malabsorption disorders, and a diagnosis of anemia in other chronic disease classified elsewhere is not also present.
	Tufts Health Planlimits Q0138 to 1020 combined units per week by any provider and the diagnosis on the claim is cancer-induced anemia, chemotherapy-induced anemia, iron deficiency anemia in chronic kidney disease, intolerance to oral iron, unsatisfactory or impossible oral administration, or malabsorption disorders.
	Tufts Health Plan will not routinely compensate Q0139 when billed with a diagnosis of end stage renal disease and a diagnosis of dialysis status is not also present on the claim.
	Tufts Health Plan does not routinely compensate Q0138 if billed without an FDA approved indication or an approved off-label indication is not present on the claim
	Tufts Health Plan limits Q0138 to 1020 combined units per DOS by any provider and the diagnosis on the claim is iron deficiency in chronic kidney disease.
	Tufts Health Plan does not routinely compensate Q0139 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Filgrastim (Neupogen®)	Tufts Health Plan does not routinely compensate for J1442, Q1501 or Q5110 if billed with a neoplasm diagnosis and a claim for either a chemotherapy administration or a chemotherapy drug has not been billed in the previous two weeks by any provider.
	Tufts Health Plan does not routinely compensate for J1442, Q1501 or Q5110 if billed by any provider on the same DOS as a cytotoxic chemotherapy drug.

Policy	Description
	Tufts Health Plan does not routinely compensate for filgrastim (J1442, Q5101) when billed with a bone marrow transplant diagnosis unless a claim for a bone marrow transplant (38204-38242) has been billed in the previous 27 days by any provider.
	Tufts Health Plan does not routinely compensate J1442, Q5101, or Q5110 when billed and Q5120, J2505, Q5108, Q5111, or Q5120 (Pegfilgrastim) has been billed on the same DOS or within the previous 13 days.
	Tufts Health Plan will not routinely compensate J1442, Q5101, or Q5110 when billed and the diagnosis on the claim is encounter for other specified aftercare, and a diagnosis describing the condition that is requiring care is not also present.
	Tufts Health Plan will not routinely compensate J1442, Q5101, or Q5110 when billed and the diagnosis on the claim is encounter for antineoplastic chemotherapy and immunotherapy and a white blood cell (WBC) count with differential has not been billed for the same DOS or in the previous week by any provider.
	Tufts Health Plan does not routinely compensate J1442, Q5101, or Q5110 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J1442, Q5101, or Q5110 when billed and the diagnosis on the claim is febrile neutropenia or neutropenia associated with HIV, and a diagnosis for neutropenia is not also present on the claim.
	Tufts Health Plan limits J1442, Q5101, or Q5110 to 1360 combined units per DOS by any provider and the diagnosis on the claim is acute exposure to myelosuppressive doses of radiation, chemotherapy-induced neutropenia, consolidation chemotherapy in acute lymphocytic leukemia, consolidation chemotherapy in acute myeloid leukemia, cyclic neutropenia, febrile neutropenia, hairy cell leukemia, HIV patients with drug-induced neutropenia, HIV-induced neutropenia, infectious complications following esophagectomy, leukemic relapse after allogeneic stem cell transplantation, myelodysplastic syndrome, non-myeloid malignancy patients undergoing myeloablative chemotherapy followed by bone marrow transplantation, or reduction of incidence of neonatal sepsis related to pre-eclampsia associated neutropenia.
Fluocinolone Acetonide, Intravitreal Implant (Iluvien)	Tufts Health Plan will not routinely compensate J7313 when billed without intravitreal injection of a pharmacologic agent (67028).
Fluocinolone Acetonide, Intravitreal Implant (Retisert®)	Tufts Health Plan does not routinely compensate J7311 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Fosaprepitant (Emend®)	Tufts Health Plan does not routinely compensate for fosaprepitant (J1453) unless a highly or moderately emetogenic chemotherapy agent is not also present on the claim for the same DOS.
	Tufts Health Plan limits J1453 to 150 combined units per DOS by any provider and the diagnosis on the claim is prevention of nausea and vomiting associated with highly and moderately emetogenic chemotherapy or prevention of nausea and vomiting associated with cisplatin-based chemotherapy with concurrent radiotherapy.
	Tufts Health Plan does not routinely compensate J1453 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Fulvestrant (Faslodex®)	Tufts Health Plan does not routinely compensate J9395 when billed by any provider more than one visit per month and the diagnosis on the claim is breast cancer or uterine sarcoma.
	Tufts Health Plan will limit J9395 to 10 combined units per DOS by any provider and the diagnosis is endometrial carcinoma or uterine sarcoma.
	Tufts Health Plan will not routinely compensate J9395 when billed by any provider more than once every two weeks and the diagnosis is breast cancer or ovarian cancer.
	Tufts Health Plan does not routinely compensate J9395 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Gemcitabine HCl (Gemzar®)	Tufts Health Plan does not routinely compensate for J9201 when billed without an FDA approved indication or an approved off-labeled indication on the claim.
	Tufts Health Plan limits J9201 to 16 combined units per DOS by any provider and the diagnosis on the claim is adult T-cell leukemia/lymphoma, AIDS-related Kaposi's sarcoma, Kaposi's sarcoma (classic), kidney cancer, primary cutaneous lymphoma, T-cell lymphoma, or urothelial carcinoma.

Policy	Description
	Tufts Health Plan limits J9201 to 17 combined units per DOS by any provider and the diagnosis on the claim is B-cell lymphoma, cervical cancer, head and neck cancer, Hodgkin lymphoma (classical), non-small cell lung cancer, occult primary, small cell lung cancer, soft tissue sarcoma, or testicular cancer.
	Tufts Health Plan does not routinely compensate J9201 when billed by any provider more than one visit per week and the diagnosis on the claim is adult T-cell leukemia/lymphoma, AIDS-related B-cell lymphoma, AIDS-related Kaposi sarcoma, B-cell lymphoma, breast cancer, cervical cancer, Ewing sarcoma, gestational trophoblastic neoplasia, head and neck cancer, hepatobiliary cancer, Kaposi sarcoma [classic], kidney cancer, malignant pleural mesothelioma, occult primary, osteosarcoma, ovarian cancer, pancreatic adenocarcinoma, post-transplant lymphoproliferative disorder, primary cutaneous lymphoma, small bowel adenocarcinoma, small cell lung cancer, soft tissue sarcoma, T-cell lymphoma, testicular cancer, thymoma or thymic carcinoma, or uterine sarcoma.
	Tufts Health Plan limits J9201 to 13 combined units per DOS by any provider and the diagnosis on the claim is AIDS-related B-cell lymphoma, Ewing sarcoma, gestational trophoblastic neoplasia, osteosarcoma, ovarian cancer, post-transplant lymphoproliferative disorder, small bowel adenocarcinoma, thymoma and thymic carcinoma, or uterine sarcoma.
	Tufts Health Plan limits J9201 to 29 combined units per DOS by any provider and the diagnosis on the claim is hepatobiliary cancer.
	Tufts Health Plan does not routinely compensate J9201 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed one.
	Tufts Health Plan limits J9201 to 10 combined units per DOS by any provider and the diagnosis on the claim is bladder cancer and 51720 (Bladder instillation therapy, intravesical) has been billed for the same DOS.
Goserelin Acetate Implant (Zoladex®)	Tufts Health Plan limits J9202 to two combined units per DOS when billed by any provider ant the diagnosis on the claim is breast cancer.
	Tufts Health Plan limits J9202 to one unit per DOS by any provider and the diagnosis on the claim is benign prostatic hyperplasia, dysfunctional uterine bleeding, endometriosis, gender dysphoria (Male-to-female transsexual), in vitro fertilization, prevention of post-chemotherapy ovarian failure, in patients with breast cancer, or uterine leiomyomata.
	Tufts Health Plan does not routinely compensate for J9202 if billed without an FDA-approved indication or an off-label recommended indication.
	Tufts Health Plan limits J9202 to three combined units per DOS by any provider and the diagnosis on the claim is central precocious puberty or precocious puberty due to hypothalamic hamartoma, or prostate cancer.
	Tufts Health Plan does not routinely compensate J9202 when billed by any provider more than one visit per month and an FDA approved or an approved off-labeled indication is present on the claim.
	Tufts Health Plan limits J9202 to seven combined units every 26 weeks by any provider and the diagnosis on the claim is benign prostatic hyperplasia, dysfunctional uterine bleeding, endometriosis, gender dysphoria (Male-to-female transsexual), in vitro fertilization, prevention of post-chemotherapy ovarian failure, in patients with breast cancer, or uterine leiomyomata.
Golimumab (Simponi Aria®)	Tufts Health Plan does not routinely compensate J1602 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.
	Tufts Health Plan does not routinely compensate J1602 when billed by any provider more than once every four weeks and the diagnosis is ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis.
	Tufts Health Plan limits J1602 to 272 combined units per DOS by any provider and the diagnosis is ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis.
Histrelin Implant (Supprelin LA®, Vantas®)	Tufts Health Plan does not routinely compensate for J9225 when billed and 11981 or 11983 (Insertion/removal and reinsertion of non-biodegradable drug delivery system) has not been billed on the same DOS by any provider.

