Xolair® (omalizumab)
(Subcutaneous)

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I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 12 months (365 days).
- Renewal: Prior authorization validity may be renewed every 12 months (365 days) thereafter.

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
- **Chronic Spontaneous Urticaria:** 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 member has been treated with the requested agent (starting on samples is not approvable); **OR**
      2. The prescriber states the member 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 member has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
            1. If the member is 6 to less than 12 years of age, then BOTH of the following:

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A. The member's pretreatment IgE level is 30 IU/mL to 1300 IU/mL; **AND**

B. The member's weight is 20 kg to 150 kg; **AND**

2. If the member is 12 years of age or over, then BOTH of the following:

A. The member's pretreatment IgE level is 30 IU/mL to 700 IU/mL; **AND**

B. The member's weight is 30 kg to 150 kg; **AND**

3. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test to a perennial aeroallergen; **AND**

4. ONE of the following:

A. The member has a history of uncontrolled asthma while on asthma control therapy (e.g., inhaled corticosteroid [ICS]/long-acting beta-2 agonist [LABA] combination therapy) as demonstrated by ONE of the following:

1. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months; **OR**

2. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months; **OR**

3. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered; **OR**

4. Baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted; **OR**

B. The member's medication history (excluding sample use) indicates use of a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma within the past 12 months; **OR**

B. The member has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) AND ALL of the following:

1. The member has had hives and itching for more than 6 weeks; **AND**

2. The prescriber has evaluated the member to determine if the member is currently treated with medications known to cause or

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worsen urticaria (e.g., NSAIDs) in order to reduce urticaria risk; **AND**

3. The member has ONE of the following:
    A. Tried and had an inadequate response to the FDA labeled maximum dose of ONE second-generation H1-antihistamine (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine,) AND ONE of the following:
        1. The member has tried and had an inadequate response to a maximally tolerated dose of ONE second-generation H1-antihistamine titrated up to 4 times above the FDA labeled maximum dose after at least a 2-week duration of therapy; **OR**
        2. There is support that the member cannot be treated with a second-generation H1-antihistamine at a dose above the FDA labeled maximum dose; **OR**
    B. An intolerance or hypersensitivity to ONE second-generation H1-antihistamine; **OR**
    C. An FDA labeled contraindication to ALL second-generation H1-antihistamines; **OR**

C. The member has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND ALL of the following:
1. BOTH of the following:
    A. The member's pretreatment IgE level is 30 IU/mL to 1500 IU/mL; **AND**
    B. The member's weight is 30 kg to 150 kg; **AND**
2. The member 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 member has had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks; **AND**
4. The member's diagnosis was confirmed by ONE of the following:
    A. Anterior rhinoscopy; **OR**
    B. Nasal endoscopy; **OR**
    C. Computed tomography (CT) of the sinuses; **AND**
5. The member has ONE of the following:

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A. Tried and had an inadequate response to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy; **OR**

B. An intolerance or hypersensitivity to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva); **OR**

C. An FDA labeled contraindication to ALL intranasal corticosteroids; **OR**

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

1. BOTH of the following:

A. The member's pretreatment IgE level is 30 IU/mL to 1850 IU/mL; **AND**

B. The member's weight is 10 kg to 150 kg; **AND**

2. The member has an 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 member has another FDA labeled indication for the requested agent and route of administration; **AND**

2. If the member has an FDA labeled indication, then ONE of the following:

A. The member'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 member's age for the requested indication; **OR**

C. The member has another indication that is supported in compendia for the requested agent and route of administration; **AND**

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

A. ONE of the following:

1. The member is NOT currently treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma (including 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**

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2. The member is currently treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia for the treatment of asthma (including the requested agent) AND ONE of the following:
    A. The member 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 member 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 member has an intolerance or hypersensitivity to ONE inhaled corticosteroid; **OR**
4. The member has an FDA labeled contraindication to ALL inhaled corticosteroids; **AND**

B. ONE of the following:
1. The member 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 member has an intolerance or hypersensitivity to ONE long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist (LTRA), or theophylline; **OR**
3. The member has an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA); **AND**

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

3. If the member has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), then ALL of the following:
    A. The member 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 member 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**
4. If the member has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]), then BOTH of the following:
    A. ONE of the following:
        1. BOTH of the following:

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A. The member is currently treated with second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine); **AND**

B. The member will continue second-generation H1-antihistamine therapy in combination with the requested agent; **OR**

2. The member has an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines; **AND**

5. If the member has a diagnosis of IgE-mediated food allergy, then ALL of the following:
   A. The member will avoid known food allergens while treated with the requested agent; **AND**
   B. The member has epinephrine on hand for emergency treatment; **AND**
6. If the request is for provider-administered Xolair vial, then ONE of the following:

Medicaid Members Only: Self administer product requirements do not apply.

   A. The member has tried a self-administered Xolair prefilled syringe or autoinjector product; **OR**
   B. The member has NOT yet received 3 doses of Xolair in the healthcare setting; **OR**
   C. There is support that self-administration is NOT appropriate for the member based on careful assessment of risk for anaphylaxis and mitigation strategies; **AND**
7. The prescriber is a specialist in the area of the member's diagnosis (e.g., asthma: allergist, immunologist, pulmonologist; CRSwNP: otolaryngologist, allergist, immunologist, pulmonologist; CSU: allergist, dermatologist, immunologist; IgE-mediated food allergy: allergist, immunologist), or the prescriber has consulted with a specialist in the area of the member's diagnosis; **AND**
8. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table):
   A. The member 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 member 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**
9. The member 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:

