Xolair® (omalizumab)
(Subcutaneous)

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I. Length of Authorization

- Initial: 6 months for moderate to severe persistent asthma, chronic spontaneous urticaria (CSU), IgE-mediated food allergy, and chronic rhinosinusitis with nasal polyps (CRSwNP); 12 months for all other indications
- Renewal: 12 months for all indications

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

Moderate to Severe Persistent Asthma
- 75 billable units every 14 days

CRSwNP and IgE-Mediated Food Allergy
- 120 billable units every 14 days

All other indications
- 60 billable units every 28 days

III. Initial Approval Criteria

Target Agent(s) will be approved when ALL of the following are met:

1. ONE of the following
   A. The requested agent is eligible for continuation of therapy AND ONE of the following:

Agents Eligible for Continuation of Therapy
All target agents are eligible for continuation of therapy

   1. The patient has been treated with the requested agent (starting on samples is not approvable) **OR**

2. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed **OR**

B. BOTH of the following:
   1. ONE of the following:

A. The patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
   1. ONE of the following:
      A. The patient is 6 to less than 12 years of age AND BOTH of the following:
         1. The patient's pretreatment IgE level is 30 IU/mL to 1300 IU/mL **AND**
         2. The patient's weight is 20 kg to 150 kg **OR**
      B. The patient is 12 years of age or over AND BOTH of the following:
         1. The patient's pretreatment IgE level is 30 IU/mL to 700 IU/mL **AND**
         2. The patient's weight is 30 kg to 150 kg **AND**
   2. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen **AND**
   3. The patient has a history of uncontrolled asthma while on asthma control therapy as demonstrated by ONE of the following:
      A. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months **OR**
      B. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months **OR**
      C. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered **OR**
      D. The patient has baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted **OR**

B. The patient has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) AND ALL of the following:
   1. The patient has had over 6 weeks of hives and itching **AND**
   2. If the patient is currently treated with medications known to cause or worsen urticaria, then ONE of the following:
      A. The prescriber has reduced the dose or discontinued any medications known to cause or worsen urticaria (e.g., NSAIDs) **OR**

B. There is support that a reduced dose or discontinuation of any medication(s) known to cause or worsen urticaria is NOT appropriate **AND**

3. ONE of the following:
   A. The patient has tried and had an inadequate response to the FDA labeled maximum dose of a second-generation H-1 antihistamine (e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine) after at least a 2-week duration of therapy **AND** ONE of the following:
      1. The patient has tried and had an inadequate response to a dose titrated up to 4 times the FDA labeled maximum dose of a second-generation H-1 antihistamine **OR**
      2. There is support that the patient cannot be treated with a dose titrated up to 4 times the FDA labeled maximum dose of a second-generation H-1 antihistamine **OR**
   B. The patient has an intolerance or hypersensitivity to therapy with a second-generation H-1 antihistamine **OR**
   C. The patient has an FDA labeled contraindication to ALL second-generation H-1 antihistamines **OR**

C. The patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND ALL of the following:
   A. BOTH of the following:
      1. The patient's pretreatment IgE level is 30 IU/mL to 1500 IU/mL **AND**
      2. The patient's weight is 30 kg to 150 kg **AND**
   B. The patient has at least TWO of the following symptoms consistent with chronic rhinosinusitis (CRS):
      A. Nasal discharge (rhinorrhea or post-nasal drainage)
      B. Nasal obstruction or congestion
      C. Loss or decreased sense of smell (hyposmia)
      D. Facial pressure or pain **AND**
   3. The patient has had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks **AND**
   4. The patient's diagnosis was confirmed by ONE of the following:
      A. Anterior rhinoscopy or endoscopy **OR**
      B. Computed tomography (CT) of the sinuses **AND**
   5. ONE of the following:
      A. The patient has tried and had an inadequate response to ONE intranasal corticosteroid therapy (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy **OR**
      B. The patient has an intolerance or hypersensitivity to ONE intranasal corticosteroid therapy (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) **OR**