Policy	Description
	Tufts Health Plan does not routinely compensate for J9226 if billed without a diagnosis of central precocious puberty (CPP) or if billed for members who are over the age of 12 on the DOS.
	Tufts Health Plan does not routinely compensate J9225 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Human Antithrombin III	Tufts Health Plan will not routinely compensate J7197 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Hydration Therapy	Effective for DOS on or after July 1, 2021, Tufts Health Plan will not routinely compensate for 96360, J7030, J7040, J7042, J7050, J7060, J7070, J7120 or J7121 (Intravenous fluids) when billed without a requisite diagnosis on the claim and the member is older than 18 years of age on the DOS.
Hydroxyprogesterone caproate (Makena)	Tufts Health Plan does not routinely compensate J1726 if billed more than one unique visit per week and the diagnosis is singleton pregnancy with history of singleton spontaneous preterm birth.
	Tufts Health Plan does not routinely compensate J1726 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Idursulfase	Tufts Health Plan does not routinely compensate J1743 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 6.
Imiglucerase	Tufts Health Plan does not routinely compensate J1786 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20.
Immune Globulins, IM, SQ (BayGam® GamaStan® S/D)	Tufts Health Plan does not routinely compensate 90281, J1460, or J1560 when billed and the patient is less than 12 years of age and the diagnosis on the claim is rubella prophylaxis in exposed, susceptible pregnant women.
	Tufts Health Plan does not routinely compensate 96365-96368, or 96372-96379 (non-chemotherapy administration, other than subcutaneous infusion technique) when billed with 90284, J1558, J1559, or J1562 and no other non-chemotherapy drug administered by other than subcutaneous infusion has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate 90281, J1460, or J1560 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Infliximab (Remicade®)	Tufts Health Plan will not routinely compensate Q5109 when billed by any provider more than two visits every 26 weeks and the diagnosis on the claim is immune checkpoint inhibitor-related toxicities.
	Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to the following when billed by any provider: • to 68 combined units • J1745, Q5103, Q5104, Q5109, or Q5121 to 82 combined units per DOS by any provider and the diagnosis on the claim is juvenile idiopathic arthritis
	Tufts Health Plan will not routinely compensate J1745, Q5103, Q5104, Q5109, or Q5121 when billed by any provider more than one visit every two weeks and the diagnosis on the claim is adult-onset Still's disease, ankylosing spondylitis (adult), Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, immune checkpoint inhibitor-related toxicity, juvenile idiopathic arthritis, plaque psoriasis, psoriatic arthritis, pyoderma gangrenosum associated with inflammatory bowel disease, reactive arthropathy, regional enteritis (Crohn's disease - adult or pediatric), rheumatoid arthritis, SAPHO syndrome, sarcoidosis, synovitis in rheumatoid arthritis, ulcerative colitis (adult or pediatric), or uveitis.
	Initial Dose – Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to 41 combined units per DOS when the diagnosis on the claim is rheumatoid arthritis and J1745, Q5103, Q5104, Q5109, or Q5121 has not been billed in the previous 14 weeks by any provider.
	Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to 68 combined units per DOS when the diagnosis on the claim is adult-onset Still's disease, ankylosing spondylitis (adult), granulomatosis with polyangiitis (Wegner's

Policy	Description
	granulomatosis), hidradenitis suppurativa, immune checkpoint inhibitor-related toxicity, plaque psoriasis, psoriatic arthritis, SAPHO syndrome, or sarcoidosis.
	Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to 544 combined units in 26 weeks by any provider and the diagnosis on the claim is regional enteritis (Crohn's disease - adult) or ulcerative colitis (adult), and the patient is greater than 18 years of age on the DOS.
	Initial Dose – Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to 68 combined units per DOS when the diagnosis on the claim is regional enteritis (Crohn's disease) (adult or pediatric) and J1745, Q5103, Q5104, Q5109, or Q5121 has not been billed in the previous 14 weeks by any provider.
	Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to 136 combined units per DOS by any provider and the diagnosis on the claim is acute graft-versus-host disease following peripheral blood stem cell transplantation, aortic arch syndrome (Takayasu's disease), Behcet's syndrome, mucocutaneous lymph node syndrome (Kawasaki disease), pyoderma gangrenosum associated with inflammatory bowel disease, reactive arthropathy, regional enteritis (Crohn's disease - adult), ulcerative colitis (adult or pediatric), or uveitis.
	Tufts Health Plan does not routinely compensate J1745, Q5103, Q5104, Q5109, or Q5121 when billed by any provider more than one visit per week and the diagnosis on the claim is acute graft-versus-host disease following peripheral blood stem cell transplantation.
	Tufts Health Plan does not routinely compensate J1745, Q5103, Q5104, Q5109, or Q5121 when billed by any provider more than four visits every 26 weeks and the diagnosis on the claim is acute graft-versus-host disease following peripheral blood stem cell transplantation or hidradenitis suppurativa.
	Tufts Health Plan will not routinely compensate J1745, Q5103, Q5104, or Q5109 when billed by any provider more than four visits every 26 weeks and the diagnosis on the claim is hidradenitis suppurativa.
	Tufts Health Plan does not routinely compensate J1745, Q5103, Q5104, Q5109, or Q5121 when billed by any provider more than six visits every 26 weeks and the diagnosis on the claim is ankylosing spondylitis (adult), SAPHO syndrome, or sarcoidosis.
	Tufts Health Plan does not routinely compensate J1745, Q5103, Q5104, Q5109, or Q5121 when billed by any provider more than five visits every 26 weeks and the diagnosis on the claim is adult-onset Still's disease, plaque psoriasis, psoriatic arthritis, or reactive arthropathy.
	Tufts Health Plan limits J1745, Q5103, Q5104, Q5109, or Q5121 to 436 combined units in 26 weeks by any provider and the diagnosis on the claim is juvenile idiopathic arthritis.
Intrauterine Contraceptive Systems and Contraceptive Implants	Tufts Health Plan will not routinely compensate J7296, J7297 or J7301 when billed and the diagnosis is not prevention of pregnancy
	Tufts Health Plan will not routinely compensate J7298 when billed and the diagnosis is not endometriosis, menopausal symptoms, menorrhagia, endometrial hyperplasia or prevention of pregnancy.
	Tufts Health Plan will not routinely compensate J7300 when billed and the diagnosis is not prevention of pregnancy.
	Tufts Health Plan will not routinely compensate J7307 when billed and the diagnosis is not endometriosis or prevention of pregnancy.
	Tufts Health Plan will not routinely compensate J7296, J7297, J7298, J7300, or J7301 when billed by any provider more than one visit every three years, and intrauterine device removal (58301) has not been billed for the same DOS, or within the previous three years.
	Tufts Health Plan will not routinely compensate J7307 when billed by any provider and drug delivery implant insertion code 11981 or 11983 has not been billed for the same DOS.
	Effective for DOS on or after July 1, 2021, Tufts Health Plan will not routinely compensate for 58300 (Insertion of intrauterine device [IUD]) when billed and J7296, J7297, J7298, J7300 or J7301 (Intrauterine device) has not been billed for the same DOS by any provider.