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1. The member has been previously approved for the requested agent through the plan's Prior Authorization process (Note: members not previously approved for the requested agent will require initial evaluation review); **AND**
2. ONE of the following:
    A. The member has a diagnosis of moderate to severe persistent asthma AND ALL of the following:
        1. The member has had clinical benefit with the requested agent; **AND**
        2. The member 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); **OR**
    B. The member has a diagnosis of chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) AND ALL of the following:
        1. The member has had clinical benefit with the requested agent; **AND**
        2. ONE of the following:
            A. The member will continue second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) in combination with the requested agent; **OR**
            B. The member has an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines; **OR**
    C. The member has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) AND ALL of the following:
        1. The member has had clinical benefit with the requested agent; **AND**
        2. The member 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; **OR**
    D. The member has a diagnosis of IgE-mediated food allergy AND ALL of the following:
        1. The member will avoid known food allergens while treated with the requested agent; **AND**
        2. The member has epinephrine on hand for emergency treatment; **OR**
    E. The member has a diagnosis other than moderate to severe persistent asthma, CSU/CIU, CRSwNP, or IgE-mediated food allergy; **AND**
        1. The member has had clinical benefit with the requested agent; **AND**
3. If the request is for provider-administered Xolair vial, then ONE of the following:

Medicaid Members Only: Self administer product requirements do not apply.

    A. The member has tried a self-administered Xolair prefilled syringe or autoinjector product; **OR**
    B. The member has NOT yet received 3 doses of Xolair in the healthcare setting; **OR**

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C. There is support that self-administration is NOT appropriate for the member based on careful assessment of risk for anaphylaxis and mitigation strategies; **AND**

4. The prescriber is a specialist in the area of the member's diagnosis (e.g., asthma: allergist, immunologist, pulmonologist; CRSwNP: otolaryngologist, allergist, immunologist, pulmonologist; CSU: allergist, dermatologist, immunologist; IgE-mediated food allergy: allergist, immunologist), or the prescriber has consulted with a specialist in the area of the member's diagnosis; **AND**
5. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table):
   A. The member 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 member 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**
6. The member 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) Avtozma (tocilizumab-anoh) 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)

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Contraindicated as Concomitant Therapy
Exdensur (depemokimab-ulaa)
Fasenra (benralizumab)
Hadlima (adalimumab-bwwd)
Hulio (adalimumab-fkjp)
Humira (adalimumab)
Hyrimoz (adalimumab-adaz)
Idacio (adalimumab-aacf)
Ilaris (canakinumab)
Ilumya (tildrakizumab-asmn)
Imuldosa (ustekinumab-srlf)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Leqselvi (deuruxolitinib)
Litfulo (ritlecitinib)
Nemluvio (nemolizumab-ilto)
Nucala (mepolizumab)
Olumiant (baricitinib)
Omlyclo (omalizumab-igec)
Omvoh (mirikizumab-mrkz)
Opzelura (ruxolitinib)
Orencia (abatacept)
Otezla (apremilast)
Otezla XR (apremilast extended-release)
Otulfi (ustekinumab-aauz)
Pyzchiva (ustekinumab-ttwe)
Remicade (infliximab)
Renflexis (infliximab-abda)
Rhapsido (remibrutinib)
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)

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Contraindicated as Concomitant Therapy
Spevigo (spesolimab-sbzo) subcutaneous injection Starjemza (ustekinumab-hmny) Stelara (ustekinumab) Steqeyma (ustekinumab-stba) Taltz (ixekizumab) Tezspire (tezepelumab-ekko) Tofacitinib Tofidence (tocilizumab-bavi) Tremfya (guselkumab) Truxima (rituximab-abbs) Tyenne (tocilizumab-aazg) Tyruko (natalizumab-sztn) Tysabri (natalizumab) Ustekinumab Velsipity (etrasimod) Wezlana (ustekinumab-auub) Xeljanz (tofacitinib) Xeljanz XR (tofacitinib extended release) Xolair (omalizumab) Yesintek (ustekinumab-kfce) 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 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 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 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 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 members ≥ 12 years

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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 members ≥ 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	
> 500 to 600	300	375	Do Not Dose	
> 600 to 700	375	Do Not Dose		

Asthma Omalizumab Doses Administered Every 2 or 4 Weeks (mg) for Pediatric Members Who Begin Omalizumab 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				

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>700-900	2	225	225	300	375
>900-1100		225	300	375	
>1100-1200		300	300		
>1200-1300		300	375		

CRSwNP 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	
>600-700		450	600	375	450	450	525		
>700-800	2	300	375	450	450	525	600		
>800-900		300	375	450	525	600			
>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)		
		Body Weight (kg)

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Pre-treatment serum IgE (IU/mL)	Dosing Freq. (weeks)	≥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					
>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							

Do Not Dose

VI. Billing Code/Availability Information

HCPCS Code:

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

NDC(s):

- Xolair 75 mg single-dose prefilled syringe or autoinjector: 50242-0214-xx

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- 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 A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime's assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	Yes: Consider for PA
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

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
J45.40	Moderate persistent asthma, uncomplicated
J45.50	Severe persistent asthma, uncomplicated
L29.89	Other pruritus
L29.9	Pruritus, unspecified

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ICD-10	ICD-10 Description
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.8	Other (chronic, recurrent) urticaria
L50.9	Urticaria, unspecified
Z91.010	Allergy to peanuts
Z91.0110	Allergy to milk products, unspecified
Z91.0111	Allergy to milk products with tolerance to baked milk
Z91.0112	Allergy to milk products with reactivity to baked milk
Z91.0120	Allergy to eggs, unspecified
Z91.0121	Allergy to eggs with tolerance to baked egg
Z91.0122	Allergy to eggs with reactivity to baked egg
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.

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Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
8	MI, IN	Wisconsin Physicians Service Insurance Corp. (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
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

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