C. The patient has an FDA labeled contraindication to ALL intranasal corticosteroids **OR**

D. The patient has a diagnosis of IgE-mediated food allergy AND ALL of the following:

1. BOTH of the following:
   A. The patient's pretreatment IgE level is 30 IU/mL to 1850 IU/mL **AND**
   B. The patient's weight is 10 kg to 150 kg **AND**
2. The patient has a confirmed IgE-mediated food allergy confirmed by an allergy diagnostic test (e.g., skin prick test, serum specific IgE test, oral food challenge) **AND**
3. The requested agent will NOT be used for the emergency treatment of allergic reactions, including anaphylaxis **OR**

E. The patient has another FDA labeled indication for the requested agent **AND**

2. If the patient has an FDA labeled indication, then ONE of the following:
   A. The patient's age is within FDA labeling for the requested indication for the requested agent **OR**
   B. There is support for using the requested agent for the patient's age for the requested indication **OR**

C. The patient has another indication that is supported in compendia for the requested agent **AND**

2. If the patient has a diagnosis of moderate to severe persistent asthma, then ALL of the following:

A. ONE of the following:

1. The patient is NOT currently treated with the requested agent AND is currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days **OR**
2. The patient is currently treated with the requested agent AND ONE of the following:
   A. The patient is currently treated with an inhaled corticosteroid for at least 3 months that is adequately dosed to control symptoms AND has been adherent for 90 days within the past 120 days **OR**
   B. The patient is currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days **OR**
3. The patient has an intolerance or hypersensitivity to therapy with an inhaled corticosteroid **OR**
4. The patient has an FDA labeled contraindication to ALL inhaled corticosteroids **AND**

B. ONE of the following:

1. The patient is currently treated for at least 3 months AND has been adherent for 90 days within the past 120 days with ONE of the following:
   A. A long-acting beta-2 agonist (LABA) **OR**
   B. A long-acting muscarinic antagonist (LAMA) **OR**
   C. A Leukotriene receptor antagonist (LTRA) **OR**
   D. Theophylline **OR**

2. The patient has an intolerance or hypersensitivity to therapy with a long-acting beta-2 agonist (LABA), a long-acting muscarinic antagonist (LAMA), a leukotriene receptor antagonist (LTRA), or theophylline **OR**
3. The patient has an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA) **AND**

C. The patient will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent **AND**

D. The requested dose is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 375 mg every 2 weeks **AND**

3. If the patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), then ALL of the following:
   A. The patient is currently treated with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) **AND**
   B. The patient will continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent **AND**
   C. The requested dose is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks **AND**
4. If the patient has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]), the requested dose is within FDA labeled dosing for the requested indication AND does NOT exceed 300 mg every 4 weeks **AND**
5. If the patient has a diagnosis of IgE-mediated food allergy, then ALL of the following:
   A. The patient will avoid known food allergens while treated with the requested agent **AND**
   B. The patient has epinephrine on hand for emergency treatment **AND**
   C. The requested dose is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks **AND**
6. If the patient has another FDA labeled indication for the requested agent, the requested quantity (dose) is within FDA labeled dosing for the requested indication **AND**
7. If the patient has another indication that is supported in compendia for the requested agent, the requested quantity (dose) is supported in compendia for the requested indication **AND**
8. The prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND**
9. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table):
   A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) **OR**
   B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following:
      1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent **AND**
      2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) **AND**
10. The patient does NOT have any FDA labeled contraindications to the requested agent

Compendia Allowed: AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use

IV. Renewal Criteria

Target Agent(s) will be approved when ALL of the following are met:

1. The patient has been previously approved for the requested agent through the plan's Medical Drug Review process [Note: patients not previously approved for the requested agent will require initial evaluation review] **AND**
2. ONE of the following:
    A. The patient has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
        1. The patient has had improvements or stabilization with the requested agent from baseline (prior to therapy with the requested agent) as indicated by ONE of the following:
            A. Increase in percent predicted Forced Expiratory Volume (FEV1) **OR**
            B. Decrease in the dose of inhaled corticosteroid required to control the patient's asthma **OR**
            C. Decrease in need for treatment with systemic corticosteroids due to exacerbations of asthma **OR**
            D. Decrease in the number of hospitalizations, need for mechanical ventilation, or visits to the emergency room or urgent care due to exacerbations of asthma **AND**
        2. The patient is currently treated within the past 90 days and is compliant with asthma control therapy (e.g., inhaled corticosteroids [ICS], ICS/long-acting beta-2 agonist [ICS/LABA], leukotriene receptor antagonist [LTRA], long-acting muscarinic antagonist [LAMA], theophylline) **AND**
        3. The requested dose is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 375 mg every 2 weeks **OR**
    B. The patient has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) AND BOTH of the following:
        1. The patient has had clinical benefit with the requested agent **AND**
        2. The requested dose is within FDA labeled dosing for the requested indication AND does NOT exceed 300 mg every 4 weeks **OR**
    C. The patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND ALL of the following:
        1. The patient has had clinical benefit with the requested agent **AND**
        2. The patient will continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent **AND**
        3. The requested dose is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks **OR**
    D. The patient has a diagnosis of IgE-mediated food allergy AND ALL of the following:
        1. The patient will avoid known food allergens while treated with the requested agent **AND**
        2. The patient has epinephrine on hand for emergency treatment **AND**

3. The requested dose is based on the patient's pretreatment serum IgE level and body weight as defined in FDA labeling AND does NOT exceed 600 mg every 2 weeks **OR**

E. The patient has a diagnosis other than moderate to severe persistent asthma, CSU/CIU, CRSwNP, or IgE-mediated food allergy AND BOTH of the following:
   1. The patient has had clinical benefit with the requested agent **AND**
   2. The requested quantity (dose) is within FDA labeled dosing (or supported in compendia) for the requested indication **AND**

3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND**
4. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table):
   A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) **OR**
   B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following:
      1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent **AND**
      2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) **AND**
5. The patient does NOT have any FDA labeled contraindications to the requested agent

Compendia Allowed: AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use

Contraindicated as Concomitant Therapy
Agents NOT to be used Concomitantly Abrilada (adalimumab-afzb) Actemra (tocilizumab) Adalimumab Adbry (tralokinumab-ldrm) Amjevita (adalimumab-atto) Arcalyst (rilonacept) Avsola (infliximab-axxq) Benlysta (belimumab) Bimzelx (bimekizumab-bkzx) Cibinqo (abrocitinib) Cimzia (certolizumab) Cinqair (reslizumab) Cosentyx (secukinumab) Cyltezo (adalimumab-adbm) Dupixent (dupilumab) Ebglyss (lebrikizumab-lbkz) Enbrel (etanercept) Entyvio (vedolizumab) Fasenra (benralizumab) Hadlima (adalimumab-bwwd)