Policy	Description
Ipilimumab (Yervoy™)	Tufts Health Plan will not routinely compensate J9228 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will limit J9228 to 136 combined units per DOS by any provider and the diagnosis on the claim is malignant pleural mesothelioma, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic small bowel, or renal cell carcinoma.
	Tufts Health Plan limits J9228 to 1360 combined units per DOS by any provider and the diagnosis on the claim is melanoma.
	Tufts Health Plan does not routinely compensate J9228 when billed with modifier JW and the units equal or exceed 50.
	Tufts Health Plan does not routinely compensate J9228 when billed by any provider more than five visits every 26 weeks and the diagnosis on the claim is melanoma.
	Tufts Health Plan does not routinely compensate J9228 when billed by any provider more than one visit every three weeks and the diagnosis on the claim is hepatocellular carcinoma, melanoma, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) advanced or metastatic small bowel, non-small cell carcinoma, renal cell carcinoma, or small cell lung cancer, or uveal melanoma.
Irinotecan (Camptosar®)	Tufts Health Plan does not routinely compensate for J9206 without an FDA-approved or an off-label recommended indication.
	Tufts Health Plan limits coverage of J9206 to 7 combined units per DOS by any provider when the diagnosis is Ewing's sarcoma or rhabdomyosarcoma.
	Tufts Health Plan does not routinely compensate J9206 if billed and the member is less than 18 years of age on the DOS and the diagnosis is any of the following: Acute lymphoblastic leukemia Acute myeloid leukemia Anaplastic glioma Breast cancer Cervical cancer Colorectal cancer Esophageal cancer Esophagogastric junction cancer Gastric cancer Glioblastoma multiforme Non-Hodgkin's lymphoma Non-small cell lung cancer Occult primary Ovarian cancer Pancreatic adenocarcinoma Small cell lung cancer Vaginal cancer
	Tufts Health Plan does not routinely compensate J9205 if billed by any provider more than once every two weeks with a diagnosis of pancreatic adenocarcinoma.
	Tufts Health Plan does not routinely compensate J9206 if billed and one of the following laboratory services has not been billed for the same DOS or in the previous 7 days by any provider: 80050 (general health panel) 80055, 80081 (obstetrical panel) 85004-85007 (differential WBC count) 85009 (manual differential WBC count, buffy coat) 85025-85027 (complete CBC) 85032 (manual cell count) G0306-G0307 (complete CBC)
	Tufts Health Plan does not routinely compensate J9206 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed two.

Policy	Description
Iron dextran (INFed®)	Tufts Health Plan limits J1750 to two units when billed by any provider and the diagnosis is iron deficiency anemia, iron deficiency anemia due to blood loss, iron deficiency anemia in patients for whom oral administration is unsatisfactory or impossible, or nutritional supplementation in patients receiving long-term total parenteral nutrition, and a diagnosis of non-myeloid malignancy, iron deficiency anemia in patients for whom oral administration is unsatisfactory or impossible, or iron deficiency anemia of pregnancy is not also present.
	Tufts Health Plan does not routinely compensate J1750 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J1750 if billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present.
	Tufts Health Plan does not routinely compensate J1750 if billed with a diagnosis of encounter for antineoplastic chemotherapy and a diagnosis of nonmyeloid malignancy is not also present.
Iron Sucrose (Venofer®)	Tufts Health Plan limits coverage of J1756 to the following when billed by any provider: 500 combined units per DOS and the diagnosis is iron deficiency anemia in patients with chronic kidney disease.
	Tufts Health Plan does not routinely compensate J1756 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J1756 to 200 combined units per DOS by any provider when the diagnosis on the claim is iron deficiency anemia associated with chronic heart failure, or iron deficiency anemia of pregnancy.
	Tufts Health Plan does not routinely compensate for J1756when billed and the patient is less than two years of age and the diagnosis is cancer-induced anemia, chemotherapy-induced anemia, iron deficiency anemia associated with chronic heart failure, iron deficiency anemia due to malabsorption disorders, iron deficiency anemia in patients with chronic kidney disease, or iron deficiency anemia of pregnancy.
	Tufts Health Plan does not routinely compensate J1756 when billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of chronic kidney disease is not also present.
	Tufts Health Plan does not routinely compensate J1756 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.
	Tufts Health Plan does not routinely compensate J1756 if billed with a diagnosis of ESRD unless a diagnosis of dialysis status is also present.
	Tufts Health Plan limits J1756 to 300 combined units per DOS by any provider when the diagnosis is cancer-induced anemia, chemotherapy-induced anemia, or iron deficiency anemia due to malabsorption disorders.
	Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of anemia in neoplastic disease and a diagnosis of non-myeloid malignancy is not also present.
	Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of encounter for antineoplastic chemotherapy and a diagnosis of non-myeloid malignancy is not also present.
	Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of chronic heart failure and a diagnosis of iron deficiency anemia is not also present.
	Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present.
Ixabepilone (Ixempra®)	Tufts Health Plan will not routinely compensate for 96413 (chemotherapy administration, IV infusion technique, first hour) when billed with ixabepilone (J9207) and 96415 (chemotherapy administration, IV infusion technique, each additional hour) has not been billed for the same DOS.
	Tufts Health Plan does not routinely compensate J9207 if billed without an FDA-approved indication or an approved off-labeled indication.
Lanreotide (Somatuline Depot®)	Tufts Health Plan does not routinely compensate for J1930 when billed without an FDA-approved indication or an approved off-labeled indication.

Policy	Description
	Tufts Health Plan will not routinely compensate for J1930 when billed by any provider more than once every 26 days and the diagnosis is carcinoid syndrome, acromegaly or gastroenteropancreatic neuroendocrine tumors.
	Tufts Health Plan will not routinely compensate J1930 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J1930 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 60.
Leuprolide acetate, 1 mg	Tufts Health Plan does not routinely compensate for J9218 without an FDA approved indication or an off-label recommended indication.
	Tufts Health Plan will not routinely compensate J9218 when billed and the patient is less than 18 years of age and the diagnosis is benign prostatic hypertrophy, breast cancer, infertility, ovarian cancer, premenstrual syndrome, or prostate cancer.
Leuprolide acetate depot, 3.75 mg (Lupron Depot®)	Tufts Health Plan does not routinely compensate for leuprolide acetate depot, 3.75 mg (J1950) J1950 when billed and the patient is less than 18 years of age and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, benign prostatic hyperplasia, breast cancer, endometriosis, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, premenstrual syndrome, prostate cancer, stuttering priapism, or uterine leiomyomata.
	Tufts Health Plan does not routinely compensate for J1950 without an FDA-approved indication or an off-label recommended indication.
	Tufts Health Plan does not routinely compensate J1950 when billed and the diagnosis is prostate cancer.
	Tufts Health Plan will limit J1950 to three combined units in 10 weeks by any provider when the diagnosis on the claim is benign prostatic hyperplasia, breast cancer, endometriosis, premenstrual syndrome, or uterine leiomyomata.
Leuprolide Acetate depot, 7.5 mg (Lupron Depot®)	Tufts Health Plan does not routinely compensate for leuprolide acetate depot, 7.5 mg (J9217) when billed and the patient's gender is male and the diagnosis on the claim is other than breast cancer, central precocious puberty, prostate cancer, salivary gland tumor, or stuttering priapism.
	Tufts Health Plan limits coverage of leuprolide acetate depot, 7.5 mg (J9217) to 12 in a 48-week period for the diagnosis of prostate cancer.
	Tufts Health Plan does not routinely compensate J9217 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J9217 when billed and the patient's gender is female and the diagnosis on the claim is other than amenorrhea induction prior to bone marrow transplant, breast cancer, central precocious puberty, ovarian/cancer/fallopian tube cancer/primary peritoneal cancer, or salivary gland tumor.
	Tufts Health Plan will not routinely compensate for Leuprolide acetate (J9217) when billed and the member is less than 18 years of age and the diagnosis is other than central precocious puberty.
	Tufts Health Plan will not routinely compensate J9217 when billed and the patient is less than 18 years of age and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, breast cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, prostate cancer, salivary gland tumor, or stuttering priapism.
Mepolizumab	Tufts Health Plan will limit J2182 to 100 combined units per DOS by any provider when billed and the diagnosis is severe asthma of eosinophilic phenotype and the patient is 12 years of age or older.
	Tufts Health Plan will not routinely compensate J2182 when billed by any provider more than once per month and the diagnosis is eosinophilic granulomatosis with polyangiitis or severe asthma of eosinophilic phenotype.
Multi-Use Vials	Tufts Health Plan does not routinely compensate a drug which is only packaged for multiple doses when billed with modifier JW (Drug amount discarded/not administered to any patient).
Natalizumab (Tysabri®)	Tufts Health Plan limits J2323 to 300 combined units per DOS by any provider and the diagnosis on the claim is multiple sclerosis.

Policy	Description
	Tufts Health Plan does not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J2323 and no other drug administered by intravenous push technique has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J2323 when billed more frequently than once a month by any provider and the diagnosis on the claim is multiple sclerosis or regional enteritis [Crohn's disease].
	Tufts Health Plan limits J2323 to 408 combined units per DOS by any provider and the diagnosis on the claim is regional enteritis [Crohn's disease].
Nivolumab (Opdivo®)	Tufts Health Plan will not routinely compensate for J9299 if billed without an FDA-approved indication.
	Tufts Health Plan limits J9299 to 480 combined units per DOS by any provider and the diagnosis on the claim is anal carcinoma, brain metastases, esophageal cancer, gestational trophoblastic neoplasia, head and neck cancer, hepatocellular carcinoma, Hodgkin's lymphoma (classical), melanoma, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer, non-small cell lung cancer, renal cell carcinoma, or urothelial carcinoma.
	Tufts Health Plan does not routinely compensate J9299 when billed by any provider more than one visit every two weeks and the diagnosis is anal carcinoma, brain metastases, esophageal cancer, extranodal NK/T-cell lymphoma, nasal type, gestational trophoblastic neoplasia, head and neck cancer, hepatocellular carcinoma, Hodgkin's lymphoma (classical), malignant pleural mesothelioma, melanoma, Merkel cell carcinoma, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer, non-small cell lung cancer, renal cell carcinoma, small cell lung cancer, or urothelial carcinoma.
	Tufts Health Plan limits J9299 to 408 combined units per DOS by any provider and the diagnosis on the claim is malignant pleural mesothelioma, Merkel cell carcinoma, or small cell lung cancer.
	Tufts Health Plan will not routinely compensate for nivolumab (J9299) when billed with modifier JW and the units equal or exceed 40.
	Tufts Health Plan limits J9299 to 136 combined units per DOS when billed with J9228 by any provider and the diagnosis is hepatocellular carcinoma or melanoma.
	Tufts Health Plan does not routinely compensate J9299 if billed with a diagnosis of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer, unless 81301, 81479, 88341, 88342, or 0037U (MSI-H or dMMR testing) or J9299 has not been previously billed by any provider in the member's lifetime.
Nusinersen	Tufts Health Plan does not routinely compensate J2326 when billed and 96450 (Intrathecal drug administration) has not been billed by any provider for the same DOS.
Obinutuzumab	Tufts Health Plan does not routinely compensate J9301 when billed by any provider more than one visit per week and the diagnosis on the claim is follicular lymphoma, B-cell lymphoma [other than follicular lymphoma], Castleman's disease (B-cell), or post-transplant lymphoproliferative disorder (B-cell).
	Tufts Health Plan does not routinely compensate J9301 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate 96413 (Chemotherapy administration, IV infusion, first hour) when billed with J9301 and 96415 (Chemotherapy administration, IV infusion technique, each additional hour) has not been billed for the same DOS.
Ocriplasmin	Tufts Health Plan limits J7316 to three combined units per DOS by any provider and the diagnosis on the claim is vitreomacular adhesion.
	Tufts Health Plan does not routinely compensate for J7316 without an FDA-approved indication or an off-label recommended indication.
Octreotide acetate	Tufts Health Plan does not routinely compensate for J2353 without an FDA-approved indication or an off-label recommended indication.

Policy	Description
(Sandostatin LAR Depot®)	Tufts Health Plan limits coverage of J2353 to the following when billed by any provider: 20 combined units per DOS by any provider when the diagnosis on the claim is postgastrectomy dumping syndrome or thymoma and thymic cancer. 30 combined units per DOS by any provider and the diagnosis on the claim is carcinoid/neuroendocrine tumor, pheochromocytoma/paraganglioma, or vasoactive intestinal peptide tumor (VIPoma). One visit every 12 days Deny J2353 when billed by any provider more than once every four weeks and the diagnosis is acromegaly, carcinoid/neuroendocrine tumor, chemotherapy-induced diarrhea, meningioma, pheochromocytoma/paraganglioma, postgastrectomy dumping syndrome, or vasoactive intestinal peptide tumor (VIPoma).
	Tufts Health Plan does not routinely compensate J2353 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J2353 when billed with a diagnosis of vasoactive intestinal polypeptide tumor (VIPoma) and a diagnosis indicating diarrhea is not also present on the claim.
	Tufts Health Plan does not routinely compensate 96365-96371, 96373-96379 (Non-chemotherapy administration other than intramuscular technique) when billed with J2353 and no other drug administered using other than a non-chemotherapy intramuscular technique has been billed for the same DOS by any provider.
	Tufts Health Plan limits J2353 to 40 combined units per DOS by any provider when the diagnosis is acromegaly, chemotherapy-induced diarrhea, or meningioma.
	Tufts Health Plan does not routinely compensate J2353 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
Ofatumumab (ARZERRA™)	Tufts Health Plan does not routinely compensate J9302 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
	Tufts Health Plan does not routinely compensate J9302 when billed by any provider more than 12 unique visits in a 26 week period and the diagnosis on the claim is chronic lymphocytic leukemia/small cell lymphoma (CLL/SLL).
Olaratumab	Tufts Health Plan does not routinely compensate J9285 if billed by any provider more than 2 visits every 3 weeks and the diagnosis is soft tissue sarcoma.
Omalizumab (Xolair®)	Tufts Health Plan limits coverage of omalizumab (J2357) to the following: 75 combined units per DOS for the diagnosis of moderate to severe persistent asthma when billed by any provider 150 combined units per month by any provider when the diagnosis on the claim is adjunct to subcutaneous immunotherapy, latex allergy, or moderate to severe persistent asthma. Deny when billed by any provider more than once every four weeks and the diagnosis on the claim is chronic idiopathic urticaria, immune checkpoint inhibitor-related toxicities, or systemic mastocytosis. 150 combined units per DOS by any provider when the diagnosis on the claim is adjunct to subcutaneous immunotherapy or latex allergy.
	Tufts Health Plan does not routinely compensate drug administration services other than for subcutaneous technique (96365-96371, 96373-96379, 96402-96450, 96542, 96549, or G0498) when billed with J2357 and no other nonchemotherapy or chemotherapy drug administered by other than subcutaneous technique has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J2357 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 30.
Oxaliplatin (Eloxatin®)	Tufts Health Plan limits J9263 to 442 combined units per DOS by any provider and the diagnosis on the claim is anal carcinoma or bladder cancer.
	Tufts Health Plan does not routinely compensate J9263 when billed and an FDA approved indication or an approved off-label indication is not present on the claim.

Policy	Description
	Tufts Health Plan does not routinely compensate J9263 when billed by any provider more than one unique visit every two weeks and the diagnosis on the claim is AIDS-related B-cell lymphomas, anal carcinoma, B-cell lymphoma, bladder cancer, colorectal cancer, esophageal cancer, esophagogastric junction cancers, Hodgkin lymphoma (classical), mantle cell lymphoma, occult primary cancer, ovarian cancer, pancreatic adenocarcinoma, post-transplant lymphoproliferative disorders, primary cutaneous lymphoma, or small bowel adenocarcinoma.
	Tufts Health Plan will not routinely compensate J9263 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.
	Tufts Health Plan does not routinely compensate J9263 when billed by any provider more than one unique visit every three weeks and the diagnosis on the claim is adult T-cell leukemia/lymphoma, breast cancer, neuroendocrine and adrenal tumors, or T-cell lymphoma.
	Tufts Health Plan limits Limit J9263 to 676 combined units per DOS by any provider and the diagnosis on the claim is of adult T-cell leukemia/lymphoma, AIDS-related B-cell lymphoma, B-cell lymphoma, biliary tract cancer, breast cancer, colorectal cancer, esophageal cancer, esophagogastric junction cancer, gastric cancer, mantle cell lymphoma, neuroendocrine and adrenal tumors, non-small cell lung cancer, occult primary cancer, ovarian cancer, pancreatic adenocarcinoma, post-transplant lymphoproliferative disorders, primary cutaneous lymphoma, small bowel adenocarcinoma, T-cell lymphoma, or testicular cancer.
Paliperidone Palmitate	Tufts Health Plan does not routinely compensate J2426 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Paclitaxel (Taxol®)	Tufts Health Plan does not routinely compensate J9267 when billed and an FDA approved or an approved off-labeled indication is present on the claim, and a laboratory test for or including white blood cell count (WBC) (80050, 80055, 80081, 85004-85007, 85009, 85025-85027, 85032,G0306-G0307) is not billed for the same DOS, or in the previous 20 days by any provider.
	Tufts Health Plan does not routinely compensate J9267 when billed by any provider more than one visit every two weeks and the diagnosis on the claim is AIDS-related Kaposi's sarcoma, gestational trophoblastic neoplasia, or kidney cancer.
	Tufts Health Plan does not routinely compensate J9267 when billed by any provider more than one visit per week and the diagnosis on the claim is angiosarcoma, bladder cancer, breast cancer, endometrial carcinoma, esophageal cancer, esophagogastric junction cancer, gastric cancer, head and neck cancer, non-small cell lung cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, prostate cancer, small cell lung cancer, testicular germ cell cancer, or vulvar cancer
	Tufts Health Plan does not routinely compensate J9267 if billed without an FDA-approved indication or an approved off-labeled indication.
Paclitaxel protein-bound particles (Abraxane®)	Tufts Health Plan does not routinely compensate for J9264 if billed without an FDA-approved or an off-label recommended indication.
	Tufts Health Plan limits 96413 or 96417 (Chemotherapy administration, intravenous infusion up to one hour), to one unit per DOS when billed with J9264 and no other drug administered via chemotherapy administration up to one hour is billed for the same DOS by any provider, and the diagnosis one the claim is AIDS-related Kaposi sarcoma, breast cancer, endometrial carcinoma, gastric cancer, hepatobiliary cancer, hypersensitivity to docetaxel or paclitaxel, melanoma, non-small cell lung cancer, ovarian cancer, pancreatic adenocarcinoma, or small bowel adenocarcinoma.
	Tufts Health Plan limits J9264 to 676 combined units per DOS by any provider and the diagnosis on the claim is ovarian cancer or small bowel adenocarcinoma.
	Tufts Health Plan does not routinely compensate J9264 if billed more than the following: • More than once within a week and the diagnosis on the claim is AIDS-related Kaposi's sarcoma, breast cancer, endometrial carcinoma, gastric cancer, hepatobiliary cancer, hypersensitivity to docetaxel or paclitaxel, melanoma, non-small cell lung cancer, ovarian cancer, pancreatic adenocarcinoma or small bowel adenocarcinoma. • More than once within three weeks and the diagnosis on the claim is head and neck cancer.

Policy	Description
	Tufts Health Plan does not routinely compensate J9264 when billed and the diagnosis on the claim is hepatobiliary cancer or pancreatic adenocarcinoma, and J9198 or J9201 (Gemcitabine HCl) has not been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J9264 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.
Palonosetron (Aloxi®)	Tufts Health Plan does not routinely compensate for administration codes 96365-96372, 96377 and 96379 when billed with J2469 unless another drug administered by non-chemotherapy administration services has been billed for the same DOS.
	Tufts Health Plan limits coverage of J2469 to 10 combined units per DOS by any provider and the patient is greater than 17 years of age and the diagnosis on the claim is chemotherapy-induced nausea and vomiting.
	Tufts Health Plan does not routinely compensate J2469 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed three.
	Tufts Health Plan limits J2469 to 60 combined units per DOS by any provider and the patient is less than 17 years of age and the diagnosis on the claim is chemotherapy-induced nausea and vomiting.
	Tufts Health Plan does not routinely compensate for J2469 without an FDA approved indication or an off-label recommended indication.
	Tufts Health Plan does not routinely compensate J9303 when billed by any provider more than one visit every two weeks and the diagnosis on the claim is colorectal cancer.
Panitumumab	Tufts Health Plan does not routinely compensate J9303 when billed with a diagnosis of colorectal cancer and testing for a RAS mutation status (0111U, 81275, 81276, 81311, 81405, 81442, 81445, 81450, 81455), or if J9303, has not been previously billed by any provider in the patient's lifetime.
	Tufts Health Plan does not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J9303 and no other chemotherapy drug administered by intravenous push technique has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J9303 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J9303 to 82 combined units per DOS by any provider and the diagnosis on the claim is colorectal cancer.
	Tufts Health Plan does not routinely compensate J9303 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
Patisiran	Tufts Health Plan does not routinely compensate C9036 or J0222 when billed by any provider more than one unique visit every three weeks and the diagnosis on the claim is polyneuropathy of hereditary transthyretin-mediated amyloidosis.
Pegaspargase	Tufts Health Plan does not routinely compensate J9266 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim
Pegfilgrastim (Neulasta®)	Tufts Health Plan does not routinely compensate for J2505,Q5108, Q5111, or Q5120 when billed by any provider less than 10 days prior to the administration of a cytotoxic chemotherapy drug.
	Tufts Health Plan does not routinely compensate for J2505, Q5108, Q5111 or Q5120 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits Q5108, Q5111, or Q5120 to 12 combined units per DOS when billed by any provider and the diagnosis on the claim is chemotherapy-induced neutropenia, myelosuppressive radiation exposure, or post-stem cell transplant supportive care.
	Tufts Health Plan limits J2505 to three combined units per DOS when billed by any provider and the diagnosis on the claim is mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation.

Policy	Description
	Tufts Health Plan will not routinely compensate for J2505 when billed more than once every 12 days by any provider and the diagnosis is any of the following: Chemotherapy-induced neutropenia Mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation
	Tufts Health Plan limits J2505 to one unit per DOS when billed by any provider and the diagnosis on the claim is chemotherapy-induced neutropenia, myelosuppressive radiation exposure, or post-stem cell transplant supportive care.
	Tufts Health Plan will not routinely compensate J2505, Q5108, Q5120 or Q5111 when billed and the diagnosis on the claim is chemotherapy-induced neutropenia, and a diagnosis of neoplasm is not also present.
Pegloticase	Tufts Health Plan will not routinely compensate J2507 when billed and laboratory service for uric acid testing (84550) has not been billed for the same DOS or in the previous two weeks by any provider.
Pembrolizumab (Keytruda®)	Tufts Health Plan will not routinely compensate for pembrolizumab HCl (J9271) if an approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will not routinely compensate for pembrolizumab (J9271) when billed by any provider more than once every three weeks and the diagnosis on the claim is anal carcinoma, cervical cancer, cutaneous squamous cell carcinoma, endometrial carcinoma, esophageal cancer, esophagogastric junction cancer, extranodal NK/T-cell lymphoma, nasal type, gastric cancer, gestational trophoblastic neoplasia, head and neck cancer, hepatocellular carcinoma, Hodgkin's lymphoma (classical), malignant pleural mesothelioma, melanoma, Merkel cell carcinoma, microsatellite instability-high cancer (MSI-H) or mismatch repair deficient (dMMR) cancer, mycosis fungoides/Sezary syndrome, non-small cell lung cancer, primary mediastinal large B-cell lymphoma, renal cell carcinoma, small cell lung cancer, soft tissue sarcoma, thymic carcinoma, tumor mutational burden-high (TMB-H) cancer, urothelial carcinoma, or vulva cancer.
	Tufts Health Plan limits J9271 to 200 combined units per DOS by any provider and the diagnosis on the claim is malignant pleural mesothelioma, soft tissue sarcoma, thymic carcinoma, or vulvar cancer.
	Tufts Health Plan does not routinely compensate J9271 if: • Billed with modifier JW and the units equal or exceed 100 • when billed by any provider and the diagnosis on the claim is microsatellite instability-high (MSI-H) cancer, mismatch repair deficient (dMMR) cancer or tumor mutational burden high (TMB-H) cancer is present on the claim header and microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR) or tumor mutational burden testing (81301, 81479, 88341, 88342, 0037U)has not been previously billed in the patient's lifetime, or J9271 has not been billed in the previous year.
Pemetrexed (Alimta®)	Tufts Health Plan does not routinely compensate for J9304 or J9305 without a FDA-approved or an off-label recommended indication.
	Tufts Health Plan does not routinely compensate for J9305 if any of the following have not been billed by any provider for the same DOS or within the past 20 days: • 80050 (general health panel) • 80081 • 80055 (obstetrical panel) • 85004 (blood count, automated differential WBC count) • 85007 (blood count; blood smear with manual differential WBC count) • 85009 (blood count, manual differential WBC count) • 85025 (CBC, automated with WBC), 85027 (CBC, automated) • 85032 (blood count; manual cell count) • 85048 (leukocyte, automated) • 85049 (blood count; platelet, automated) • 82575 (creatinine clearance) • G0306 (CBC, automated with WBC) • G0307 (CBC, automated)
	Tufts Health Plan does not routinely compensate for chemotherapy administration codes other than IV push when billed with J9304 or J9305 and no other drug administered via chemotherapy administration has been billed for the same DOS.

Policy	Description
	Tufts Health Plan does not routinely compensate J9304 or J9305 when billed by any provider more than once every three weeks and the diagnosis on the claim is bladder cancer, gastric cancer, head and neck cancer, mesothelioma, non-small cell lung cancer, ovarian cancer, primary central nervous system lymphoma, thymoma or thymic carcinoma, or urothelial carcinoma of the prostate.
	Tufts Health Plan limits coverage of J9304 or J9305 to 156 combined units per DOS by any provider when the diagnosis on the claim is bladder cancer, breast cancer, or urothelial carcinoma of the prostate.
	Tufts Health Plan limits J9304 or J9305 to 130 combined units per DOS by any provider when the diagnosis on the claim is gastric cancer, head and neck cancer, mesothelioma, non-small cell lung cancer, or thymoma and thymic carcinoma.
	Tufts Health Plan does not routinely compensate J9305 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 10.
	Tufts Health Plan does not routinely compensate 96409 or 96411 (IV chemotherapy administration) if billed with J9304 or J9305 in any combination with more than one unit and no other drug administered by IV chemotherapy push has been billed for the same DOS by any provider.
Pertuzumab (Perjeta®)	Tufts Health Plan does not routinely compensate J9306 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J9306 when billed by any provider more than once every three weeks and the diagnosis on the claim is HER2-overexpressing metastatic breast cancer or HER2-overexpressing metastatic colorectal cancer
	Tufts Health Plan does not routinely compensate 96409 or 96411 (IV push chemotherapy administration) if billed with J9306 and no other drug administered by IV chemotherapy push has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J9306 when billed and the diagnosis on the claim is HER2-overexpressing metastatic breast cancer or HER2-overexpressing metastatic colorectal cancer, and HER2 testing has not been previously billed in the patient's lifetime, or J9306 has not been billed within the previous year by any provider.
	Tufts Health Plan does not routinely compensate J9306 when billed and the diagnosis on the claim is HER2-overexpressing metastatic breast cancer or HER2-overexpressing metastatic colorectal cancer, and trastuzumab (J9355, Q5112-Q5114, Q5116, Q5117 and J9356) has not been billed for the same DOS by any provider.
	Tufts Health Plan will limit J9306 to 420 units when billed and J9306 has been billed in the previous six weeks and the diagnosis is HER2-positive breast cancer or HER2-overexpressing metastatic colorectal cancer.
Plerixafor	Tufts Health Plan does not routinely compensate J2562 when billed and the diagnosis on the claim is mobilization of hematopoietic progenitor cells in patients with non-Hodgkin's lymphoma, or multiple myeloma and J1442, J1447, Q5101, or Q5110 (Granulocyte-colony stimulating factor) has not been billed in the previous four days by any provider
	Tufts Health Plan does not routinely compensate J2562 when billed and the diagnosis on the claim is mobilization of hematopoietic progenitor cells in patients with non-Hodgkin's lymphoma, or multiple myeloma and J1442, J1447, Q5101, or Q5110 (Granulocyte-colony stimulating factor) has not been billed for the same DOS by any provider.
Pralatrexate	Tufts Health Plan does not routinely compensate J9307 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20.
Radium Ra-223 Dichloride	Tufts Health Plan does not routinely compensate A9606 when billed with a diagnosis of secondary malignant neoplasm of bone and bone marrow, and a diagnosis of prostate cancer is not also present on the claim.
	Tufts Health Plan does not routinely compensate A9606 when billed by any provider with a diagnosis on the claim of prostate cancer and hematologic testing (neutrophils, platelets, hemoglobin) has not been billed for the same DOS or in the previous six days.

Policy	Description
Ramucirumab	Tufts Health Plan does not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J9308 and no other chemotherapy drug administered by intravenous push technique has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J9308 when billed by any provider more than one visit every two weeks and the diagnosis on the claim is colorectal cancer, esophageal cancer, esophagogastric junction cancer, gastric cancer, hepatocellular carcinoma, or non-small cell lung.
	Tufts Health Plan does not routinely compensate J9308 when billed by any provider more than one visit every three weeks and the diagnosis on the claim is urothelial carcinoma
	Tufts Health Plan will not routinely compensate J9308 when billed with a diagnosis of colorectal cancer and concomitant chemotherapy agent J9190 (5-Fluorouracil) or J9206 (Irinotecan) has not been billed by any provider for the same DOS.
	Tufts Health Plan will not routinely compensate J9308 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20.
Ranibizumab (Lucentis®)	Tufts Health Plan does not routinely compensate for ranibizumab (J2778) unless billed with intravitreal injection of a pharmacologic agent (67028).
	Tufts Health Plan does not routinely compensate for ranibizumab (J2778) when billed without an FDA-approved indication or an off-label indication.
	Tufts Health Plan does not routinely compensate J2778 when billed by any provider more than two unique visits per month and an FDA approved or an approved off-labeled indication is present.
	Tufts Health Plan does not routinely compensate 67028 (Intravitreal injection of a pharmacologic agent) when billed with J2778 and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.
	Tufts Health Plan limits J2778 to 10 units per month when billed by any provider and an FDA approved or an approved off-labeled indication is present.
Regadenoson (Lexiscan™)	Tufts Health Plan does not routinely compensate J2785 if billed and a myocardial stress test has not been billed on the same DOS.
Reslizumab	Tufts Health Plan does not routinely compensate J2786 when billed by any provider more than one visit per month and the diagnosis on the claim is severe asthma with eosinophilic phenotype.
Risperidon (Risperdal Consta)	Tufts Health Plan does not routinely compensate J2794 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J2794 when billed by any provider more than one unique visit every two weeks and the diagnosis on the claim is bipolar I disorder or schizophrenia.
Rituximab (Rituxan®)	Tufts Health Plan does not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J9312, Q5115, or Q5119 and no other drug administered by chemotherapy administration by intravenous push has been billed for the same DOS by any provider.
	Tufts Health Plan limits J9312, Q5115, or Q5119 to 98 combined units per DOS by any provider and the diagnosis on the claim is acquired factor VIII deficiency, acute lymphoblastic leukemia, AIDS-related B-cell lymphoma, autoimmune hemolytic anemia, B-cell lymphoma, Castleman's disease, chronic graft-versus-host disease following stem cell transplantation, epidermolysis bullosa acquisita, Epstein-Barr virus disease prophylaxis in stem cell transplantation, Evan's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hairy cell leukemia, human herpesvirus 8 (HHV-8) infection, immune checkpoint inhibitor-related toxicity (encephalitis), malignant ascites in non-Hodgkin's lymphoma, microscopic polyangiitis, multifocal motor neuropathy, nodular lymphocyte-predominant Hodgkin's lymphoma, pediatric aggressive mature B-cell lymphoma, post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, thrombotic thrombocytopenic purpura, or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed with a diagnosis of chronic graft-versus-host disease and a diagnosis of complications of stem cell transplant is not also present on the claim.

Policy	Description
	• Tufts Health Plan limits J9312, Q5115, or Q5119 to 100 combined units per DOS when the diagnosis on the claim is bullous pemphigoid, cryoglobulinemia, cryoglobulinemia-induced renal disease, dermatopolymyositis, eosinophilic granulomatosis with polyangiitis (Churg-Strauss), immune checkpoint inhibitor-related toxicity (bullous dermatosis), immune (idiopathic) thrombocytopenic purpura, lupus nephritis, mucous membrane pemphigoid, nephrotic syndrome, neuromyelitis optica, pemphigus foliaceus, pemphigus vulgaris, pre-renal transplant to suppress anti-HLA antibodies, rheumatoid arthritis, Sjogren's syndrome, or systemic lupus erythematosus.
	• Tufts Health Plan limits J9312, Q5115, or Q5119 to 130 combined units per DOS when the diagnosis on the claim is chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), immune checkpoint inhibitor-related toxicity (myasthenia gravis), myasthenia gravis, or primary central nervous system lymphoma.
	Tufts Health Plan limits J9312, Q5115, or Q5119 to 588 combined units every 26 weeks by any provider and the diagnosis on the claim is cryoglobulinemia, cryoglobulinemia-induced renal disease, immune (idiopathic) thrombocytopenic purpura, or neuromyelitis optica.
	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed ten.
	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed by any provider more than one visit per week and the diagnosis on the claim is acquired factor VIII deficiency, AIDS-related B-cell lymphoma, anti-MAG polyneuropathy, autoimmune hemolytic anemia, bullous pemphigoid, Castleman disease, chronic graft-versus-host disease following stem cell transplantation, component of Zevalin therapy, cryoglobulinemia, cryoglobulinemia-induced renal disease, dermatopolymyositis, epidermolysis bullosa acquisita, Epstein-Barr virus disease prophylaxis in stem cell transplantation, eosinophilic granulomatosis with polyangiitis (Churg-Strauss), Evan's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hairy cell leukemia, human herpesvirus 8 (HHV-8) infection, immune (idiopathic) thrombocytopenic purpura, immune checkpoint inhibitor-related toxicity (encephalitis), immune checkpoint inhibitor-related toxicity (myasthenia gravis), lupus nephritis, microscopic polyangiitis, minimal change disease, mucous membrane pemphigoid, multifocal motor polyneuropathy, multiple sclerosis, myasthenia gravis, nephrotic syndrome, neuromyelitis optica, nodular lymphocyte-predominant Hodgkin's lymphoma, pemphigus vulgaris, post-transplant lymphoproliferative disorder (PTLD), systemic lupus erythematosus, or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
Rituximab (Rituxan®)	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed by any provider more than eight visits every 26 weeks and the diagnosis on the claim is acute lymphoblastic leukemia, autoimmune hemolytic anemia, Castleman disease, chronic graft-versus-host disease following stem cell transplantation, chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), Epstein-Barr virus disease prophylaxis in stem cell transplantation, human herpesvirus 8 (HHV-8) infection, malignant ascites in non-Hodgkin's lymphoma, or thrombotic thrombocytopenic purpura.
	Tufts Health Plan does not routinely compensate 96413 (Chemotherapy administration, IV infusion technique, first hour) when billed with J9312, Q5115, or Q5119 and a diagnosis of diffuse large B-cell lymphoma or follicular non-Hodgkin's lymphoma (B-cell lymphomas) is not present, and 96415 (Chemotherapy administration, IV infusion technique, each additional hour) has not been billed for the same DOS.
	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed by any provider more than six visits every 26 weeks and the diagnosis on the claim is hairy cell leukemia.
	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed by any provider more than 11 visits every 26 weeks and the diagnosis on the claim is AIDS-related B-cell lymphoma, B-cell lymphoma, leptomeningeal metastases, pediatric aggressive mature B-cell lymphoma, or primary cutaneous B-cell lymphoma.

Policy	Description
	Tufts Health Plan does not routinely compensate J9312, Q5115, or Q5119 when billed by any provider more than one visit every three days and the diagnosis on the claim is acute lymphoblastic leukemia, B-cell lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), leptomeningeal metastases, malignant ascites in non-Hodgkin's lymphoma, pediatric aggressive mature B-cell lymphoma, primary central nervous system lymphoma, primary cutaneous B-cell lymphoma, or thrombotic thrombocytopenic purpura.
	Tufts Health Plan does not routinely compensate J9312, Q5115 or Q5119 when billed by any provider more than one visit every two weeks and the diagnosis on the claim is Grave's disease ophthalmopathy, immune checkpoint inhibitor-related toxicity (bullous dermatosis), pemphigus foliaceus, pre-renal transplant to suppress anti-HLA antibodies, rheumatoid arthritis, or Sjogren's syndrome.
	Tufts Health Plan will limit J9312 or Q5115 to 392 combined units in a patient's lifetime by any provider and the diagnosis on the claim is cryoglobulinemia or dermatopolymyositis.
Rituximab and Hyaluronidase	Tufts Health Plan will not routinely compensate J9311 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J9311 when billed and J9311 (Rituximab and hyaluronidase), or J9312, Q5115, Q5119 (Rituximab) has not been billed in the previous 12 weeks by any provider and the diagnosis on the claim is Castleman's disease, chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), diffuse large B-cell lymphoma (DLBCL), follicular lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorders, primary cutaneous B-cell lymphoma, or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
	Tufts Health Plan will not routinely compensate J9311 when billed and J9312 or Q5115 (Rituximab) has not been billed in the previous 21 weeks by any provider and the diagnosis is diffuse large B-cell lymphoma (DLBCL).
Romiplostim (Nplate®)	Tufts Health Plan does not routinely compensate J2796 if billed by any provider more than once a week and the diagnosis is chronic immune thrombocytopenia (ITP).
	Tufts Health Plan does not routinely compensate nonchemotherapy drug administration services (other than for subcutaneous technique) if billed with J2796 and no other drug administered by other than subcutaneous technique has been billed for the same DOS by any provider.
	Tufts Health Plan will not routinely compensate J2796 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will not routinely compensate J2796 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.
Sipuleucel-T	Tufts Health Plan does not routinely compensate Q2043 if billed with an inappropriate bill type.
Sodium hyaluronan or derivative (Euflexxa®)	Tufts Health Plan limits J7321, J7323, J7324, J7326, J7327, or J7333 to two combined units per DOS by any provider and the diagnosis on the claim is osteoarthritis of the knee.
	Tufts Health Plan limits J7325 to 96 combined units per DOS by any provider and the diagnosis on the claim is osteoarthritis of the knee.
	Tufts Health Plan does not routinely compensate 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) when billed with J7318, J7320-J7329, or J7331-J7333 and modifier LT (Left side) or RT (Right side), or 50 (Bilateral procedure) is not appended to 20610 or 20611.
	Tufts Health Plan does not routinely compensate 20610 or 20611 (Arthrocentesis, aspiration and/or injection; major joint) when billed with J7318, J7320-J7329, J7331, J7332, or J7333 and the diagnosis on the claim is not osteoarthritis of the knee or shoulder.
	Tufts Health Plan does not routinely compensate J7318, J7320-J7329, J7331, J7332, or J7333 when billed by any provider more than six visits every 26 weeks and the diagnosis on the claim is osteoarthritis of the knee.
	Tufts Health Plan does not routinely compensate J7324 when billed by any provider more than eight visits every 26 weeks and the diagnosis on the claim is osteoarthritis of the knee.

Policy	Description
	Tufts Health Plan does not routinely compensate J7318, J7320-J7329, J7331, J7332, or J7333 when billed without 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) for the same DOS.
	Tufts Health Plan does not routinely compensate J7318, J7320-J7329, J7331, J7332, or J7333 when billed by any provider more than two visits per week and the diagnosis on the claim is osteoarthritis of the knee.
Taliglucerase alfa	Tufts Health Plan does not routinely compensate J3060 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20.
TBO-filgrastim (GRANIXTM)	Tufts Health Plan does not routinely compensate for TBO-filgrastim (J1447) when billed by any provider on the same DOS as a cytotoxic chemotherapy drug.
	Tufts Health Plan will not routinely compensate J1447 when billed and the diagnosis on the claim is agranulocytosis secondary to cancer chemotherapy and a diagnosis of neoplasm is not also present.
	Tufts Health Plan limits J1447 to 300 units per DOS by any provider and the diagnosis on the claim is myelodysplastic syndrome.
	Tufts Health Plan limits J1447 to 680 units per DOS by any provider and the diagnosis on the claim is chemotherapy-induced neutropenia, or post-hematopoietic cell transplant supportive care.
	Tufts Health Plan does not routinely compensate J1447 when billed and J2505, Q5108, Q5111 or Q5120 (Pegfilgrastim) has been billed on the same DOS or within the previous 13 days.
	Tufts Health Plan will not routinely compensate J1447 when billed and the diagnosis on the claim is chemotherapy-induced neutropenia, HIV-induced neutropenia, myelodysplastic syndrome, post-hematopoietic cell transplant supportive care, or progenitor stem cell mobilization and a CBC has not been billed by any provider for the same DOS or within the past week.
Tocilizumab (Actemra®)	Tufts Health Plan limits coverage of tocilizumab (J3262) to 800 units for the diagnosis of rheumatoid arthritis.
	Tufts Health Plan limits J3262 to 162 combined units per DOS by any provider when the diagnosis on the claim is giant cell arteritis.
	Tufts Health Plan limits J3262 to 5600 combined units every 26 weeks by any provider and the diagnosis on the claim is rheumatoid arthritis.
	Tufts Health Plan does not routinely compensate J3262 if billed with modifier JW and the units equal or exceed 80, and 96365-96368 (IV infusion) is present on the claim.
Trabectedin	Tufts Health Plan does not routinely compensate J9352 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate J9352 when billed by any provider more than once every three weeks and the diagnosis is soft-tissue sarcoma or uterine sarcoma.
Trastuzumab (Herceptin®)	Tufts Health Plan does not routinely compensate for J9355, Q5112-Q5114, Q5116, or Q511 if billed without an FDA-approved indication or an approved off-labeled indication.
	Tufts Health Plan does not routinely compensate for 96409 or 96411 (intravenous push chemotherapy administration) when billed with J9355, Q5112-Q5114, Q5116, or Q5117 unless another drug administered by chemotherapy administration has been billed for the same DOS by any provider.
	Tufts Health Plan does not routinely compensate J9355, Q5112-Q5114, Q5116, or Q5117 when billed by any provider more than one unique visit every two weeks and the diagnosis on the claim is HER2-overexpressing esophageal cancer, HER2-overexpressing esophagogastric junction cancer, or HER2-overexpressing gastric cancer.
	Tufts Health Plan does not routinely cover J9355, Q5112-Q5114, Q5116, or Q5117 when billed by any provider more than one unique visit per week and the diagnosis on the claim is HER2-overexpressive breast cancer or HER2-overexpressing colorectal cancer.
	Tufts Health Plan limits 96415 to one unit when billed with J9355, Q5112-Q5114, Q5116, or Q5117 and no other chemotherapy drug administered by IV infusion for greater than one hour has been billed for the same DOS by any provider.

Policy	Description
	Tufts Health Plan will limit J9355, Q5112-Q5114, Q5116, or Q5117 to 762 combined units every 26 weeks by any provider and the diagnosis on the claim is HER2-overexpressing colorectal cancer, HER2-overexpressing endometrial carcinoma, HER2-overexpressing esophageal cancer, HER2-overexpressing esophagogastric junction cancer, or HER2-overexpressing gastric cancer
	Tufts Health Plan limits J9355, Q5112-Q5114, Q5116, or Q5117 to 109 combined units per DOS by any provider and the diagnosis on the claim is HER2-overexpressing breast cancer, HER2-overexpressing colorectal cancer, HER2-overexpressing endometrial carcinoma, HER2-overexpressing esophageal cancer, HER2-overexpressing esophagogastric junction cancer, or HER2-overexpressing gastric cancer.
Treprostinil	Tufts Health Plan will limit J7686 to one unit per DOS by any provider when billed and the diagnosis is pulmonary arterial hypertension.
Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation	Tufts Health Plan will not routinely compensate J3304 when billed and 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) has not been billed for the same DOS.
	Tufts Health Plan does not routinely compensate J3304 when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan does not routinely compensate 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) when billed with J3304 and modifier LT (Left side) or RT (Right side), or 50 (Bilateral procedure) is not appended to 20610 or 20611.
Triptorelin Pamoate (Trelstar®)	Tufts Health Plan does not routinely compensate for J3315 if billed without an FDA-approved indication or an approved off-label indication.
Ustekinumab	Tufts Health Plan does not routinely compensate J3358 when billed and J3357 or J3358 has been billed by any provider in the previous eight weeks and the diagnosis on the claim is regional enteritis (Crohn's disease) or ulcerative colitis.
Vedolizumab (Entyvio®)	Tufts Health Plan does not routinely compensate J3380 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits J3380 to 300 combined units per DOS and/or 5 times every 26 weeks by any provider and the diagnosis is regional enteritis (Crohn's disease) or ulcerative colitis.
Velaglucerase (VPRIV®)	Tufts Health Plan does not routinely compensate J3385 when billed by any provider more than one visit every two weeks and the diagnosis is Gaucher disease.
	Tufts Health Plan does not routinely compensate J3385 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 4.
Vincristine Sulfate Liposome	Tufts Health Plan does not routinely compensate J9371 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Ziv-Aflibercept	Tufts Health Plan does not routinely compensate J9400 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Zoledronic acid (Reclast®, Zometa®)	Tufts Health Plan does not routinely compensate J3489 when billed with a diagnosis of long term use of aromatase inhibitors and personal history of breast cancer, and a diagnosis of disorder of bone density and structure is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J3489 when billed without an FDA approved indication or an off-label recommended indication.
	Tufts Health Plan does not routinely compensate for J3489 when billed more than once every three weeks and the diagnosis is bone metastasesor multiple myeloma.
	Tufts Health Plan limits coverage of J3489 to four units per DOS when billed by any provider and the diagnosis is bone metastases, early breast cancer in women with postmenopausal reproductive hormone levels, hypercalcemia of malignancy, monoclonal gammopathy of uncertain significance with osteopenia or osteoporosis, multiple myeloma, postmenopausal women taking letrozole for early breast cancer, or prostate cancer patients receiving androgen deprivation therapy.
	Tufts Health Plan does not routinely compensate J3489 when billed with a diagnosis of long term use of other medications and personal history of prostate cancer, and a diagnosis of disorder of bone density, and structure is not also present on the claim.

Policy	Description
	Tufts Health Plan does not routinely compensate J3489 when billed by any provider more than once per year and the diagnosis is glucocorticoid-induced osteoporosis, heterotopic ossification (myositis ossificans), Volkmann's ischemic contracture, osteoporosis in men, postmenopausal osteoporosis treatment, or systemic mastocytosis osteoporosis.
	Tufts Health Plan limits J3489 to five units per DOS when billed by any provider and the diagnosis is glucocorticoid-induced osteoporosis, heterotopic ossification (myositis ossificans), Volkmann's ischemic contracture, osteitis deformans (Paget's disease), osteoporosis in men, postmenopausal osteoporosis prophylaxis, postmenopausal osteoporosis treatment, or systemic mastocytosis osteoporosis.
	Tufts Health Plan does not routinely compensate J3489 when billed and the patient is less than 18 years of age and an FDA approved or an approved off-labeled indication is present.