BIO
BIOTECHNOLOGY
INDUSTRY ORGANIZATION

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BY ELECTRONIC DELIVERY

Kerry N. Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1404-P (Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates)

Dear Acting Administrator Weems:

The Biotechnology Industry Organization (BIO) is pleased to submit the following comments on the Centers for Medicare and Medicaid Services' (CMS) final rule regarding revisions to the hospital outpatient prospective payment system (OPPS) and 2009 payment rates, published in the Federal Register on July 18, 2008 (the "Proposed Rule").[1] BIO is the largest trade organization to serve and represent the biotechnology industry in the United States and around the globe. BIO represents more than 1,150 biotechnology companies, academic institutions, state biotechnology centers, and related organizations in the United States. BIO members are involved in the research and development of health care, agricultural, industrial and environmental biotechnology products.

As the representative of an industry that is devoted to improving health care through the discovery of new therapies, BIO understands that appropriate reimbursement based on an accurate payment methodology is essential to protecting beneficiary access to care and encouraging continued investment in innovation. We are extremely concerned that CMS proposes to continue to use a rate-setting methodology for drugs and biologicals that studies by the Medicare

[1] 73 Fed. Reg. 41416 (July 18, 2008).

Payment Advisory Commission (MedPAC), CMS's contractor, RTI International, and stakeholder analyses have shown to be deeply flawed. Based on this methodology, CMS reduced reimbursement for most separately paid drugs and biologicals from average sales price (ASP) plus six percent to ASP plus five percent in 2008, and proposes to reduce payments again in 2009 to ASP plus four percent, with no adjustment for pharmacy service costs. Although CMS recognizes that charge compression creates inaccurate cost estimates and payment rates, the agency does not propose to correct this problem immediately, but instead proposes complex and burdensome changes to cost reports in the hopes of being able to set more accurate rates in 2011. BIO believes that a much simpler and effective solution is available to CMS right now, and we urge the agency to pay for the acquisition cost of drugs and biologicals at ASP plus six percent and implement the pharmacy stakeholder group proposal to reimburse hospitals more appropriately for drugs, biologicals, and pharmacy services in 2009.

Our comments also address the reconfiguration of the drug administration ambulatory payment classifications (APCs), payment for intravenous immune globulin (IVIG) preadministration services, packaging of diagnostic radiopharmaceuticals and contrast agents, payment for clotting factors, and payment for drugs and biologicals in Ambulatory Surgical Centers (ASCs).

In short, we recommend that CMS:

- pay no less than ASP plus six percent for the acquisition cost of drugs and biologicals administered in hospital outpatient departments and implement the pharmacy stakeholder proposal to pay for pharmacy services in 2009;
- make separate payment for all drugs and biologicals with Health Care Common Procedure Coding System (HCPCS) codes or alternatively, not increase the packaging threshold for these therapies;
- comply with the statute and Congressional intent by reinstating separate payment for contrast agents and diagnostic radiopharmaceuticals;
- reimburse clotting factors at ASP plus six percent;
- implement the proposed reconfiguration of the drug administration APCs and study the effects of RTI's recommendations to improve payment accuracy on the revised APCs;
- continue payment for preadministration-related services for IVIG;

- apply any changes CMS makes to improve access to drugs and biologicals in hospital outpatient departments to ASCs as well;
- continue efforts to expand quality reporting in the outpatient setting, but regularly update quality measures to reflect standard-of-care and add coordination of care measures as soon as possible;
- establish a sub-regulatory process for updating technical specifications of quality measures;
- refrain from expanding its hospital-acquired conditions payment policy until it has garnered additional experience with the payment mechanism in the inpatient setting, has resolved issues regarding causation in the outpatient setting, and has obtained comments on the proposal in its entirety; and
- change the date of service from the date of collection to the date of performance for certain novel laboratory-developed tests.

These comments are discussed in detail below.

I. CMS should pay no less than ASP plus six percent for the acquisition cost of drugs and biologicals administered in hospital outpatient departments and should implement the pharmacy stakeholder proposal to pay for pharmacy services. [Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Status]

A. CMS should pay no less than ASP plus six percent for the acquisition cost of drugs and biologicals administered in the OPPS.

In the OPPS proposed rule for 2009, CMS proposes to reduce payment for separately paid drugs and biologicals that do not have pass-through status to ASP plus 4 percent.[2] By making this proposal, CMS disregards the findings of its own contractor – RTI, MedPAC, and numerous stakeholders that the current payment methodology for drugs and biologicals is deeply flawed and produces inaccurate rates. Three years ago, MedPAC reported that hospitals incur significant pharmacy service costs that are not reflected in the charges or payment rates for individual

[2] Id. at 41490.

drugs. Last year, RTI reported that CMS's cost estimates for drugs and biologicals are distorted and produce inaccurate payment rates, and its most recent report confirms that charge compression and other data problems create inaccurate payment rates for both the inpatient and outpatient payment systems. Our own analysis found that CMS's methodology produces wide variations in cost estimates on a drug-by-drug basis and significantly underestimates the acquisition and pharmacy service costs of separately paid drugs. Moreover, in addition to its methodological flaws, CMS's approach to setting payment rates violates Congressional intent and the plain language of the Social Security Act (SSA). We discuss each of these analyses below.

In 2006, CMS commissioned a study from RTI on the accuracy of the agency's rate setting methodology under the inpatient prospective payment system. After RTI's report found that charge compression creates significant problems with this methodology, CMS recognized that the problems also could affect the OPPS, and the agency asked RTI to expand its analysis to cover both payment systems. RTI's report, released in July 2008, concludes that CMS's methodology for estimating aggregate average acquisition and pharmacy service and handling cost substantially underestimates the actual costs of acquiring and supplying separately paid drugs and biologicals.[3] Using RTI's calculations of more accurate cost-to-charge ratios (CCR), we calculated an estimated mean unit cost for separately paid drugs of ASP plus 20 percent. RTI recommends that CMS take steps in the short term to calculate drug and biological costs more accurately. In its comments on the inpatient PPS, MedPAC agreed with RTI's conclusion that immediate action is needed to improve the accuracy and fairness of Medicare's payment rates.[4]

The RTI report corroborates our conclusion that CMS's methodology produces inaccurate cost estimates. As we have explained in comments on prior years' rules, CMS's methodology clearly produces inaccurate and unpredictable results on a drug-by-drug basis and in the aggregate because it fails to account for charge compression. The agency's estimated costs for all drugs and biologicals, compared to ASP on a drug-by-drug basis, fail to recognize hospitals' variability in setting charges or adjust for the fact that hospitals tend to mark up their charges for

[3] Kathleen Dalton et. al., Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights, July 2008, at 6.

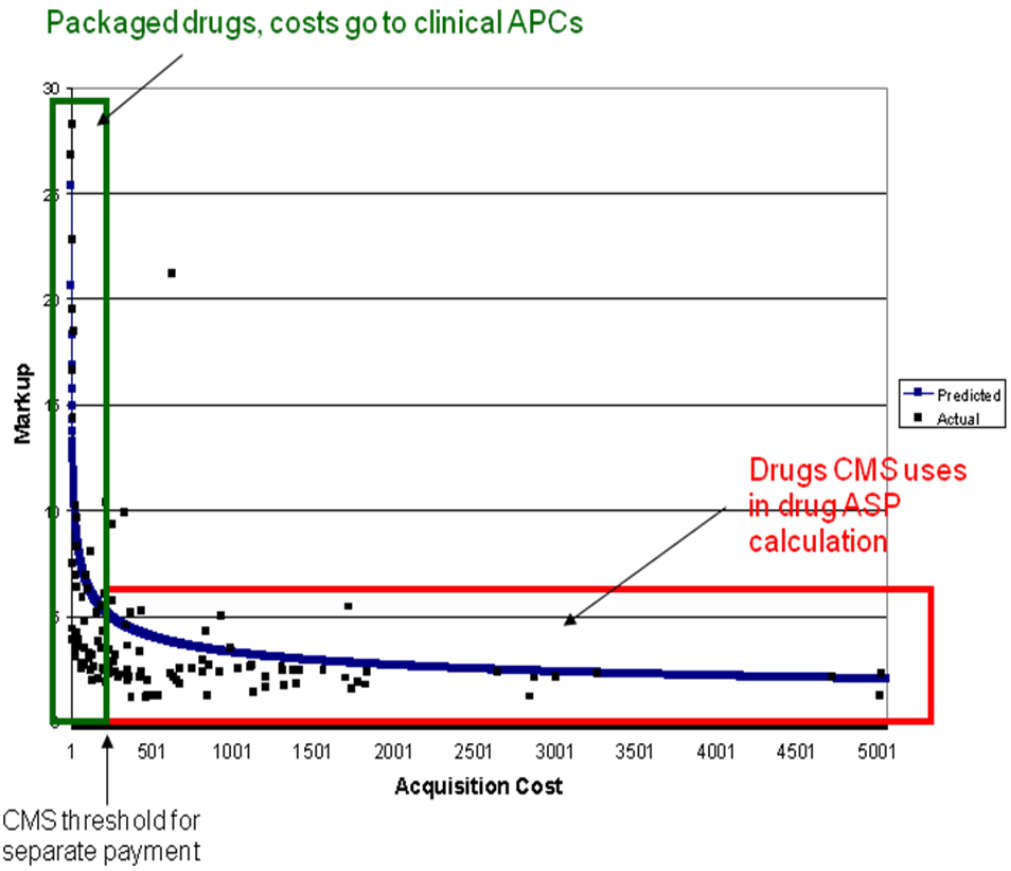
[4] See Letter from G. Hackbarth, Chairman, MedPAC, to K. Weems, Acting Administrator, CMS, regarding file Code CMS-1390-P [the inpatient prospective payment system proposed rule for 2009], June 10, 2008, at http://www.medpac.gov/documents/06102008_IPPS_comment_JS.pdf.

more costly drugs and biologicals less than their charges for lower priced therapies. CMS's methodology also results in findings that are inaccurate and vary widely. Our own analysis found that CMS's methodology produces estimated average unit costs, stated as a percentage of ASP, that range from ASP minus 97 percent to ASP plus 8869 percent.

In addition, because CMS applies the CCR for all drugs to the separately paid drugs – a group of drugs that tend to have smaller mark-ups than lower cost packaged drugs – the agency underestimates the costs associated with separately paid drugs in the aggregate. CMS's methodology assumes that hospitals allocate their overhead costs evenly among all drugs by applying a uniform percentage markup to each drug. As CMS acknowledges in the Proposed Rule, BIO and other stakeholders have explained that "CMS' methodology of using a single CCR to determine the acquisition and pharmacy overhead cost for all drugs attributes a greater relative share of pharmacy overhead cost to the lower-priced packaged drugs and a lower relative share of pharmacy overhead cost to the more expensive, separately payable drugs."[5] As a result, the estimated cost of separately paid drugs and biologicals produced by CMS's methodology – ASP plus four percent – greatly underestimates the true overhead costs associated with those therapies. A CCR derived from all drugs will only create accurate estimates when applied to all drugs. By applying the CCR derived from all drugs to only a subset of those drugs, CMS artificially skews estimated costs lower because pharmacy services and handling costs associated with those drugs are not distributed within that group; they are packaged into the APCs. As a result, the average CCR for all drugs is lower than the actual CCR for this subset. Applying the CCR for all drugs to all drugs is a simple solution that yields a more accurate estimate. The graphic on the following page illustrates this issue.

[5] 73 Fed. Reg. at 41491.

Illustration 1: Drugs Included in CMS' Calculation Have Lower Percentage Markup



The effect of CMS's methodology on the allocation of overhead costs between separately paid and packaged drugs can be seen if we replicate the methodology using different packaging thresholds. At the current packaging threshold of $60 per day, the mean unit cost of separate paid drugs is ASP plus four percent. This reflects allocation of a disproportionately large share of overhead costs to the packaged drugs. If CMS set the packaging threshold at zero dollars and paid separately for all drugs with HCPCS codes, it would achieve a mean unit cost, on average, of ASP plus 13 percent. When all drugs are separately paid, the methodology allocates the overhead costs evenly to all drugs. As the packaging threshold is increased, however, the opposite effect happens – the estimated mean acquisition cost declines as the share of overhead costs allocated to separately paid drugs declines. If CMS set the packaging threshold at $150, it would achieve a mean unit cost of ASP plus 1.9 percent. If CMS set the packaging threshold at $500, it would achieve a mean unit cost of ASP minus 11.1 percent.

Obviously, hospitals do not acquire the more costly drugs at ASP minus 11.1 percent or have negative overhead costs for these drugs. Therefore, CMS's allocation of overhead costs to the separately paid drugs must be incorrect at any level.

Rather than taking immediate action to correct its flawed methodology, CMS instead proposes to implement burdensome changes to hospital's cost reports that could collect data that would affect payment rates no earlier than 2011, and this proposal would do nothing to improve payment accuracy in the meantime. A timeframe of 2011 is conservative given CMS's experience with slow hospital implementation of the Nuclear Medicine revenue code and cost center changes that have taken several years to see significant reporting. There is no justification for any further delay in establishing appropriate payments for critical drug and biological therapies and the important pharmacy services necessary to administer them safely. We urge CMS to act now to establish appropriate reimbursement for drugs, biologicals, and related pharmacy services in the final rule for 2009.