Contraindicated as Concomitant Therapy
Hulio (adalimumab-fkjp)
Humira (adalimumab)
Hyrimoz (adalimumab-adaz)
Idacio (adalimumab-aacf)
Ilaris (canakinumab)
Ilumya (tildrakizumab-asmn)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Leqselvi (deuruxolitinib)
Litfulo (ritlecitinib)
Nemluvio (nemolizumab-ilto)
Nucala (mepolizumab)
Olumiant (baricitinib)
Omvoh (mirikizumab-mrkz)
Opzelura (ruxolitinib)
Orencia (abatacept)
Otezla (apremilast)
Otulfi (ustekinumab-aauz)
Pyzchiva (ustekinumab-ttwe)
Remicade (infliximab)
Renflexis (infliximab-abda)
Riabni (rituximab-arrx)
Rinvoq (upadacitinib)
Rituxan (rituximab)
Rituxan Hycela (rituximab/hyaluronidase human)
Ruxience (rituximab-pvvr)
Saphnelo (anifrolumab-fnia)
Selarsdi (ustekinumab-aekn)
Siliq (brodalumab)
Simlandi (adalimumab-ryvk)
Simponi (golimumab)
Simponi ARIA (golimumab)
Skyrizi (risankizumab-rzaa)
Sotyktu (deucravacitinib)
Spevigo (spesolimab-sbzo) subcutaneous injection
Stelara (ustekinumab)
Taltz (ixekizumab)
Tezspire (tezepelumab-ekko)
Tofidence (tocilizumab-bavi)
Tremfya (guselkumab)
Truxima (rituximab-abbs)
Tyenne (tocilizumab-aazg)
Tysabri (natalizumab)
Velsipity (etrasimod)

Contraindicated as Concomitant Therapy
Wezlana (ustekinumab-auub) Xeljanz (tofacitinib) Xeljanz XR (tofacitinib extended release) Xolair (omalizumab) Yuflyma (adalimumab-aaty) Yusimry (adalimumab-aqvh) Zeposia (ozanimod) Zymfentra (infliximab-dyyb)

V. Dosage/Administration

Indication	Dose
Moderate to Severe Persistent Asthma	75 to 375 mg administered subcutaneously by a health care provider every 2 or 4 weeks. Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL), measured before the start of treatment, and body weight (kg). See tables below.
Chronic Spontaneous Urticaria	150 or 300 mg administered subcutaneously by a health care provider every 4 weeks. Dosing is not dependent on serum IgE (free or total) level or body weight.
Chronic Rhinosinusitis with Nasal Polyps	75 to 600 mg administered subcutaneously by a health care provider every 2 or 4 weeks. Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL), measured before the start of treatment, and body weight (kg). See table below.
IgE-Mediated Food Allergy	75 to 600 mg administered subcutaneously by a health care provider every 2 or 4 weeks. Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL), measured before the start of treatment, and body weight (kg). See table below.

Asthma Omalizumab Doses Administered Every 4 Weeks (mg) in patients ≥ 12 years				
Pre-treatment serum IgE (IU/mL)	**Body weight (kg)**			
	30 to 60	**> 60 to 70**	**> 70 to 90**	**> 90 to 150**
≥ 30 to 100	150	150	150	300
> 100 to 200	300	300	300	See the following table.
> 200 to 300	300	See the following table.	See the following table.	See the following table.

Asthma Omalizumab Doses Administered Every 2 Weeks (mg) in patients ≥ 12 years				
Pre-treatment serum IgE (IU/mL)	**Body weight (kg)**			
	30 to 60	**> 60 to 70**	**> 70 to 90**	**> 90 to 150**

> 100 to 200	See previous table.	See previous table.	See previous table.	225
> 200 to 300	See previous table.	225	225	300
> 300 to 400	225	225	300	Do not dose.
> 400 to 500	300	300	375	Do not dose.
> 500 to 600	300	375	Do not dose.	Do not dose.
> 600 to 700	375	Do not dose.	Do not dose.	Do not dose

Asthma Omalizumab Doses Administered Every 2 or 4 Weeks (mg) for Pediatric Patients Who Begin Xolair Between the Ages of 6 to <12 Years

Pre-treatment serum IgE (IU/mL)	Dosing Freq. (weeks)	Body Weight (kg)									
		20-25	>25-30	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
30-100	4	75	75	75	150	150	150	150	150	300	300
>100-200		150	150	150	300	300	300	300	300	225	300
>200-300		150	150	225	300	300	225	225	225	300	375
>300-400		225	225	300	225	225	225	300	300	Do Not Dose	
>400-500		225	300	225	225	300	300	375	375		
>500-600		300	300	225	300	300	375	Do Not Dose			
>600-700		300	225	225	300	375	Do Not Dose				
>700-900	2	225	225	300	375	Do Not Dose					
>900-1100		225	300	375	Do Not Dose						
>1100-1200		300	300	Do Not Dose							
>1200-1300		300	375	Do Not Dose							

