COMMUNITY HEALTH CHOICE

Clinician Administered Drugs – Site of Care

Effective Date: 08/01/25
Medical Care Management Committee Approval: 01/16/2025

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Coverage Policy

This Medical Review Guideline (Guideline) is provided for informational purposes only and does not constitute medical advice. It is intended solely for the use of Community Health Choice, Inc. (Community) clinical staff as a guideline for use in determining medical necessity of requested procedures, medications and therapy. This Guideline does not address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline. If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This policy applies to medication infusion services provided by hospital outpatient facilities to patients who are ≥ 18 years of age with the following Place of Service codes:

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

Infusion services provided to patients < 18 years of age are not subject to this policy.

We will require use of the following alternative non-hospital sites of care if clinically appropriate in non-emergency situations for patients who are considered medically stable and in whom a delay in care due to change in site would not be expected to result in disease progression or member harm, or to cause a barrier to regimen compliance:

- Non-hospital outpatient infusion centers
- Physician office
- Ambulatory infusion centers
- Home infusion services

Community will provide coverage for medication infusion services in hospital-based outpatient

infusion facilities for patients who meet the requirements for Hospital-based Outpatient Infusion criteria. This policy applies only to the site of care where the patient receives the infusion. Additional prior authorization approval may be required for the requested medication.

Hospital-based Outpatient Infusion Criteria

Medication infusion in a hospital outpatient setting will be considered medically necessary with documentation and attestation that the use of a non-hospital-based infusion site would result in one of the following:

1. Make patient harm, death or disease progression probable; OR
2. Potentially cause a barrier to the patient's adherence or compliance with the plan of care; OR
3. Because of the timeliness of the delivery or dosage requirements, necessitate delivery by a different pharmacy

Approval for medication infusion in a hospital outpatient setting will be limited to 6 months to allow for reassessment of the patient's ability to receive treatment at an alternative non-hospital site of care.

Applicable Codes

This policy applies to the following clinician administered drugs:

NDC	HCPCS	NDC Label Name
00310-1730-30	J0517	FASENRA 30 MG/ML SYRINGE
00310-1830-30	J0517	FASENRA PEN 30 MG/ML
25682-0001-01	J1300	SOLIRIS 300 MG/30 ML VIAL
64764-0300-20	J3380	ENTYVIO 300 MG VIAL
76125-0900-02	J1561	GAMMAKED 1 GRAM/10 ML VIAL
76125-0900-26	J1561	GAMMAKED 2.5 GRAM/25 ML VIA
00074-1050-01	J2327	SKYRIZI Risankizumab-rzaa, intravenous, 1 mg
00074-1065-01	J2327	SKYRIZI Risankizumab-rzaa, intravenous, 1 mg
00074-1070-01	J2327	SKYRIZI Risankizumab-rzaa, intravenous, 1 mg
50242-0150-01	J2350	OCREVUS Injection, ocrelizumab, 1 mg
67386-0130-51	J3032	Injection, eptinezumab-jjmr, 1 mg
50242-0051-10	J9312	Injection, rituximab, 10 mg
50242-0051-21	J9312	Injection, rituximab, 10 mg
50242-0053-06	J9312	Injection, rituximab, 10 mg
63459-0103-10	Q5115	Injection, rituximab-abbs, (Truxima), 10mg
63459-0104-50	Q5115	Injection, rituximab-abbs, (Truxima), 10mg

00069-0249-01	Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg
0069-0238-01	Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg
55513-224-01	Q5123	Injection, rituximab,arrx, biosimilar, (Riabni), 10 mg
55513-326-01	Q5123	Injection, rituximab,arrx, biosimilar, (Riabni), 10 mg
57894-0030-01	J1745	Injection, infliximab, excludes biosimilar, 10 mg per unit
57894-0160-01	J1745	Injection, infliximab, excludes biosimilar, 10 mg per unit
78206-0162-01	Q5104	Injection, INFLIXIMAB-ABDA, (RENFLEXIS), 10 MG
00006-4305-02	Q5104	Injection, INFLIXIMAB-ABDA, (RENFLEXIS), 10 MG
0069-0809-01	Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg per unit
55513-0670-01	Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg per unit
00006-3026-01	J9271	Injection, pembrolizumab, 1 mg
00006-3026-04	J9271	Injection, pembrolizumab, 1 mg
00006-3026-02	J9271	Injection, pembrolizumab, 1 mg
00003-3734-13	J9299	Injection, nivolumab, 1 mg
00003-3756-14	J9299	Injection, nivolumab, 1 mg
00003-3774-12	J9299	Injection, nivolumab, 1 mg
00003-3772-11	J9299	Injection, nivolumab, 1 mg

References

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American Academy of Allergy Asthma and Immunology. Guidelines for the site of care for administration of IVIG therapy. December 2011.

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Texas Insurance Code - INS § 1369.764. Certain Limitations on Coverage of Clinician-Administered Drugs Prohibited. 88th Leg., R.S., Ch. 417 (H.B. 1647), Sec. 1, eff. September 1, 2023

Policy Revision History

Status	Effective Date	Description
Baseline	2/1/21	Initial version of Clinician Administered Drugs Site of Care Policy
Update	4/1/25	Update in accordance with HB1647
Update	8/1/25	Addition of pembrolizumab and nivolumab to applicable codes