In addition to these methodological issues, we have identified another reason why CMS's cost estimates do not reflect the actual costs of acquiring and preparing drugs and biologicals at most hospitals. CMS calculates mean unit costs using data from all hospitals, including hospitals that purchase drugs and biologicals under the 340B program. Sales under the 340B program are excluded from the ASP calculation, however. Thus, CMS is mixing apples with oranges in its rate-setting calculations for these therapies.

As detailed in Attachment A and B, the 340B program aims to improve access to care for poor and uninsured by allowing certain hospitals and other entities that serve those patients to purchase drugs at deep discounts. Approximately one-third of all billed drugs and biologicals (by cost) under the OPPS are provided by 340B hospitals. Although the discounts are designed to help the 340B hospitals better serve their patients, including drugs purchased at 340B prices in the OPPS payment rate calculations could harm access to care at non-340B hospitals by significantly reducing the estimated mean unit cost of separately paid drugs. When these hospitals are included, the estimated mean unit cost for separately paid drugs is ASP plus 4 percent. When these hospitals are excluded, the mean unit cost rises to ASP plus 7.6 percent. Because the 340B program was not intended to harm access to care for patients of other hospitals, we

believe that these hospitals should be excluded from the OPPS payment calculations. By correctly applying the CCR for all drugs and biologicals and excluding 340B hospitals from the OPPS payment calculations, the mean unit cost is 16 percent. These results are summarized in the table below based on an analysis of the 2007 claims file.

Markup of Cost over ASP (the X in Cost = ASP +X%), by Hospital 340B status

	All Hospitals	Non-340B	340B
Mathematically correct: Using CCR across all drugs	12.5%	16.0%	7.40%
CMS Methodology: Using CCR on separately-paid only	4.0%	7.6%	-1.10%
340B impact on average cost	**-3.6%**		

Note: 2009 File Analysis (2007 claims)

Overall, we urge CMS to pay at a minimum ASP plus six percent for drugs and biologicals administered in the OPPS in 2009 as CMS further evaluates options for improving payment accuracy. This rate would ensure that hospitals are reimbursed appropriately for the acquisition costs of drugs and biologicals. Payment at ASP plus six percent is supported by our analysis of mean unit costs for non-340B hospitals yet is less than the estimated costs calculated using RTI's recommended changes to CMS's methodology. Moreover, unlike CMS's current methodology, reimbursement for acquisition cost at ASP plus six percent is consistent with Congressional intent and the plain language of the Medicare statute. The SSA requires Medicare to reimburse specified covered outpatient drugs (SCODs) at the "average acquisition cost for the drug for the year," as determined by the Secretary using survey data.[6] If acquisition cost data are not available, the payment shall be set at the average price for the drug established under section 1842(o), 1847A, or 1847B (e.g., ASP plus 6 percent or the rates determined under the Competitive Acquisition Program).[7]

Since the Government Accountability Office (GAO) concluded its survey of acquisition cost in 2004, neither GAO nor CMS has conducted the subsequent periodic surveys required by the statute, and therefore CMS does not have the data necessary to set payment at average acquisition cost. We appreciate that these

[6] SSA § 1833(t)(14)(A)(iii)(I).
[7] SSA § 1833(t)(14)(A)(iii)(II).

surveys are difficult to conduct and generally have supported the use of ASP plus six percent as a proxy for acquisition cost instead of asking the agency to incur the administrative and financial burden of conducting additional surveys. We continue to believe that ASP plus six percent would be a reasonable payment for acquisition cost. We believe it is inconsistent with both the language and the intent of the statute to use aggregate costs derived from charges as a proxy for average acquisition cost and pharmacy service and handling costs for each drug when CMS's current methodology for calculating those costs is severely flawed and does not even approximate acquisition cost alone—much less acquisition *and* handling costs. Congress enacted these provisions because it disagreed with CMS's use of claims data to set payment rates for these drug and biological therapies. The statute requires CMS to use either an accurate methodology to determine average acquisition cost for each drug or the rates established under sections 1842(o), 1847A, or 1847B. Accordingly, we urge CMS to pay at least ASP plus six percent for the acquisition cost of drugs and biologicals administered in the OPPS.

B. CMS should implement the pharmacy stakeholder proposal to ensure that pharmacy service costs are more adequately reimbursed.

In addition to proposing to reduce reimbursement for most separately paid drugs and biologicals, CMS again proposes to make no additional payment for the substantial pharmacy service costs associated with these therapies. To provide drugs safely and prevent medication errors, hospitals incur the significant costs of complex and resource-intensive pharmacy services. In 2005, MedPAC reported that pharmacy department wages, salaries, fringe benefits, and supplies made up 26 to 28 percent of pharmacy department direct costs.[8] MedPAC noted that most hospitals do not set charges for handling costs and lack precise information about the magnitude of these expenses;[9] therefore, to the extent that these costs are included in hospitals' charges for drugs, it is unlikely that the charges for any individual drug or biological reflect the costs of the pharmacy services associated with providing that therapy. Instead, these costs may be included in hospitals' charges for all drugs and biologicals in the aggregate. Thus, any estimate of these costs also must consider all drugs and biologicals dispensed by hospital pharmacies, not just the therapies that are separately reimbursed under the OPPS.

[8] MedPAC, Report to the Congress: Issues in a Modernized Medicare Program, June 2005, at 140.
[9] Id. at 139-140.

When CMS's methodology is applied to all drugs with HCPCS codes, including the drugs and biologicals that are packaged under the OPPS, the mean unit cost, on average, is ASP plus 13 percent. These rates are more likely to represent hospitals' pharmacy service costs plus drug acquisition costs in the aggregate than CMS's proposed rate of ASP plus four percent.

By failing to account for hospitals' significant costs of safely preparing and handling drugs and biological products, CMS disregards Congressional intent, MedPAC's findings, the APC Panel's recommendations, and the advice of numerous stakeholders. We believe that the reasons CMS gave in the final rule for 2007 for not setting payment at rates determined by its estimation methodology remain valid in 2008. Specifically, CMS noted that its methodology produced a payment rate for both drug acquisition and pharmacy service costs (ASP plus four percent) that was comparable to the GAO's survey data for acquisition cost only.[10] We see no reason to believe that ASP plus four percent would be any more appropriate in 2009 than ASP plus four percent was in 2007.

For these reasons, we urge CMS to implement the stakeholder proposal to reimburse hospitals more accurately for drug and biological acquisition and pharmacy service costs. Under this proposal, CMS would create a pool of available funds that best represents the cost of critical pharmacy services in the complex hospital environment by setting the payment for all drugs and biologicals at no less than ASP plus six percent. Separately paid drugs would be reimbursed at no less than ASP plus six percent, and for packaged drugs, the cost of the drug attributed to the cost of the associated procedure would be at least ASP plus six percent for the drug. CMS then could set aside in a separate pool the difference between estimated mean unit cost as calculated for all drugs with HCPCS codes (currently, ASP plus 13 percent) and payment for acquisition cost (ASP plus six percent).

At its March 2008 meeting, the APC Panel recommended that CMS work with stakeholders to conduct an impact analysis of the proposal. In the Proposed Rule, CMS notes that the stakeholder proposal is "administratively simple" for hospitals to implement and that it would "estimate pharmacy overhead cost in a budget neutral manner without redistributing money from nondrug components of

[10] 71 Fed. Reg. 68059, 68091 (Nov. 24, 2006).

other services to payment for drugs."[11] We agree with these conclusions. In contrast, CMS's proposal to split the cost center into drugs with high overhead costs and drugs with low overhead costs charged to patients would require significant changes in hospital's practices and would impose substantial administrative burdens. The data produced by this change would likely not merit the investment of significant time and effort by CMS and hospitals to implement these changes. CMS has the power to correct payment inaccuracies now while also being sensitive to hospital's operational realities.

CMS notes that the stakeholder proposal would be a "highly significant change" to CMS's established methodology, and the agency is concerned about the implications of the proposal for the agency's methods of estimating costs of items packaged into primary services. We believe this change to CMS's methodology is justified and has no implications for the estimates of costs of other items. Drugs and biologicals are unique because the statute establishes a specific methodology for measuring their cost – ASP. No other item or service within the OPPS has a similar market-based mechanism for identifying its cost. Furthermore, CMS already treats drugs and biologicals differently from other items and services under the OPPS by applying a packaging threshold and establishing payment based on a comparison of mean unit cost to ASP. In light of these deviations from CMS's standard rate-setting methodology, using ASP for both separately paid and packaged drugs instead of the current inaccurate estimation methodology is appropriate and warranted. After all, the reallocation of overhead is necessary because of the agency's decision to create a packaging threshold. Paying separately for all drugs and biologicals with HCPCS codes, as discussed below, also could solve the problem.

Congress intended that drugs and biologicals be treated uniquely in the OPPS by establishing ASP plus six percent as the appropriate payment rate for separately paid drugs when specific information about "actual acquisition cost for the drug for the year" is not available. Fulfilling this intent would have no implications for the estimates of costs of other items within the payment system as these other items are treated differently under the statute. Further, the stakeholder methodology relies on CMS's own data, and no external data are required. The methodology merely would have CMS package drugs at an imputed rate of ASP plus six percent. CMS's data then would be used again to calculate the aggregate

[11] 73 Fed. Reg. at 41489.

estimated mean unit cost of all drugs and biologicals with HCPCS codes and ASPs using CMS's current costs-reduced-to-charges methodology. The difference between this amount and the amount when valuing those same drugs and biologicals at ASP plus six percent, creates the pharmacy services and handling pool to be reallocated to the separately paid drugs and biologicals.

In the Proposed Rule, CMS also notes that "it is not clear to use what approach for redistributing pharmacy overhead dollars would be most accurate and operationally feasible for CMS."[12] We recommend that CMS allocate the funds in the pharmacy services pool by setting different payments for each of three tiers of pharmacy services representing low, medium, and high complexity. CMS would assign all separately paid drugs and biological products to one of these pharmacy service categories and would make a payment for pharmacy services automatically each time a hospital bills one of these therapies. Payment rates for the three categories would use roughly the same ratios MedPAC suggested. Our estimates would set the payment rates at $12.50, $38, and $65. This would be similar to the plan recommended by the APC Panel in the past and could be implemented through the OPPS pricer without requiring changes to how hospitals code their services.[13] It also is broadly supported by the stakeholder group and would be both accurate and operationally feasible for CMS. We believe this stakeholder proposal has been sufficiently analyzed and should be implemented in 2009. Included at the end of our comments in Attachment C is the file of HCPCS assignments to the "high", "medium" and "low" overhead categories developed by the broad stakeholder group.

C. CMS should make separate payment for all drugs and biologicals with HCPCS codes or alternatively, not increase the packaging threshold for these therapies.

CMS proposes to maintain the packaging threshold at $60 and to continue to package payment for all diagnostic radiopharmaceuticals and contrast agents.[14] BIO believes that CMS should make separate payment for all drugs and biologicals with HCPCS codes in the OPPS just as it does for these therapies when they are

[12] Id. at 41490.
[13] APC Panel on Ambulatory Payment Classification Groups, Recommendations: March 7-8, 2007, at 2, http://www.cms.hhs.gov/FACA/Downloads/Mtg_Rpt_0372007.zip.
[14] 73 Fed. Reg. at 41485-86.

administered in a physician office. Although we recognize this is inconsistent with the agency's desire to increase packaging across the board, BIO believes that paying separately for HCPCS-coded drugs and biologicals would help ensure appropriate reimbursement to hospitals while the agency is working on more permanent fixes for charge compression and adequate payment for pharmacy services and overhead. In addition, paying separately for all drugs and biologicals with HCPCS will remove the incentives currently built into the OPPS that discourage hospitals from using packaged therapies that might be the most appropriate clinically. It also would help to improve transparency for beneficiaries attempting to compare the costs of treatment in different settings and would eliminate site-of-service reimbursement differentials that could inappropriately drive where care is delivered.

Separately reimbursing all drugs and biologicals with HCPCS codes would not increase hospitals' administrative burdens because hospitals are strongly encouraged to code for these drugs currently.[15] Our analysis of claims data indicates that hospitals indeed are coding for many of these therapies. In fact, paying separately for these therapies should only further encourage hospitals to code correctly, improving the data upon which future rates will be set.

Moreover, such treatment is consistent with payment in the physician office setting and would be more equitable for hospitals. In the past, CMS has expressed concern that differences in reimbursement methodologies should not drive patient care from one setting to another. Yet this is precisely what will occur if all drugs and biological products with HCPCS codes are reimbursed at ASP plus six percent in the physician office but only certain drugs are paid separately in the hospital outpatient department, and the reimbursement rate for those drugs is less. These differences also are counter to the transparency initiative and make it difficult for beneficiaries to compare costs for care administered in different settings.

Although we are opposed to packaging payment for any drugs or biologicals in principle, BIO does appreciate that CMS has proposed to maintain the packaging threshold at $60 rather than increasing it substantially. In the absence of CMS deciding to pay separately for all drugs and biologicals with HCPCS codes,

[15] January 2006 Update of the OPPS: Summary of Payment Policy Changes, OPPS PRICER Logic Changes, and Instructions for Updating the Outpatient Provider Specific File (OPSF), Transmittal 804, Change Request 4250, Jan. 3, 2006, at 12.

BIO urges CMS to finalize the proposed $60 packaging threshold and to freeze it at this level permanently. At a minimum, CMS should not increase the threshold until the bigger issues of charge compression and adjustments for pharmacy services and overhead have been resolved.

BIO supports CMS's proposal to continue to make separate payment for all oral and injectable forms of 5HT3 anti-emetics.[16] We agree that CMS should "continue to ensure that Medicare's payment rules do not impede a beneficiary's access to particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician."[17] We also believe this desire should influence Medicare's payment policy for all therapies, and CMS should eliminate the packaging threshold for all drug and biological products accordingly.

II. CMS should comply with the statute and Congressional intent by reinstating separate payment for contrast agents and diagnostic radiopharmaceuticals. [Proposed Payment for Diagnostic Radiopharmaceuticals and Contrast Agents]

CMS proposes to continue packaging payment for all diagnostic radiopharmaceuticals and contrast agents into the payment for the associated procedure, regardless of their per day costs.[18] Starting in 2008, CMS packaged payment for all diagnostic radiopharmaceuticals and contrast agents believing that these therapies can be treated differently from other SCODs because the statutory packaging threshold has expired. CMS further states that these drugs "function effectively as supplies that enable the provision of an independent service, rather than serving themselves as the therapeutic modality."[19] This reasoning ignores the clear language of the statute and Congressional intent. The statute defines a SCOD as a "covered outpatient drug for which a separate ambulatory payment classification group (APC) has been established" and that is a radiopharmaceutical or a drug or biological for which pass-through payments were made on or before December 31, 2002.[20]

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[16] 73 Fed. Reg. at 41486.
[17] Id.
[18] Id.
[19] Id.
[20] SSA § 1833(t)(14)(B).

The SSA does not distinguish between drugs and biologicals that serve as a therapeutic modality and those that are used with other services.[21] CMS has no authority to reclassify a drug or biological as a supply simply to avoid payment as a SCOD. Additionally, Congress did not intend for CMS to circumvent the statutory payment provisions for SCODS by establishing high packaging thresholds or packaging whole classes of therapies. By doing so, CMS has rendered the statute's explicit payment instructions meaningless. When Congress enacted this definition, it established a packaging threshold of $50 per administration for drugs administered in 2005 and 2006[22] because it objected to the $150 packaging threshold that the agency established in 2003. Congress intended for CMS to establish a low packaging threshold for all drugs and biological products, and the absence of a statutory requirement regarding the packaging threshold after 2006 should not be interpreted as support for widespread packaging. We urge CMS to comply with the language and intent of the statute and to unpackage diagnostic radiopharmaceutical agents from their associated procedures.

Also, CMS proposes to continue packaging payment for all contrast agents into payment for the associated diagnostic or therapeutic procedure.[23] BIO continues to oppose this proposal for the same reasons that we opposed expanded packaging of other drugs, biological products, or radiopharmaceuticals. As stated above, because CMS does not use an accurate methodology for determining the acquisition cost of drugs, it likely is not accounting for the full costs of these drugs in its payments. Additionally, if CMS continues to package payment for contrast agents or other drugs and biologicals, it is likely to discourage accurate coding and will lose the ability to set appropriate and more accurate rates in the future. BIO believes that all drugs, radiopharmaceuticals, and biologicals with HCPCS codes – including contrast agents – should be paid separately under the OPPS and urges CMS to do so in the final rule.

If CMS continues to package contrast agents within the APCs, BIO requests that CMS publish data showing the mean costs and utilization of contrast agents and identifying the APCs into which the costs have been packaged. By doing so, stakeholders could analyze the methodology to ensure that hospitals are receiving

[21] Id.
[22] SSA § 1833(t)(16)(B).
[23] 73 Fed. Reg. at 41487.

appropriate payments reflecting the total costs of administering and furnishing contrast agents. BIO also requests that CMS continue to make pass-through payments for new contrast agents with the appropriate opportunity for public input and comment.

III. CMS should reimburse clotting factors at ASP plus six percent. [Proposed Payment for Blood Clotting Factors]

CMS proposes to reduce the payment for blood clotting factors from ASP plus five percent to ASP plus four percent, consistent with the proposed rates for other separately paid drugs and biologicals without pass-through status.[24] We believe this reduction is inappropriate for the same reasons that reducing payment for other drugs and biologicals is inappropriate, as discussed above. Accordingly, we urge CMS to pay ASP plus six percent for clotting factors in order to ensure beneficiary access to them.

IV. Implement the proposed reconfiguration of the drug administration APCs and study the effects of RTI's recommendations to improve payment accuracy on the revised APCs. [Proposed OPPS Payment for Drug Administration Services]

CMS proposes to reconfigure the drug administration APCs by consolidating the current six APCs into five APCs.[25] BIO supported CMS's decision to use the full set of Current Procedural Terminology (CPT) codes for drug administration services beginning in 2007, and we are pleased to see that this coding change has produced data for more accurate rate setting. After reviewing the claims data collected with these codes, CMS found several "two-times rule" violations among the APCs. To improve the clinical and resource homogeneity of the APCs, CMS proposes to reconfigure the drug administration APCs. BIO supports these changes, and we thank CMS for taking advantage of improved data to establish more appropriate payment rates and APC assignments.

In its report to CMS, RTI explains that corrections to cost report line assignments and mapping of revenue codes to cost centers have a significant

[24] Id. at 41492.
[25] Id. at 41503.

impact on the median costs of the drug administration APCs.[26] In addition, corrections to adjust for the effects of charge compression also affect the median costs of drug administration APCs by revising the estimated costs of packaged drugs. We ask CMS to investigate how implementation of these changes would affect the median costs of the drug administration APCs under the proposed reconfiguration and to consider implementing any changes necessary to ensure that the payment rates for these APCs accurately reflect hospitals' costs.

V. CMS should continue payment for preadministration-related services for IVIG. [IVIG Preadministration-Related Services]

CMS proposes to eliminate the payment for IVIG preadministration-related services (G0332) in 2009.[27] BIO is concerned by this proposal and urges the agency to continue its policy of paying hospitals for preadministration services in order to ensure that Medicare beneficiaries have access to this vital therapy. CMS implemented the preadministration payment policy for CY 2006 in recognition of the challenges that hospitals were facing in acquiring IVIG.[28] BIO believes that these challenges still exist, warranting continuation of the preadministration payment policy.

In support of terminating the preadministration payment for 2009, CMS relies on a HHS Office of the Inspector General April 2007 study of the IVIG market (OIG Report), [29] the issuance of new codes for certain therapies, and a slight increase in IVIG utilization. BIO believes that none of these factors, taken individually or together, support CMS's conclusion to terminate the preadministration payments. CMS refers to the OIG Report's findings that 59 percent of IVIG sales to physicians by the three largest distributors occurred at prices below the Medicare payment amounts as support for an improved marketplace.[30] The percentage of sales below Medicare's payment rates may be even lower if sales by smaller distributors are considered. BIO does not believe that there is stability in the IVIG marketplace when over 40 percent of the

[26] Kathleen Dalton et. al., Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights, July 2008, at 89.
[27] 73 Fed. Reg. at 41457.
[28] 70 Fed. Reg. at 68648-50 (Nov. 10, 2005).
[29] Office of Inspector General, U.S. Dep't of Health and Human Services., *Intravenous Immune Globulin: Medicare Payment and Availability* (OEI-03-05-00404) (2007).
[30] 73 Fed. Reg. at 41457.

providers cannot purchase IVIG at or below the Medicare payment rate. In addition, the OIG Report did not consider hospitals' ability to purchase IVIG at the proposed rate of ASP plus four percent. Further, CMS states that no other comprehensive studies have been conducted on the IVIG market. BIO, therefore, urges CMS to maintain the preadministration payment until other studies present clearer and more definitive evidence that the IVIG market has stabilized, especially in light of the lower reimbursement in this setting.

Second, CMS states that recent IVIG coding revisions have contributed to increased payments for IVIG and better market conditions. Specifically, CMS created new HCPCS codes as of July 2007 to implement a separate payment for each of the liquid formulations of IVIG not included in a billing and payment code as of October 1, 2003. CMS correctly identifies that that the payment rates have increased for the IVIG HCPCS codes. BIO thanks CMS for creating these new codes but does not believe that this action resolved the many IVIG payment issues. While this policy impacts some, but not all, difficulties in the liquid IVIG therapy market, it does not address ongoing concern in the lyophilized IVIG therapy market. A large number of Medicare beneficiaries are treated with lyophilized IVIG. All of the lyophilized IVIG products continue to be bundled in the same HCPCS code.

To the best of our knowledge, CMS has not taken any specific steps to increase payment rates for IVIG, separate from calculating updated rates based on ASP submissions by the manufacturers of each therapy. Nevertheless, even with the updated payment rates and some brand-specific IVIG codes, there is no evidence that elimination of the preadministration-related services payment would not adversely affect patient access to IVIG therapy.

Finally, CMS cites the increase in IVIG utilization as evidence to support the elimination of payment for preadministration-related services. BIO does not agree with this conclusion. In fact, BIO believes that the increase in utilization supports the continuation of the preadministration payment. This payment was created to help compensate physicians for the challenges in locating and administering IVIG. If utilization is increasing, it shows that the payment for preadministration-related services is working as it originally was intended.

BIO urges CMS to continue the pre-administration payment for IVIG for calendar year 2009. The preadministration payment improves Medicare beneficiary access to IVIG. Because there have been no findings or reports indicating that the market conditions that led to this policy have substantially improved, BIO believes that it would be inappropriate to discontinue the preadministration payment for 2009.

VI. Any changes CMS makes to improve access to drugs and biologicals in hospital outpatient departments also should apply to ASCs. [Proposed Update of the Revised Ambulatory Surgical Center Payment System]

BIO agrees with CMS's policy of paying ASCs separately for drugs and biologicals that have pass-through status under the OPPS when the drug or biological is integral to a covered surgical procedure. We believe the decision to reimburse these therapies in ASCs at the rates determined under the OPPS will help to ensure that patients have a choice of settings for surgical procedures. At the same time, however, we are concerned that equalizing payment in these settings could harm beneficiary access to care if CMS simply imports the same flawed rates and packaging policies from the HOPD into ASCs. Now that payment in ASCs is linked to the OPPS rates and policies, it is especially important that CMS set appropriate payment rates and packaging thresholds for these therapies. We urge CMS to consider the effect on access to care in ASCs as it evaluates our comments on payment for drugs under the OPPS. CMS must ensure that Medicare's payment policies support access to care in both of these important settings.

VII. CMS should continue efforts to expand quality reporting in the outpatient setting, but regularly update quality measures to reflect standard-of-care and add coordination of care measures as soon as possible. [Hospital Outpatient Quality Measures for CY 2009]

BIO supports CMS's ongoing efforts to introduce quality reporting in the outpatient setting. These efforts align with BIO's goals of improving patient care while ensuring that hospitals receive appropriate payments.[31]

[31] CMS proposes to wait until a future rulemaking to implement a quality reporting program for ASCs, and BIO supports this cautious approach. Id.

A. CMS should ensure that measures reflect the most up-to-date standard-of-care.

CMS should ensure that the measures used for quality reporting reflect the most up-to-date clinical guidelines so that Medicare patients receive the relevant standard-of-care. The proposed acute myocardial infarction measure OP-4: Aspirin at Arrival is an example of a measure that should be updated to reflect current guidelines. The measure should require administration of clopidogrel or aspirin, or both, as an anti-platelet therapy, as endorsed by the National Quality Forum (NQF) and recommended by the American College of Cardiology and American Heart Association Guidelines for Unstable Angina and Non-ST Elevation Myocardial Infarction.[32] Further, CMS should work with the measure owners to include additional anti-platelet therapies as the standard-of-care evolves.

For 2011, CMS is proposing several medication measures that drive the standard-of-care given by providers for patients with osteoporosis or depression. These measures could also improve or change care provided by HOPD providers. BIO is supportive of the addition of these measures. Because medication reconciliation is also a proposed measure, BIO recommends the addition of the PQRI CAD measure to also be reported by HOPD providers to harmonize with CMS's proposed ED-AMI measures and the patient's medical home.

B. CMS should add coordination of care measures to the measure set in the future.

BIO encourages CMS to bolster the development and inclusion of measures relating to care coordination. CMS is considering two measures for CY 2011 (Communication with the Physician Managing Ongoing Care Post Fracture (#12) and Medication Reconciliation (#16)) that would address the issue of care coordination, and BIO strongly urges the agency to adopt both measures.[33] As patients are transferred between care settings, including between primary care and

[32] NQF, National Voluntary Consensus Standards for Ambulatory Care: An Initial Physician-Focused Performance Measure Set at 10 (May 2006), available at http://www.qualityforum.org/;
E. Antman, et al., 2007 Focused Update of the ACC/AHA 2004 Guidelines for the Management of Patient with ST-Elevation Myocardial Infarction, Circulation Vol 117, 296-329, available online at http://circ.ahajournals.org/cgi/content/full/117/2/296.
[33] 73 Fed. Reg. at 41542.

specialty physicians, different departments in the hospital, or multiple facilities, communication can be difficult. Adequate communication between providers in different settings is necessary for continuity of care and to assist patients and their caretakers in preparing for appropriate follow-up.

C. BIO supports the establishment of a sub-regulatory process for updating technical specifications of quality measures.

BIO supports CMS's current process of adopting measures through the rulemaking process. However, BIO would also be supportive of CMS establishing a sub-regulatory process that will allow for the update of the technical specifications when a consensus building entity such as the NQF updates the measure specifications for an adopted measure. This process must remain fully transparent to protect the interests of both the patient and the HOPD provider. BIO is also supportive of CMS's proposal to provide at least three months notification of any updates through posts on both the QualityNet website and in the Hospital Outpatient Quality Measures Specifications Manual (Specifications Manual).

VIII. CMS should refrain from expanding its hospital-acquired conditions payment policy until it has garnered additional experience with the payment mechanism in the inpatient setting, has resolved issues regarding causation in the outpatient setting, and has obtained comments on the proposal in its entirety. [Healthcare Associated Conditions]

As CMS contemplates possible expansion of its hospital-acquired condition (HAC) payment policy to other settings, including outpatient hospital departments, BIO urges the agency to refrain from action in the near term. In particular, BIO believes CMS should await feedback from this year's implementation of the HAC in the inpatient setting prior to introducing the approach more broadly. In addition, BIO encourages CMS to proceed with caution in expanding the payment policy given that the agency is seeking comments on its statutory authority to do so.[34]

In the inpatient setting, CMS will implement the HAC payment policy starting on October 1, 2008. Under this policy, authorized under section

[34] Id. at 41548.

1886(d)(4)(D) of the SSA, Medicare will reimburse hospitals at a lower Medicare Severity-Diagnosis Related Group (MS-DRG) when a patient develops one of an enumerated set of conditions during his or her stay. CMS added three HACs to the prior eight in the final Inpatient Prospective Payment Systems (IPPS) rule, finding that the conditions met the statutory requirements that HACs (1) be high cost, high volume, or both; (2) result in assignment to a higher paying MS-DRG when present as a secondary diagnosis; and (3) be reasonably preventable through the application of evidence-based guidelines.[35]

In this Proposed Rule, CMS seeks comments on its proposed expansion of HACs from the inpatient to the outpatient setting.[36] BIO agrees with the agency's goals of aligning incentives across settings through value-based payment and quality initiatives. BIO believes, however, it would be premature to implement an analogous HAC payment mechanism in the outpatient context before the payment policy is tested in the inpatient setting. In particular, BIO is concerned that using the approach in the outpatient setting would raise serious issues because outpatient departments see patients only on an occasional and limited basis. In contrast, inpatient facilities have continuous control over a patient, thus making it more likely that a hospital can employ guidelines to prevent a secondary infection or other condition from developing. In the case of outpatient departments, causation is more difficult to determine when a patient develops a secondary infection or condition. In cases where a patient acquires an infection or other condition at home or in the community, it would be unfair for the outpatient department to be penalized by receiving a lower payment. While extending the HAC to infections in the HOPD is not appropriate, there are instances that may be appropriate for inclusion in the outpatient setting. Specifically, the "never event" related to death or serious disability due to medication errors could likely be implemented in both the inpatient and outpatient settings. We also note that CMS was directed to create an outpatient quality measure for reporting medication errors in the Tax Relief and Health Care Act of 2006.[37]

As the HAC payment policy is improved in terms of present on arrival coding and other refinements, it may be possible for CMS to develop an approach that would be fair to employ in the outpatient setting. Until such time, CMS

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[35] Id.
[36] Id.
[37] SSA § 1833(t)(17)(C).

should refrain from considering expansion of the HAC policy to the outpatient setting.

In addition, BIO requests that CMS facilitate public comments on the HAC expansion proposals by issuing the proposals in a single rule. Rather than seeking comments in a piecemeal fashion in rules issued for various settings, CMS should seek more meaningful comments on the proposal as a whole. Consolidating the proposals into a single rule would facilitate the provision of more holistic feedback.

IX. BIO urges CMS to change the date of service from the *date of collection* to the *date of performance* for certain novel laboratory-developed tests.

Medicare's Laboratory Date of Service for Specimens regulations[38] establish the date of service for laboratory tests to be the date on which the specimen was collected. While the regulations provide exceptions for tests performed on stored specimens, the exceptions only apply to specimens stored for at least 14 days following the date the patient was discharged from the hospital. As a result, for tests performed on specimens obtained during hospital procedures, any test furnished within the 14-day window is deemed to have been provided on the date the specimen was collected.

In addition, Medicare's bundling rules[39] result in an unintended effect of the dates of service regulation when applied to certain novel laboratory-developed tests. In cases where the date of service for the laboratory test coincides with the date on which the patient was a hospital patient, Medicare's bundling rules treat the service as if it were furnished by the hospital even though the hospital may have nothing to do with the ordering or use of the test.

In order for laboratory tests that are technically furnished "during a hospital stay or encounter" to be covered, the hospital providing the treatment must bill for the laboratory service and assume professional responsibility for the test quality. Hospitals are reluctant to assume responsibility for the following reasons:

[38] 42 C.F.R. § 414.510.
[39] 42 C.F.R. §§ 411.15 and 410.42.

- The test is completely unrelated to the patient's hospital stay and is not used in the management of the patient during the hospital stay;
- Hospitals are reluctant to assume professional responsibility for tests that are not offered by the hospital and which are offered by laboratories that are unaffiliated and unfamiliar to the hospital;
- In instances where the test was furnished to a patient who was a hospital inpatient at the time the specimen was obtained, the payment made under the inpatient PPS is only payment available to the hospital, and hospitals are therefore reluctant to share with the laboratory a Medicare payment that does not reflect the cost of the laboratory service; and
- In instances where the patient was a hospital outpatient when the specimen was obtained, Medicare will make a separate payment for the test under the Clinical Laboratory Fee Schedule, but the hospitals must assume the financial risk that the service is covered and that Medicare will reimburse as the hospital is obligated to pay the laboratory.

For these reasons, hospitals are delaying orders to avoid the responsibility required if the date of service relates the tests back to the hospital stay or encounter and are therefore cancelling orders.

BIO urges CMS to change the date of service from the date of collection to the date of performance for tests with the following criteria: the test is a genetics, genomic, proteomic or cancer chemosensitivity assay; it is developed in-house; it is performed after the patient discharge or encounter; and the results are not used to manage the patient during the stay or encounter.

X. Conclusion

BIO thanks CMS for this opportunity to comment on the OPPS Proposed Rule for 2009. We look forward to continuing to work with the agency to ensure that hospitals are reimbursed appropriately for the costs of acquiring, preparing, and administering drug and biological therapies. Overall, we believe it is imperative for CMS to act now to preserve patient access for drug and biological therapies in the critical hospital outpatient setting. Rather than waiting years to collect the data necessary to correct for charge compression by implementing two different cost centers for drugs, BIO urges CMS to fix this problem in 2009. Specifically, we ask CMS to pay no less than ASP plus six percent for drugs and biologicals administered in the OPPS and to implement the stakeholder proposal to adjust payments to ensure that pharmacy service costs are reimbursed adequately.

Please contact Laurel Todd at (202) 962-9220 if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted,

/s/

Laurel Todd
Director, Reimbursement &
Economic Policy

Attachments

Attachment A

Background on the 340B Program

- The 340B program is a program administered by the Health Resources and Services Administration (HRSA) that allows certain health care providers to obtain access to Medicaid-level drug discounts.
- Eligible covered entities include:
    - Certain public and non-profit disproportionate share hospitals
    - Federally Qualified Health Centers (FQHCs)
    - Urban Indian Health Centers
    - Family planning clinics
    - Certain federal grantees
- There are more than 800 hospitals (and 1600 individual sites) receiving 340B pricing, and they account for 35% of Medicare's Hospital Outpatient Prospective Payment System's drug cost volume.
- The 340B price is a "ceiling price." Covered entities may negotiate prices with manufacturers below this level. 340B prices are proprietary and therefore not published publicly. On average, 340B drugs and biologicals cost 20 to 40 percent below Average Wholesale Price.
    - The 340B price is calculated as either average manufacturer price (AMP) minus 15.1% or AMP minus best price.
    - Manufacturers are required to participate in the 340B program as a condition of participating in the Medicaid program.
    - 340B pricing applies to drugs and biologicals in the outpatient setting only.
- 340B participating entities may not dispense drugs and biologicals at 340B prices if the state Medicaid program will be requesting a rebate ("double dipping" prohibition). Participating entities are also prohibited from reselling or otherwise transferring drugs and biologicals purchased at the 340B prices to individuals who are not patients of the participating entity.

- Reasons for non-enrollment:
    - Lack of awareness of the 340B program
    - Regulatory, operational, and compliance requirements such as maintaining two inventories of 340B and non-340B drugs and biologicals and additional record keeping
    - Cost-benefit analysis and expected cost savings
    - Insufficient personnel to efficiently operate the program

Attachment B

Memorandum

To: Interested parties
From: Christopher Hogan, Direct Research, LLC
Subject: Update of 4/15/2008 memo on 340B hospitals and Medicare OPPS mean drug costs.
Date: 7/27/2008

This analysis uses the OPPS 2009 Proposed Rule file to estimate the impact of the Section 340B drug price discounts. It is an update of a prior analysis using last year's file. Results using the most recent file (2007 claims) are essentially identical to results from last year's file.

- The 340B hospitals' share of drug cost increased from 34 percent to 35 percent.
- The 340B hospitals' drug costs averaged 8 to 9 percent below other hospitals' costs.
- The 340B discounts reduce OPPS drug costs, on average, by about 3.5 percentage points (prior analysis) or 3.6 percentage points (current analysis).

Summary of Background and Methods

- The Section 340B program is a federally-administered program that allows certain health care providers to obtain access to Medicaid-level drug discounts.
- To estimate the effect of these discounts, I extracted a list of the current 340B hospitals from the DHHS HRSA website, http://opanet.hrsa.gov/opa/CE/CEExtract.aspx. Most hospitals were readily identified based on the CMS hospital ID embedded within HRSA's identifier. Others were matched to the CMS provider-of-services listing to obtain the hospital identifier necessary for use in analyzing the claims data. I identified a total of 802 Section 340B hospitals. These hospitals tended to be large, urban public hospitals.
- I processed the 2009 Proposed Rule file using CMS's methods to calculate mean cost per drug unit for each OPPS-paid drug. I calculated these separately for the 340B and non-340B hospitals. These mean unit costs were then used in the calculation of the markup of cost over ASP, that is, the X in the equation Cost = ASP + X%, again using the same methods as CMS.
- My overall estimate of ASP + X from the claims is slightly different from the CMS 2008 OPPS Final Rule calculation or 2009 Proposed Rule calculation. I re-based mine to match the CMS calculation when I included all hospitals in the calculation.

Summary of Prior and Current Results

The 340B share of all drug costs rose slightly, from 34 percent to 35 percent of OPPS file drug costs (Table 1).

Table 1: Cost Share and Average Cost Index, OPPS Drugs, by Hospital 340B Status

	All	Non-340B	340B
2008 File Analysis (2006 claims)			
Total cost ($billions)	$ 2.8	$ 1.8	$ 0.9
Percent of total cost	100%	66%	34%
2009 File Analysis (2007 claims)			
Total cost ($billions)	$ 3.1	$ 2.0	$ 1.1
Percent of total cost	100%	65%	35%

Source: Analysis of OPPS 2008 proposed rule file (CY 2006 claims) and OPPS 2009 Proposed Rule File (2007 claims)

The overall impact of 340B discounts on OPPS average drug costs increased from a 3.5 percentage point reduction to a 3.6 percentage point reduction (Table 2). That is the difference in costs that occurs when the 340B hospitals are excluded from the calculation of average costs. On this table, the first column replicates CMS's results, showing that cost is ASP plus 3.4 percent (last year) or ASP plus 4 percent (this year), for separately paid drugs. The second and third columns show the impact of separating the 340B hospitals from others. The difference between those two columns shows the net 340B discount. It appears to average between 8 and 9 percentage points. That is true whether the analysis looks at all drugs or only at the separately-paid drugs.

Table 2: Markup of Cost Over ASP (the X in Cost = ASP + X%), by Hospital 340B Status			
	All hospitals	**non-340B**	**340B**
2008 File Analysis (2006 claims)			
All Identified Drugs	13.0%	16.1%	8.8%
Separately-Paid Drugs Only	3.4%	6.9%	-1.7%
Memo: 340B impact on average cost	**-3.5%**		
2009 File Analysis (2007 claims)			
All Identified Drugs	12.5%	16.0%	7.4%
Separately-Paid Drugs Only	4.0%	7.6%	-1.1%
Memo: 340B impact on average cost	**-3.6%**		
Source: Analysis of OPPS 2008 proposed rule file (2006 claims) and CMS 2008 Final Rule drug medians, and October 2007 ASP files (prior year analysis); and OPPS 2009 Proposed rule, CMS 2009 proposed rule drug medians, and April 2008 ASP file (current year analysis).			

As was the case last year, the apparent drug discounts were far from uniform. The ratio of 340B to non-340B average cost varied across drugs. The table above captures only the weighted average effect of the discounts.

Attachment C

Assignment of HCPCS Codes to Pharmacy Overhead Categories

Pharmacy Service Levels:

- Low - pre-prepared, no clinical assessment
- Medium - minor clinical assessment and minor manipulation, e.g., compound mini-bags
- High - complex compound and complex clinical assessment and calculations, special containers

HCPCS CODE	DESCRIPTION	PHARMACY SERVICE LEVEL
90371	HEPATITIS B IMMUNE GLOBULIN (HBIG), HUMAN, FOR INTRAMUSCULAR USE	L
90375	RABIES IMMUNE GLOBULIN (RIG), HUMAN, FOR INTRAMUSCULAR USE AND/OR SUBCUTANEOUS USE	L
90376	RABIES IMMUNE GLOBULIN, HEAT-TREATED (RIG-HT), HUMAN, FOR INTRAMUSCULAR AND/OR SUBCUTANEOUS USE	L
90385	RHO(D) IMMUNE GLOBULIN (RHIG), HUMAN, MINI-DOSE, FOR INTRAMUSCULAR USE	M
90393	VACCINA IG, IM	L
90396	VARICELLA-ZOSTER IG, IM	L
90476	ADENOVIRUS VACCINE, TYPE 4	L
90477	ADENOVIRUS VACCINE, TYPE 7	L
90581	ANTHRAX VACCINE, SC	L
90585	BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR TUBERCULOSIS, LIVE, FOR PERCUTANEOUS USE	M
90632	HEPATITIS A VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE	L
90633	HEPATITIS A VACCINE, PEDIATRIC/ADOLESCENT DOSAGE-2 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	L
90634	HEP A VACC, PED/ADOL, 3 DOSE	L
90636	HEP A/HEP B VACC, ADULT IM	L
90645	HEMOPHILUS INFLUENZA B VACCINE (HIB), HBOC CONJUGATE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	L
90646	HIB VACCINE, PRP-D, IM	L
90647	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3 DOSE SCHEDULE) FOR INTRAMUSCULAR USE	L
90648	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-T CONJUGATE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	L
90665	LYME DISEASE VACCINE, IM	L
90675	RABIES VACCINE, FOR INTRAMUSCULAR USE	L
90676	RABIES VACCINE, FOR INTRADERMAL USE	L
90680	ROTOVIRUS VACC 3 DOSE, ORAL	L
90690	TYPHOID VACCINE, ORAL	L
90691	TYPHOID VACCINE, VI CAPSULAR POLYSACCHARIDE (VICPS), FOR INTRAMUSCULAR USE	L
90692	TYPHOID VACCINE, H-P, SC/ID	L
90698	DTAP-HIB-IP VACCINE, IM	L
90700	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	L
90702	DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	L
90703	TETANUS TOXOID ADSORBED, FOR INTRAMUSCULAR USE	L
90704	MUMPS VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	L
90705	MEASLES VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	L
90706	RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	L
90707	MEASLES, MUMPS AND RUBELLA VIRUS VACCINE (MMR), LIVE, FOR SUBCUTANEOUS USE	L
90708	MEASLES-RUBELLA VACCINE, SC	L

90710	**MMRV VACCINE, SC**	**L**
90712	**ORAL POLIOVIRUS VACCINE**	**L**
90713	**POLIOVIRUS VACCINE, INACTIVATED, (IPV), FOR SUBCUTANEOUS OR INTRAMUSCULAR USE**	**L**
90714	**TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE**	**L**
90715	**TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE**	**L**
90717	**YELLOW FEVER VACCINE, LIVE, FOR SUBCUTANEOUS USE**	**L**
90718	**TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE**	**L**
90719	**DIPHTHERIA VACCINE, IM**	**L**
90720	**DTP/HIB VACCINE, IM**	**L**
90721	**DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE AND HEMOPHILUS INFLUENZA B VACCINE (DTAP-HIB), FOR INTRAMSUCULAR USE**	**L**
90725	**CHOLERA VACCINE, INJECTABLE**	**L**
90727	**PLAGUE VACCINE, IM**	**L**
90733	**MENINGOCOCCAL POLYSACCHARIDE VACCINE (ANY GROUP(S)), FOR SUBCUTANEOUS USE**	**L**
90734	**MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS A, C, Y AND W-135 (TETRAVALENT), FOR INTRAMUSCULAR USE**	**L**
90735	**JAPANESE ENCEPHALITIS VIRUS VACCINE, FOR SUBCUTANEOUS USE**	**L**
90749	**VACCINE TOXOID**	**L**
A9535	**INJECTION, METHYLENE BLUE, 1 ML**	**L**
A9698	**NON-RADIOACTIVE CONTRAST IMAGING MATERIAL, NOT OTHERWISE CLASSIFIED, PER STUDY**	**L**
C9003	**PALIVIZUMAB-RSV-IGM, PER 50 MG**	**H**
C9121	**INJECTION, ARGATROBAN, PER 5 MG**	**M**
J0120	**TETRACYCLIN INJECTION**	**M**
J0128	**ABARELIX INJECTION**	**H**
J0129	**INJECTION, ABATACEPT, 10 MG**	**H**
J0130	**INJECTION ABCIXIMAB, 10 MG**	**H**
J0132	**INJECTION, ACETYLCYSTEINE, 100 MG**	**H**
J0133	**INJECTION, ACYCLOVIR, 5 MG**	**H**
J0135	**INJECTION, ADALIMUMAB, 20 MG**	**H**
J0150	**INJECTION, ADENOSINE FOR THERAPEUTIC USE, 6 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)**	**L**
J0152	**INJECTION, ADENOSINE FOR DIAGNOSTIC USE, 30 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS; INSTEAD USE A9270)**	**L**
J0170	**INJECTION, ADRENALIN, EPINEPHRINE, UP TO 1 ML AMPULE**	**L**
J0180	**INJECTION, AGALSIDASE BETA, 1 MG**	**M**
J0190	**INJ BIPERIDEN LACTATE/5 MG**	**M**
J0200	**ALATROFLOXACIN MESYLATE**	**M**
J0205	**INJECTION, ALGLUCERASE, PER 10 UNITS**	**M**
J0207	**AMIFOSTINE**	**H**
J0210	**INJECTION, METHYLDOPATE HCL, UP TO 250 MG**	**M**

J0215	**INJECTION, ALEFACEPT, 0.5 MG**	**L**
J0220	**ALGLUCOSIDASE ALFA INJECTION**	**M**
J0256	**INJECTION, ALPHA 1 - PROTEINASE INHIBITOR - HUMAN, 10 MG**	**M**
J0278	**INJECTION, AMIKACIN SULFATE, 100 MG**	**H**
J0280	**INJECTION, AMINOPHYLLIN, UP TO 250 MG**	**M**
J0282	**INJECTION, AMIODARONE HYDROCHLORIDE, 30 MG**	**M**
J0285	**INJECTION, AMPHOTERICIN B, 50 MG**	**H**
J0287	**INJECTION, AMPHOTERICIN B LIPID COMPLEX, 10 MG**	**H**
J0288	**AMPHO B CHOLESTERYL SULFATE**	**H**
J0289	**INJECTION, AMPHOTERICIN B LIPOSOME, 10 MG**	**H**
J0290	**INJECTION, AMPICILLIN SODIUM, 500 MG**	**M**
J0295	**INJECTION, AMPICILLIN SODIUM/SULBACTAM SODIUM, PER 1.5 GM**	**M**
J0300	**INJECTION, AMOBARBITAL, UP TO 125 MG**	**L**
J0330	**INJECTION, SUCCINYLCHOLINE CHLORIDE, UP TO 20 MG**	**L**
J0348	**INJECTION, ANADULAFUNGIN, 1 MG**	**H**
J0350	**INJECTION, ANISTREPLASE, PER 30 UNITS**	**M**
J0360	**INJECTION, HYDRALAZINE HCL, UP TO 20 MG**	**M**
J0364	**INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG**	**H**
J0365	**INJECTION, APROTONIN, 10,000 KIU**	**H**
J0380	**INJ METARAMINOL BITARTRATE**	**M**
J0390	**CHLOROQUINE INJECTION**	**H**
J0395	**ARBUTAMINE HCL INJECTION**	**M**
J0400	**ARIPIPRAZOLE INJECTION**	**M**
J0456	**INJECTION, AZITHROMYCIN, 500 MG**	**M**
J0460	**INJECTION, ATROPINE SULFATE, UP TO 0.3 MG**	**L**
J0470	**INJECTION, DIMERCAPROL, PER 100 MG**	**M**
J0475	**INJECTION, BACLOFEN, 10 MG**	**M**
J0476	**INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL**	**H**
J0480	**INJECTION, BASILIXIMAB, 20 MG**	**H**
J0500	**INJECTION, DICYCLOMINE HCL, UP TO 20 MG**	**L**
J0515	**INJECTION, BENZTROPINE MESYLATE, PER 1 MG**	**L**
J0520	**INJECTION, BETHANECHOL CHLORIDE, MYOTONACHOL OR URECHOLINE, UP TO 5 MG**	**M**
J0530	**INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 600,000 UNITS**	**L**
J0540	**INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 1,200,000 UNITS**	**L**
J0550	**INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 2,400,000 UNITS**	**L**
J0560	**INJECTION, PENICILLIN G BENZATHINE, UP TO 600,000 UNITS**	**L**
J0570	**INJECTION, PENICILLIN G BENZATHINE, UP TO 1,200,000 UNITS**	**L**
J0580	**INJECTION, PENICILLIN G BENZATHINE, UP TO 2,400,000 UNITS**	**L**
J0583	**INJECTION, BIVALIRUDIN, 1 MG**	**M**
J0585	**BOTULINUM TOXIN TYPE A, PER UNIT**	**M**
J0587	**BOTULINUM TOXIN TYPE B, PER 100 UNITS**	**M**
J0592	**INJECTION, BUPRENORPHINE HYDROCHLORIDE, 0.1 MG**	**L**
J0594	**BUSULFAN INJECTION**	**H**
J0594	**INJECTION, BUSULFAN, 1 MG**	**H**
J0595	**INJECTION, BUTORPHANOL TARTRATE, 1 MG**	**L**
J0600	**INJECTION, EDETATE CALCIUM DISODIUM, UP TO 1000 MG**	**M**
J0610	**INJECTION, CALCIUM GLUCONATE, PER 10 ML**	**M**

J0620	**CALCIUM GLYCER & LACT/10 ML**	**M**
J0630	**INJECTION, CALCITONIN SALMON, UP TO 400 UNITS**	**L**
J0636	**INJECTION, CALCITRIOL, 0.1 MCG**	**L**
J0637	**INJECTION, CASPOFUNGIN ACETATE, 5 MG**	**M**
J0640	**LEUCOVORIN CALCIUM INJECTION**	**M**
J0670	**INJECTION, MEPIVACAINE HYDROCHLORIDE, PER 10 ML**	**L**
J0690	**INJECTION, CEFAZOLIN SODIUM, 500 MG**	**M**
J0692	**INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG**	**M**
J0694	**INJECTION, CEFOXITIN SODIUM, 1 GM**	**M**
J0696	**INJECTION, CEFTRIAXONE SODIUM, PER 250 MG**	**M**
J0697	**INJECTION, STERILE CEFUROXIME SODIUM, PER 750 MG**	**M**
J0698	**INJECTION, CEFOTAXIME SODIUM, PER GM**	**M**
J0702	**INJECTION, BETAMETHASONE ACETATE AND BETAMETHASONE SODIUM PHOSPHATE, PER 3 MG**	**L**
J0704	**INJECTION, BETAMETHASONE SODIUM PHOSPHATE, PER 4 MG**	**L**
J0706	**INJECTION, CAFFEINE CITRATE, 5MG**	**L**
J0710	**CEPHAPIRIN SODIUM INJECTION**	**M**
J0713	**INJECTION, CEFTAZIDIME, PER 500 MG**	**M**
J0715	**INJECTION, CEFTIZOXIME SODIUM, PER 500 MG**	**M**
J0720	**INJECTION, CHLORAMPHENICOL SODIUM SUCCINATE, UP TO 1 GM**	**L**
J0725	**INJECTION, CHORIONIC GONADOTROPIN, PER 1,000 USP UNITS**	**L**
J0735	**INJECTION, CLONIDINE HYDROCHLORIDE, 1 MG**	**L**
J0740	**INJECTION, CIDOFOVIR, 375 MG**	**M**
J0743	**INJECTION, CILASTATIN SODIUM; IMIPENEM, PER 250 MG**	**M**
J0744	**INJECTION, CIPROFLOXACIN FOR INTRAVENOUS INFUSION, 200 MG**	**M**
J0745	**INJECTION, CODEINE PHOSPHATE, PER 30 MG**	**M**
J0760	**INJECTION, COLCHICINE, PER 1MG**	**L**
J0770	**INJECTION, COLISTIMETHATE SODIUM, UP TO 150 MG**	**L**
J0780	**INJECTION, PROCHLORPERAZINE, UP TO 10 MG**	**L**
J0795	**INJECTION, CORTICORELIN OVINE TRIFLUTATE, 1 MICROGRAM**	**M**
J0800	**INJECTION, CORTICOTROPIN, UP TO 40 UNITS**	**M**
J0835	**INJECTION, COSYNTROPIN, PER 0.25 MG**	**L**
J0850	**INJECTION, CYTOMEGALOVIRUS IMMUNE GLOBULIN INTRAVENOUS (HUMAN), PER VIAL**	**H**
J0878	**INJECTION, DAPTOMYCIN, 1 MG**	**M**
J0881	**INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)**	**M**
J0882	**INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS)**	**M**
J0885	**INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS**	**M**
J0886	**INJECTION, EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)**	**M**
J0894	**INJECTION, DECITABINE, 1 MG**	**M**
J0895	**INJECTION, DEFEROXAMINE MESYLATE, 500 MG**	**M**
J0900	**TESTOSTERONE ENANTHATE INJ**	**M**
J0945	**BROMPHENIRAMINE MALEATE INJ**	**M**
J0970	**INJECTION, ESTRADIOL VALERATE, UP TO 40 MG**	**L**
J1000	**INJECTION, DEPO-ESTRADIOL CYPIONATE, UP TO 5 MG**	**L**
J1020	**INJECTION, METHYLPREDNISOLONE ACETATE, 20 MG**	**L**
J1030	**INJECTION, METHYLPREDNISOLONE ACETATE, 40 MG**	**L**
J1040	**INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG**	**L**

J1051	**INJECTION, MEDROXYPROGESTERONE ACETATE, 50 MG**	**L**
J1060	**INJECTION, TESTOSTERONE CYPIONATE AND ESTRADIOL CYPIONATE, UP TO 1 ML**	**M**
J1070	**INJECTION, TESTOSTERONE CYPIONATE, UP TO 100 MG**	**M**
J1080	**INJECTION, TESTOSTERONE CYPIONATE, 1 CC, 200 MG**	**M**
J1094	**INJECTION, DEXAMETHASONE ACETATE, 1 MG**	**L**
J1100	**INJECTION, DEXAMETHASONE SODIUM PHOSPHATE, 1MG**	**L**
J1110	**INJECTION, DIHYDROERGOTAMINE MESYLATE, PER 1 MG**	**L**
J1120	**INJECTION, ACETAZOLAMIDE SODIUM, UP TO 500 MG**	**L**
J1160	**INJECTION, DIGOXIN, UP TO 0.5 MG**	**M**
J1162	**INJECTION, DIGOXIN IMMUNE FAB (OVINE), PER VIAL**	**H**
J1165	**INJECTION, PHENYTOIN SODIUM, PER 50 MG**	**M**
J1170	**INJECTION, HYDROMORPHONE, UP TO 4 MG**	**M**
J1180	**DYPHYLLINE INJECTION**	**M**
J1190	**DEXRAZOXANE HCL INJECTION**	**M**
J1200	**INJECTION, DIPHENHYDRAMINE HCL, UP TO 50 MG**	**L**
J1205	**INJECTION, CHLOROTHIAZIDE SODIUM, PER 500 MG**	**L**
J1212	**INJECTION, DMSO, DIMETHYL SULFOXIDE, 50%, 50 ML**	**M**
J1230	**INJECTION, METHADONE HCL, UP TO 10 MG**	**M**
J1240	**INJECTION, DIMENHYDRINATE, UP TO 50 MG**	**L**
J1245	**INJECTION, DIPYRIDAMOLE, PER 10 MG**	**L**
J1250	**INJECTION, DOBUTAMINE HYDROCHLORIDE, PER 250 MG**	**L**
J1260	**DOLASETRON MESYLATE**	**M**
J1265	**INJECTION, DOPAMINE HCL, 40 MG**	**H**
J1270	**INJECTION, DOXERCALCIFEROL, 1 MCG**	**L**
J1300	**ECULIZUMAB INJECTION**	**M**
J1320	**AMITRIPTYLINE INJECTION**	**M**
J1324	**INJECTION, ENFUVIRTIDE, 1 MG**	**M**
J1325	**INJECTION, EPOPROSTENOL, 0.5 MG**	**L**
J1327	**INJECTION, EPTIFIBATIDE, 5 MG**	**L**
J1330	**ERGONOVINE MALEATE INJECTION**	**M**
J1335	**INJECTION, ERTAPENEM SODIUM, 500 MG**	**M**
J1364	**INJECTION, ERYTHROMYCIN LACTOBIONATE, PER 500 MG**	**M**
J1380	**INJECTION, ESTRADIOL VALERATE, UP TO 10 MG**	**L**
J1390	**INJECTION, ESTRADIOL VALERATE, UP TO 20 MG**	**L**
J1410	**INJECTION, ESTROGEN CONJUGATED, PER 25 MG**	**M**
J1430	**INJECTION, ETHANOLAMINE OLEATE, 100 MG**	**M**
J1435	**INJECTION ESTRONE PER 1 MG**	**M**
J1436	**INJECTION, ETIDRONATE DISODIUM, PER 300 MG**	**M**
J1438	**INJECTION, ETANERCEPT, 25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)**	**M**
J1440	**FILGRASTIM 300 MCG INJECTION**	**M**
J1441	**FILGRASTIM 480 MCG INJECTION**	**M**
J1450	**INJECTION FLUCONAZOLE, 200 MG**	**M**
J1451	**INJECTION, FOMEPIZOLE, 15 MG**	**M**
J1452	**INTRAOCULAR FOMIVIRSEN NA**	**M**
J1455	**INJECTION, FOSCARNET SODIUM, PER 1000 MG**	**M**
J1457	**INJECTION, GALLIUM NITRATE, 1 MG**	**M**
J1458	**INJECTION, GALSULFASE, 1 MG**	**M**
J1460	**INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 1 CC**	**M**

J1470	**INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 2 CC**	**M**
J1480	**GAMMA GLOBULIN 3 CC INJ**	**M**
J1490	**INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 4 CC**	**M**
J1500	**GAMMA GLOBULIN 5 CC INJ**	**M**
J1510	**GAMMA GLOBULIN 6 CC INJ**	**M**
J1520	**GAMMA GLOBULIN 7 CC INJ**	**M**
J1530	**GAMMA GLOBULIN 8 CC INJ**	**M**
J1540	**GAMMA GLOBULIN 9 CC INJ**	**M**
J1550	**INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 10 CC**	**M**
J1561	**GAMUNEX INJECTION**	**M**
J1562	**INJECTION, IMMUNE GLOBULIN, SUBCUTANEOUS, 100 MG**	**H**
J1565	**INJECTION, RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN, INTRAVENOUS, 50 MG**	**M**
J1566	**INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG**	**H**
J1568	**OCTAGAM INJECTION**	**M**
J1569	**GAMMAGARD LIQUID INJECTION**	**M**
J1570	**INJECTION, GANCICLOVIR SODIUM, 500 MG**	**M**
J1571	**HEPAGAM B IM INJECTION**	**M**
J1572	**FLEBOGAMMA INJECTION**	**M**
J1573	**HEPAGAM B INTRAVENOUS, INJ**	**M**
J1580	**INJECTION, GARAMYCIN, GENTAMICIN, UP TO 80 MG**	**M**
J1590	**INJECTION, GATIFLOXACIN, 10MG**	**M**
J1595	**INJECTION, GLATIRAMER ACETATE, 20 MG**	**L**
J1600	**INJECTION, GOLD SODIUM THIOMALATE, UP TO 50 MG**	**L**
J1610	**INJECTION, GLUCAGON HYDROCHLORIDE, PER 1 MG**	**L**
J1620	**INJECTION, GONADORELIN HYDROCHLORIDE, PER 100 MCG**	**L**
J1626	**GRANISETRON HCL INJECTION**	**M**
J1630	**INJECTION, HALOPERIDOL, UP TO 5 MG**	**M**
J1631	**INJECTION, HALOPERIDOL DECANOATE, PER 50 MG**	**M**
J1640	**INJECTION, HEMIN, 1 MG**	**L**
J1642	**INJECTION, HEPARIN SODIUM, (HEPARIN LOCK FLUSH), PER 10 UNITS**	**M**
J1644	**INJECTION, HEPARIN SODIUM, PER 1000 UNITS**	**M**
J1645	**INJECTION, DALTEPARIN SODIUM, PER 2500 IU**	**M**
J1650	**INJECTION, ENOXAPARIN SODIUM, 10 MG**	**M**
J1652	**INJECTION, FONDAPARINUX SODIUM, 0.5 MG**	**M**
J1655	**INJECTION, TINZAPARIN SODIUM, 1000 IU**	**M**
J1670	**INJECTION, TETANUS IMMUNE GLOBULIN, HUMAN, UP TO 250 UNITS**	**L**
J1675	**INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS**	**L**
J1700	**HYDROCORTISONE ACETATE INJ**	**M**
J1710	**HYDROCORTISONE SODIUM PH INJ**	**M**
J1720	**INJECTION, HYDROCORTISONE SODIUM SUCCINATE, UP TO 100 MG**	**L**
J1730	**INJECTION, DIAZOXIDE, UP TO 300 MG**	**M**
J1740	**INJECTION, IBANDRONATE SODIUM, 1 MG**	**L**
J1742	**INJECTION, IBUTILIDE FUMARATE, 1 MG**	**L**
J1743	**IDURSULFASE INJECTION**	**M**
J1745	**INFLIXIMAB INJECTION**	**H**
J1751	**INJECTION, IRON DEXTRAN 165, 50 MG**	**H**
J1752	**IRON DEXTRAN 267 INJECTION**	**H**

J1756	**INJECTION, IRON SUCROSE, 1 MG**	**M**
J1785	**INJECTION, IMIGLUCERASE, PER UNIT**	**L**
J1790	**INJECTION, DROPERIDOL, UP TO 5 MG**	**L**
J1800	**INJECTION, PROPRANOLOL HCL, UP TO 1 MG**	**L**
J1815	**INJECTION, INSULIN, PER 5 UNITS**	**L**
J1817	**INSULIN FOR ADMINISTRATION THROUGH DME (I.E., INSULIN PUMP) PER 50 UNITS**	**M**
J1830	**INJECTION INTERFERON BETA-1B, 0.25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)**	**M**
J1835	**INJECTION, ITRACONAZOLE, 50 MG**	**M**
J1840	**INJECTION, KANAMYCIN SULFATE, UP TO 500 MG**	**M**
J1850	**INJECTION, KANAMYCIN SULFATE, UP TO 75 MG**	**M**
J1885	**INJECTION, KETOROLAC TROMETHAMINE, PER 15 MG**	**M**
J1890	**CEPHALOTHIN SODIUM INJECTION**	**M**
J1931	**INJECTION, LARONIDASE, 0.1 MG**	**M**
J1940	**INJECTION, FUROSEMIDE, UP TO 20 MG**	**L**
J1945	**INJECTION, LEPIRUDIN, 50 MG**	**L**
J1950	**LEUPROLIDE ACETATE /3.75 MG**	**L**
J1956	**INJECTION, LEVOFLOXACIN, 250 MG**	**M**
J1960	**LEVORPHANOL TARTRATE INJ**	**M**
J1980	**INJECTION, HYOSCYAMINE SULFATE, UP TO 0.25 MG**	**L**
J1990	**INJECTION, CHLORDIAZEPOXIDE HCL, UP TO 100 MG**	**L**
J2001	**INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG**	**L**
J2010	**INJECTION, LINCOMYCIN HCL, UP TO 300 MG**	**M**
J2020	**INJECTION, LINEZOLID, 200MG**	**M**
J2060	**INJECTION, LORAZEPAM, 2 MG**	**M**
J2150	**INJECTION, MANNITOL, 25% IN 50 ML**	**M**
J2170	**INJECTION, MECASERMIN, 1 MG**	**L**
J2175	**INJECTION, MEPERIDINE HYDROCHLORIDE, PER 100 MG**	**M**
J2180	**MEPERIDINE/PROMETHAZINE INJ**	**M**
J2185	**INJECTION, MEROPENEM, 100 MG**	**M**
J2210	**INJECTION, METHYLERGONOVINE MALEATE, UP TO 0.2 MG**	**L**
J2248	**INJECTION, MICAFUNGIN SODIUM, 1 MG**	**M**
J2250	**INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG**	**M**
J2260	**INJECTION, MILRINONE LACTATE, 5 MG**	**L**
J2270	**INJECTION, MORPHINE SULFATE, UP TO 10 MG**	**M**
J2271	**INJECTION, MORPHINE SULFATE, 100MG**	**M**
J2275	**INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG**	**M**
J2278	**INJECTION, ZICONOTIDE, 1 MICROGRAM**	**L**
J2280	**INJECTION, MOXIFLOXACIN, 100 MG**	**M**
J2300	**INJECTION, NALBUPHINE HYDROCHLORIDE, PER 10 MG**	**L**
J2310	**INJECTION, NALOXONE HYDROCHLORIDE, PER 1 MG**	**L**
J2315	**INJECTION, NALTREXONE, DEPOT FORM, 1 MG**	**M**
J2320	**INJECTION, NANDROLONE DECANOATE, UP TO 50 MG**	**L**
J2321	**INJECTION, NANDROLONE DECANOATE, UP TO 100 MG**	**L**
J2322	**INJECTION, NANDROLONE DECANOATE, UP TO 200 MG**	**L**
J2323	**INJECTION, NATALIZUMAB, 1 MG**	**H**
J2325	**INJECTION, NESIRITIDE, 0.1 MG**	**M**

J2353	**OCTREOTIDE INJECTION, DEPOT**	**M**
J2354	**OCTREOTIDE INJ, NON-DEPOT**	**M**
J2355	**OPRELVEKIN INJECTION**	**M**
J2357	**INJECTION, OMALIZUMAB, 5 MG**	**M**
J2360	**INJECTION, ORPHENADRINE CITRATE, UP TO 60 MG**	**L**
J2370	**INJECTION, PHENYLEPHRINE HCL, UP TO 1 ML**	**L**
J2400	**INJECTION, CHLOROPROCAINE HYDROCHLORIDE, PER 30 ML**	**L**
J2405	**ONDANSETRON HCL INJECTION**	**M**
J2410	**INJECTION, OXYMORPHONE HCL, UP TO 1 MG**	**M**
J2425	**INJECTION, PALIFERMIN, 50 MICROGRAMS**	**M**
J2430	**PAMIDRONATE DISODIUM /30 MG**	**M**
J2440	**INJECTION, PAPAVERINE HCL, UP TO 60 MG**	**L**
J2460	**OXYTETRACYCLINE INJECTION**	**M**
J2469	**PALONOSETRON HCL**	**M**
J2501	**INJECTION, PARICALCITOL, 1 MCG**	**L**
J2503	**INJECTION, PEGAPTANIB SODIUM, 0.3 MG**	**M**
J2504	**INJECTION, PEGADEMASE BOVINE, 25 IU**	**M**
J2505	**INJECTION, PEGFILGRASTIM 6MG**	**L**
J2510	**INJECTION, PENICILLIN G PROCAINE, AQUEOUS, UP TO 600,000 UNITS**	**L**
J2513	**INJECTION, PENTASTARCH, 10% SOLUTION, 100 ML**	**L**
J2515	**INJECTION, PENTOBARBITAL SODIUM, PER 50 MG**	**M**
J2540	**INJECTION, PENICILLIN G POTASSIUM, UP TO 600,000 UNITS**	**M**
J2543	**INJECTION, PIPERACILLIN SODIUM/TAZOBACTAM SODIUM, 1 GRAM/0.125 GRAMS (1.125 GRAMS)**	**M**
J2550	**INJECTION, PROMETHAZINE HCL, UP TO 50 MG**	**L**
J2560	**INJECTION, PHENOBARBITAL SODIUM, UP TO 120 MG**	**L**
J2590	**INJECTION, OXYTOCIN, UP TO 10 UNITS**	**L**
J2597	**INJECTION, DESMOPRESSIN ACETATE, PER 1 MCG**	**L**
J2650	**INJECTION, PREDNISOLONE ACETATE, UP TO 1 ML**	**L**
J2670	**TOTAZOLINE HCL INJECTION**	**M**
J2675	**INJECTION, PROGESTERONE, PER 50 MG**	**L**
J2680	**INJECTION, FLUPHENAZINE DECANOATE, UP TO 25 MG**	**L**
J2690	**INJECTION, PROCAINAMIDE HCL, UP TO 1 GM**	**L**
J2700	**INJECTION, OXACILLIN SODIUM, UP TO 250 MG**	**M**
J2710	**INJECTION, NEOSTIGMINE METHYLSULFATE, UP TO 0.5 MG**	**L**
J2720	**INJECTION, PROTAMINE SULFATE, PER 10 MG**	**L**
J2724	**PROTEIN C CONCENTRATE**	**M**
J2725	**INJ PROTIRELIN PER 250 MCG**	**M**
J2730	**INJECTION, PRALIDOXIME CHLORIDE, UP TO 1 GM**	**L**
J2760	**INJECTION, PHENTOLAMINE MESYLATE, UP TO 5 MG**	**L**
J2765	**INJECTION, METOCLOPRAMIDE HCL, UP TO 10 MG**	**L**
J2770	**INJECTION, QUINUPRISTIN/DALFOPRISTIN, 500 MG (150/350)**	**M**
J2778	**RANIBIZUMAB INJECTION**	**H**
J2780	**INJECTION, RANITIDINE HYDROCHLORIDE, 25 MG**	**M**
J2783	**RASBURICASE**	**M**
J2788	**INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, MINIDOSE, 50 MCG**	**M**
J2790	**INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, FULL DOSE, 300 MCG**	**M**
J2791	**RHOPHYLAC INJECTION**	**M**
J2792	**INJECTION, RHO D IMMUNE GLOBULIN, INTRAVENOUS, HUMAN,**	**M**

	SOLVENT DETERGENT, 100 IU	
J2794	**INJECTION, RISPERIDONE, LONG ACTING, 0.5 MG**	**L**
J2795	**INJECTION, ROPIVACAINE HYDROCHLORIDE, 1 MG**	**L**
J2800	**INJECTION, METHOCARBAMOL, UP TO 10 ML**	**L**
J2805	**INJECTION, SINCALIDE, 5 MICROGRAMS**	**L**
J2810	**INJECTION, THEOPHYLLINE, PER 40 MG**	**M**
J2820	**SARGRAMOSTIM INJECTION**	**M**
J2850	**INJECTION, SECRETIN, SYNTHETIC, HUMAN, 1 MICROGRAM**	**L**
J2910	**AUROTHIOGLUCOSE INJECITON**	**M**
J2916	**INJECTION, SODIUM FERRIC GLUCONATE COMPLEX IN SUCROSE INJECTION, 12.5 MG**	**M**
J2920	**INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 40 MG**	**L**
J2930	**INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 125 MG**	**L**
J2940	**SOMATREM INJECTION**	**M**
J2941	**INJECTION, SOMATROPIN, 1 MG**	**L**
J2993	**INJECTION, RETEPLASE, 18.1 MG**	**M**
J2995	**INJECTION, STREPTOKINASE, PER 250,000 IU**	**M**
J2997	**INJECTION, ALTEPLASE RECOMBINANT, 1 MG**	**M**
J3000	**INJECTION, STREPTOMYCIN, UP TO 1 GM**	**M**
J3010	**INJECTION, FENTANYL CITRATE, 0.1 MG**	**M**
J3030	**INJECTION, SUMATRIPTAN SUCCINATE, 6 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)**	**L**
J3070	**INJECTION, PENTAZOCINE, 30 MG**	**L**
J3100	**INJECTION, TENECTEPLASE, 50MG**	**M**
J3105	**INJECTION, TERBUTALINE SULFATE, UP TO 1 MG**	**L**
J3120	**INJECTION, TESTOSTERONE ENANTHATE, UP TO 100 MG**	**L**
J3130	**INJECTION, TESTOSTERONE ENANTHATE, UP TO 200 MG**	**L**
J3140	**TESTOSTERONE SUSPENSION INJ**	**M**
J3150	**TESTOSTERON PROPIONATE INJ**	**M**
J3230	**INJECTION, CHLORPROMAZINE HCL, UP TO 50 MG**	**L**
J3240	**INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL**	**L**
J3243	**INJECTION, TIGECYCLINE, 1 MG**	**M**
J3246	**INJECTION, TIROFIBAN HCL, 0.25MG**	**M**
J3250	**INJECTION, TRIMETHOBENZAMIDE HCL, UP TO 200 MG**	**L**
J3260	**INJECTION, TOBRAMYCIN SULFATE, UP TO 80 MG**	**M**
J3265	**INJECTION, TORSEMIDE, 10 MG/ML**	**L**
J3280	**THIETHYLPERAZINE MALEATE INJ**	**M**
J3285	**INJECTION, TREPROSTINIL, 1 MG**	**M**
J3301	**INJECTION, TRIAMCINOLONE ACETONIDE, PER 10MG**	**L**
J3302	**INJECTION, TRIAMCINOLONE DIACETATE, PER 5MG**	**L**
J3303	**INJECTION, TRIAMCINOLONE HEXACETONIDE, PER 5MG**	**L**
J3305	**INJ TRIMETREXATE GLUCORONATE**	**M**
J3310	**PERPHENAZINE INJECITON**	**M**
J3315	**INJECTION, TRIPTORELIN PAMOATE, 3.75 MG**	**L**
J3320	**INJECTION, SPECTINOMYCIN DIHYDROCHLORIDE, UP TO 2 GM**	**L**
J3350	**UREA INJECTION**	**M**
J3355	**INJECTION, UROFOLLITROPIN, 75 IU**	**L**

J3360	**INJECTION, DIAZEPAM, UP TO 5 MG**	**M**
J3364	**INJECTION, UROKINASE, 5000 IU VIAL**	**L**
J3365	**INJECTION, IV, UROKINASE, 250,000 I.U. VIAL**	**M**
J3370	**INJECTION, VANCOMYCIN HCL, 500 MG**	**M**
J3396	**INJECTION, VERTEPORFIN, 0.1 MG**	**M**
J3400	**TRIFLUPROMAZINE HCL INJ**	**M**
J3410	**INJECTION, HYDROXYZINE HCL, UP TO 25 MG**	**L**
J3411	**INJECTION, THIAMINE HCL, 100 MG**	**L**
J3415	**INJECTION, PYRIDOXINE HCL, 100 MG**	**L**
J3420	**INJECTION, VITAMIN B-12 CYANOCOBALAMIN, UP TO 1000 MCG**	**L**
J3430	**INJECTION, PHYTONADIONE (VITAMIN K), PER 1 MG**	**L**
J3465	**INJECTION, VORICONAZOLE, 10 MG**	**M**
J3470	**INJECTION, HYALURONIDASE, UP TO 150 UNITS**	**L**
J3471	**INJECTION, HYALURONIDASE, OVINE, PRESERVATIVE FREE, PER 1 USP UNIT (UP TO 999**	**L**
J3472	**INJECTION, HYALURONIDASE, OVINE, PRESERVATIVE FREE, PER 1000 USP UNITS**	**L**
J3473	**INJECTION, HYALURONIDASE, RECOMBINANT, 1 USP UNIT**	**L**
J3475	**INJECTION, MAGNESIUM SULFATE, PER 500 MG**	**M**
J3480	**INJECTION, POTASSIUM CHLORIDE, PER 2 MEQ**	**M**
J3485	**INJECTION, ZIDOVUDINE, 10 MG**	**M**
J3486	**INJECTION, ZIPRASIDONE MESYLATE, 10 MG**	**M**
J3487	**ZOLEDRONIC ACID**	**M**
J3488	**RECLAST INJECTION**	**M**
J3530	**NASAL VACCINE INHALATION**	**L**
J3590	**UNCLASSIFIED BIOLOGICS**	**H**
J7030	**INFUSION, NORMAL SALINE SOLUTION , 1000 CC**	**L**
J7040	**INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML=1 UNIT)**	**L**
J7042	**5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)**	**L**
J7050	**INFUSION, NORMAL SALINE SOLUTION , 250 CC**	**L**
J7060	**5% DEXTROSE/WATER (500 ML = 1 UNIT)**	**L**
J7070	**INFUSION, D5W, 1000 CC**	**L**
J7100	**INFUSION, DEXTRAN 40, 500 ML**	**L**
J7110	**INFUSION, DEXTRAN 75, 500 ML**	**L**
J7120	**RINGERS LACTATE INFUSION, UP TO 1000 CC**	**L**
J7120	**RINGERS LACTATE INFUSION**	**L**
J7130	**HYPERTONIC SALINE SOLUTION**	**L**
J7187	**INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR, PER IU**	**H**
J7189	**FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PER 1 MICROGRAM**	**H**
J7190	**FACTOR VIII (ANTIHEMOPHILIC FACTOR, HUMAN) PER I.U.**	**H**
J7191	**FACTOR VIII (PORCINE)**	**H**
J7192	**FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U.**	**H**
J7193	**FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT) PER I.U.**	**H**
J7194	**FACTOR IX, COMPLEX, PER I.U.**	**H**
J7195	**FACTOR IX (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U.**	**H**
J7197	**ANTITHROMBIN III (HUMAN), PER I.U.**	**H**

J7198	**ANTI-INHIBITOR, PER I.U.**	**H**
J7306	**LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES**	**L**
J7308	**AMINOLEVULINIC ACID HCL FOR TOPICAL ADMINISTRATION, 20%, SINGLE UNIT DOSAGE FORM (354 MG)**	**M**
J7310	**GANCICLOVIR, 4.5 MG, LONG-ACTING IMPLANT**	**M**
J7311	**FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT**	**L**
J7321	**HYALGAN/SUPARTZ INJ PER DOSE**	**H**
J7322	**SYNVISC INJ PER DOSE**	**H**
J7323	**EUFLEXXA INJ PER DOSE**	**H**
J7324	**ORTHOVISC INJ PER DOSE**	**H**
J7340	**DERMAL AND EPIDERMAL TISSUE OF HUMAN ORIGIN, WITH OR WITHOUT BIOENGINEERED OR PROCESSED ELEMENTS, WITH METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER**	**M**
J7341	**DERMAL (SUBSTITUTE) TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITH METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER**	**M**
J7342	**DERMAL TISSUE, OF HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITH METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER**	**M**
J7343	**DERMAL AND EPIDERMAL, TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER**	**M**
J7344	**DERMAL TISSUE, OF HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER**	**M**
J7346	**INJECTABLE HUMAN TISSUE**	**H**
J7347	**INTEGRA MATRIX TISSUE**	**H**
J7348	**TISSUEMEND TISSUE**	**H**
J7349	**PRIMATRIX TISSUE**	**H**
J7500	**AZATHIOPRINE, ORAL, 50 MG**	**L**
J7501	**AZATHIOPRINE, PARENTERAL, 100 MG**	**L**
J7502	**CYCLOSPORINE, ORAL, 100 MG**	**L**
J7504	**LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, EQUINE, PARENTERAL, 250 MG**	**M**
J7505	**MUROMONAB-CD3, PARENTERAL, 5 MG**	**H**
J7506	**PREDNISONE ORAL**	**L**
J7507	**TACROLIMUS, ORAL, PER 1 MG**	**H**
J7509	**METHYLPREDNISOLONE ORAL, PER 4 MG**	**L**
J7510	**PREDNISOLONE ORAL, PER 5 MG**	**L**
J7511	**LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, RABBIT, PARENTERAL, 25MG**	**M**
J7513	**DACLIZUMAB, PARENTERAL, 25 MG**	**M**
J7515	**CYCLOSPORINE, ORAL, 25 MG**	**M**
J7516	**CYCLOSPORIN, PARENTERAL, 250 MG**	**M**
J7517	**MYCOPHENOLATE MOFETIL, ORAL, 250 MG**	**L**
J7518	**MYCOPHENOLIC ACID, ORAL, 180 MG**	**L**
J7520	**SIROLIMUS, ORAL, 1 MG**	**M**

J7525	**TACROLIMUS, PARENTERAL, 5 MG**	**M**
J7599	**IMMUNOSUPPRESSIVE DRUG NOC**	**H**
J7607	**LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH**	**L**
J7609	**ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME,**	**L**
J7610	**ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME,**	**L**
J7615	**LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH**	**L**
J7620	**ALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 0.5 MG, FDA-APPROVED**	**L**
J7627	**BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME,**	**L**
J7634	**BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME,**	**L**
J7640	**FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME,**	**L**
J7645	**IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED**	**L**
J7647	**ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH**	**L**
J7650	**ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH**	**L**
J7657	**ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED**	**L**
J7660	**ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED**	**L**
J7667	**METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED**	**L**
J7670	**METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED**	**L**
J7674	**METHACHOLINE CHLORIDE ADMINISTERED AS INHALATION SOLUTION THROUGH A NEBULIZER, PER 1 MG**	**L**
J7685	**TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME,**	**H**
J7799	**NON-INHALATION DRUG FOR DME**	**L**
J8498	**ANTIEMETIC DRUG, RECTAL/SUPPOSITORY, NOT OTHERWISE SPECIFIED**	**L**
J8501	**APREPITANT, ORAL, 5 MG**	**L**
J8510	**ORAL BUSULFAN**	**L**
J8515	**CABERGOLINE, ORAL, 0.25 MG**	**L**
J8520	**CAPECITABINE, ORAL, 150 MG**	**L**
J8521	**CAPECITABINE, ORAL, 500 MG**	**M**
J8530	**CYCLOPHOSPHAMIDE ORAL 25 MG**	**L**
J8540	**DEXAMETHASONE, ORAL, 0.25 MG**	**L**
J8560	**ETOPOSIDE ORAL 50 MG**	**L**
J8597	**ANTIEMETIC DRUG, ORAL, NOT OTHERWISE SPECIFIED**	**L**
J8600	**MELPHALAN ORAL 2 MG**	**L**
J8610	**METHOTREXATE ORAL 2.5 MG**	**L**
J8650	**NABILONE, ORAL, 1 MG**	**L**
J8700	**TEMOZOLOMIDE**	**L**
J9000	**DOXORUBIC HCL 10 MG VL CHEMO**	**H**

J9001	**DOXORUBICIN HCL LIPOSOME INJ**	**H**
J9010	**ALEMTUZUMAB INJECTION**	**H**
J9015	**ALDESLEUKIN/SINGLE USE VIAL**	**H**
J9017	**ARSENIC TRIOXIDE**	**H**
J9020	**ASPARAGINASE INJECTION**	**H**
J9025	**INJECTION, AZACITIDINE, 1 MG**	**H**
J9027	**INJECTION, CLOFARABINE, 1 MG**	**M**
J9031	**BCG LIVE INTRAVESICAL VAC**	**H**
J9035	**BEVACIZUMAB INJECTION**	**H**
J9040	**BLEOMYCIN SULFATE INJECTION**	**H**
J9041	**BORTEZOMIB INJECTION**	**H**
J9045	**CARBOPLATIN INJECTION**	**H**
J9050	**CARMUS BISCHL NITRO INJ**	**H**
J9055	**CETUXIMAB INJECTION**	**H**
J9060	**CISPLATIN 10 MG INJECTION**	**H**
J9062	**CISPLATIN, 50 MG**	**H**
J9065	**INJ CLADRIBINE PER 1 MG**	**H**
J9070	**CYCLOPHOSPHAMIDE 100 MG INJ**	**H**
J9080	**CYCLOPHOSPHAMIDE 200 MG INJ**	**H**
J9090	**CYCLOPHOSPHAMIDE, 500 MG**	**H**
J9091	**CYCLOPHOSPHAMIDE, 1.0 GRAM**	**H**
J9092	**CYCLOPHOSPHAMIDE, 2.0 GRAM**	**H**
J9093	**CYCLOPHOSPHAMIDE LYOPHILIZED**	**H**
J9094	**CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG**	**H**
J9095	**CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG**	**H**
J9096	**CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM**	**H**
J9097	**CYCLOPHOSPHAMIDE LYOPHILIZED**	**H**
J9098	**CYTARABINE LIPOSOME, 10 MG**	**H**
J9100	**CYTARABINE HCL 100 MG INJ**	**H**
J9110	**CYTARABINE, 500 MG**	**H**
J9120	**DACTINOMYCIN ACTINOMYCIN D**	**H**
J9130	**DACARBAZINE 100 MG INJ**	**H**
J9140	**DACARBAZINE, 200 MG**	**H**
J9150	**DAUNORUBICIN**	**H**
J9151	**DAUNORUBICIN CITRATE LIPOSOM**	**H**
J9160	**DENILEUKIN DIFTITOX, 300 MCG**	**H**
J9165	**DIETHYLSTILBESTROL INJECTION**	**H**
J9170	**DOCETAXEL**	**H**
J9175	**ELLIOTTS B SOLUTION PER ML**	**M**
J9178	**INJECTION, EPIRUBICIN HCL, 2 MG**	**H**
J9181	**ETOPOSIDE 10 MG INJ**	**H**
J9182	**ETOPOSIDE, 100 MG**	**H**
J9185	**FLUDARABINE PHOSPHATE INJ**	**H**
J9190	**FLUOROURACIL INJECTION**	**H**
J9200	**FLOXURIDINE INJECTION**	**H**
J9201	**GEMCITABINE HCL**	**H**
J9202	**GOSERELIN ACETATE IMPLANT**	**L**
J9206	**IRINOTECAN INJECTION**	**H**
J9208	**IFOSFOMIDE INJECTION**	**H**
J9209	**MESNA INJECTION**	**H**
J9211	**IDARUBICIN HCL INJECTION**	**H**
J9212	**INTERFERON ALFACON-1**	**M**

J9213	**INTERFERON ALFA-2A INJ**	**M**
J9214	**INTERFERON ALFA-2B INJ**	**M**
J9215	**INTERFERON ALFA-N3 INJ**	**M**
J9216	**INTERFERON GAMMA 1-B INJ**	**M**
J9217	**LEUPROLIDE ACETATE SUSPENSION**	**L**
J9218	**LEUPROLIDE ACETATE INJECTION**	**L**
J9219	**LEUPROLIDE ACETATE IMPLANT**	**L**
J9225	**HISTRELIN IMPLANT, 50 MG**	**L**
J9226	**SUPPRELIN LA IMPLANT**	**H**
J9230	**MECHLORETHAMINE HCL INJ**	**H**
J9245	**INJ MELPHALAN HYDROCHL 50 MG**	**H**
J9250	**METHOTREXATE SODIUM INJ**	**H**
J9260	**METHOTREXATE SODIUM, 50 MG**	**H**
J9261	**INJECTION, NELARABINE, 50 MG**	**M**
J9263	**OXALIPLATIN**	**H**
J9264	**INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG**	**H**
J9265	**PACLITAXEL INJECTION**	**H**
J9266	**PEGASPARGASE/SINGL DOSE VIAL**	**H**
J9268	**PENTOSTATIN INJECTION**	**H**
J9270	**PLICAMYCIN (MITHRAMYCIN) INJ**	**H**
J9280	**MITOMYCIN 5 MG INJ**	**H**
J9290	**MITOMYCIN, 20 MG**	**H**
J9291	**MITOMYCIN, 40 MG**	**H**
J9293	**MITOXANTRONE HYDROCHL / 5 MG**	**H**
J9300	**GEMTUZUMAB OZOGAMICIN**	**H**
J9303	**PANITUMUMAB INJECTION**	**H**
J9305	**PEMETREXED INJECTION**	**H**
J9310	**RITUXIMAB CANCER TREATMENT**	**H**
J9320	**STREPTOZOCIN INJECTION**	**H**
J9340	**THIOTEPA INJECTION**	**H**
J9350	**TOPOTECAN**	**H**
J9355	**TRASTUZUMAB**	**H**
J9357	**VALRUBICIN, 200 MG**	**H**
J9360	**VINBLASTINE SULFATE INJ**	**H**
J9370	**VINCRISTINE SULFATE 1 MG INJ**	**H**
J9375	**VINCRISTINE SULFATE, 2 MG**	**H**
J9380	**VINCRISTINE SULFATE 5 MG INJ**	**H**
J9390	**VINORELBINE TARTRATE/10 MG**	**H**
J9395	**INJECTION, FULVESTRANT**	**H**
J9600	**PORFIMER SODIUM**	**H**
P9041	**INFUSION, ALBUMIN (HUMAN), 5%, 50 ML**	**M**
P9043	**INFUSION, PLASMA PROTEIN FRACTION (HUMAN), 5%, 50 ML**	**M**
P9045	**INFUSION, ALBUMIN (HUMAN), 5%, 250 ML**	**M**
P9046	**INFUSION, ALBUMIN (HUMAN), 25%, 20 ML**	**M**
P9047	**INFUSION, ALBUMIN (HUMAN), 25%, 50 ML**	**M**
P9048	**INFUSION, PLASMA PROTEIN FRACTION (HUMAN), 5%, 250ML**	**M**
Q0163	**DIPHENHYDRAMINE HCL 50MG**	**L**
Q0164	**PROCHLORPERAZINE MALEATE 5MG**	**L**
Q0166	**GRANISETRON HCL 1 MG ORAL**	**L**
Q0167	**DRONABINOL 2.5MG ORAL**	**L**
Q0169	**PROMETHAZINE HCL 12.5MG ORAL**	**L**
Q0171	**CHLORPROMAZINE HCL 10MG ORAL**	**L**

Q0173	**TRIMETHOBENZAMIDE HCL 250MG**	**L**
Q0174	**THIETHYLPERAZINE MALEATE10MG**	**L**
Q0175	**PERPHENAZINE 4MG ORAL**	**L**
Q0177	**HYDROXYZINE PAMOATE 25MG**	**L**
Q0179	**ONDANSETRON HCL 8MG ORAL**	**L**
Q0180	**DOLASETRON MESYLATE ORAL**	**L**
Q0515	**INJECTION, SERMORELIN ACETATE, 1 MICROGRAM**	**M**
Q2009	**INJECTION, FOSPHENYTOIN, 50 MG**	**M**
Q2017	**TENIPOSIDE, 50 MG**	**H**
Q3025	**INJECTION, INTERFERON BETA-1A, 11 MCG FOR INTRAMUSCULAR USE**	**H**
Q4080	**ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME, UP TO 20 MICROGRAMS**	**L**
Q4081	**INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)**	**M**
Q9951	**LOW OSMOLAR CONTRAST MATERIAL, 400 OR GREATER MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9953	**INJECTION, IRON-BASED MAGNETIC RESONANCE CONTRAST AGENT, PER ML**	**L**
Q9954	**ORAL MAGNETIC RESONANCE CONTRAST AGENT, PER 100 ML**	**L**
Q9955	**INJECTION, PERFLEXANE LIPID MICROSPHERES, PER ML**	**H**
Q9956	**INJECTION, OCTAFLUOROPROPANE MICROSPHERES, PER ML**	**H**
Q9957	**INJECTION, PERFLUTREN LIPID MICROSPHERES, PER ML**	**H**
Q9958	**HIGH OSMOLAR CONTRAST MATERIAL, UP TO 149 MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9959	**HIGH OSMOLAR CONTRAST MATERIAL, 150-199 MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9960	**HIGH OSMOLAR CONTRAST MATERIAL, 200-249 MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9961	**HIGH OSMOLAR CONTRAST MATERIAL, 250-299 MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9962	**HIGH OSMOLAR CONTRAST MATERIAL, 300-349 MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9963	**HIGH OSMOLAR CONTRAST MATERIAL, 350-399 MG/ML IODINE CONCENTRATION, PER ML**	**L**
Q9964	**HIGH OSMOLAR CONTRAST MATERIAL, 400 OR GREATER MG/ML IODINE CONCENTRATION, PER ML**	**L**