Nasal Polyps Omalizumab Doses Administered Every 2 or 4 Weeks (mg)

Pre-treatment serum IgE (IU/mL)	Dosing Freq. (weeks)	Body Weight (kg)							
		>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
30-100	4	75	150	150	150	150	150	300	300
>100-200		150	300	300	300	300	300	450	600
>200-300		225	300	300	450	450	450	600	375
>300-400		300	450	450	450	600	600	450	525
>400-500		450	450	600	600	375	375	525	600
>500-600		450	600	600	375	450	450	600	Do Not Dose
>600-700		450	600	375	450	450	525	Do Not Dose	
>700-800	2	300	375	450	450	525	600	Do Not Dose	
>800-900		300	375	450	525	600	Do Not Dose		
>900-1000		375	450	525	600	Do Not Dose			

>1000-1100		375	450	600
>1100-1200		450	525	600
>1200-1300		450	525	
>1300-1500		525	600	

IgE-Mediated Food Allergy Omalizumab Doses Administered Every 2 or 4 Weeks (mg)														
Pre-treatment serum IgE (IU/mL)	**Dosing Freq. (weeks)**	**Body Weight (kg)**												
		≥10-12	**>12-15**	**>15-20**	**>20-25**	**>25-30**	**>30-40**	**>40-50**	**>50-60**	**>60-70**	**>70-80**	**>80-90**	**>90-125**	**>125-150**
≥30-100	4	75	75	75	75	75	75	150	150	150	150	150	300	300
>100-200		75	75	75	150	150	150	300	300	300	300	300	450	600
>200-300		75	75	150	150	150	225	300	300	450	450	450	600	375
>300-400		150	150	150	225	225	300	450	450	450	600	600	450	525
>400-500		150	150	225	225	300	450	450	600	600	375	375	525	600
>500-600		150	150	225	300	300	450	600	600	375	450	450	600	
>600-700		150	150	225	300	225	450	600	375	450	450	525		
>700-800	2	150	150	150	225	225	300	375	450	450	525	600		
>800-900		150	150	150	225	225	300	375	450	525	600			
>900-1000		150	150	225	225	300	375	450	525	600				
>1000-1100		150	150	225	225	300	375	450	600					
>1100-1200		150	150	225	300	300	450	525	600	Do Not Dose				
>1200-1300		150	225	225	300	375	450	525						
>1300-1500		150	225	300	300	375	525	600						
>1500-1850			225	300	375	450	600							

VI. Billing Code/Availability Information

HCPCS Code:

- J2357 – Injection, omalizumab, 5 mg; 1 billable unit = 5 mg

NDC:

- Xolair 75 mg single-dose prefilled syringe or autoinjector: 50242-0214-xx
- Xolair 150 mg single-dose prefilled syringe or autoinjector: 50242-0215-xx
- Xolair 150 mg single-dose vial powder for injection: 50242-0040-xx
- Xolair 300 mg single-dose prefilled syringe or autoinjector: 50242-0227-xx

VII. References

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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified

ICD-10	ICD-10 Description
J45.40	Moderate persistent asthma, uncomplicated
J45.50	Severe persistent asthma, uncomplicated
L29.89	Other pruritus
L29.9	Pruritus, unspecified
L50.1	Idiopathic urticaria
Z91.010	Allergy to peanuts
Z91.011	Allergy to milk products
Z91.012	Allergy to eggs
Z91.013	Allergy to seafood
Z91.018	Allergy to other foods

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes		
Jurisdiction	**NCD/LCA/LCD Document (s)**	**Contractor**
6, K	A52448	National Government Services, Inc

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp. (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp. (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC