Permanent J-code available for OCREVUS ZUNOVO®

Effective April 1, 2025

J2351*	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq

EXAMPLE CODING AND BILLING FOR

OCREVUS® (ocrelizumab) AND OCREVUS ZUNOVO® (ocrelizumab and hyaluronidase-ocsq)

Tips and considerations for claims submission

*These codes are not all-inclusive; appropriate codes can vary by patient, setting of care and payer. Correct coding is the responsibility of the provider submitting the claim for the item or service. Please check with the payer to verify codes and special billing requirements. Genentech does not make any representation or guarantee concerning reimbursement or coverage for any item or service.

Please see additional Important Safety Information throughout and click here for full OCREVUS Prescribing Information and Medication Guide. For OCREVUS ZUNOVO, click here for full Prescribing Information and Medication Guide.

EXAMPLE CODING FOR **OCREVUS® (ocrelizumab) [IV]**

This coding information may assist you as you complete the payer forms for OCREVUS [IV].

TYPE	CODE	DESCRIPTION
Diagnosis: ICD-10-CM	G35	Multiple sclerosis
Drug: HCPCS	J2350	Injection, ocrelizumab, 1 mg
Drug: NDC	10-digit	Ocrelizumab, 300 mg single-dose vial
	50242-150-01	
	11-digit	
	50242-0150-01	
Administration procedures: CPT*	96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
	96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)
	96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
	96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
	99601	Home infusion/specialty drug administration, per visit (up to 2 hours)
	99602	Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)
Home Infusion: HCPCS	S9329	Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with S9330 or S9331)
	S9379	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
HCPCS Modifier†	JZ	Zero drug amount discarded/not administered to any patient

Check your billable units on the claim: Generally, a 300-mg dose of OCREVUS [IV] is billed at 300 units and a 600-mg dose of OCREVUS [IV] is billed at 600 units.

CPT=Current Procedural Terminology; HCPCS=Healthcare Common Procedure Coding System; ICD-10-CM=International Classification of Diseases, 10th Revision, Clinical Modification; IV=intravenous; NDC=National Drug Code.

*For payers who do not recognize OCREVUS [IV] as approved for chemotherapy administration codes 96413 and 96415, other administration codes, such as 96365 and 96366, may be used depending on individual payer policy.

†The JZ modifier is required on claims for all single-dose containers or single-use drugs when no drug is discarded/administered to any patient as of July 1, 2023. For more information on the JZ modifier, visit CMS.gov.

Please see additional Important Safety Information throughout and click here for full OCREVUS Prescribing Information and Medication Guide. For OCREVUS ZUNOVO, click here for full Prescribing Information and Medication Guide.

EXAMPLE CODING FOR **OCREVUS ZUNOVO® (ocrelizumab and hyaluronidase-ocsq)**

This coding information may assist you as you complete the payer forms for OCREVUS ZUNOVO. The permanent J-code for OCREVUS ZUNOVO is J2351 and is effective for dates of service beginning April 1, 2025. For dates of service prior to April 1, 2025, bill using the appropriate miscellaneous J-code or permanent C-code for Medicare claims for hospital outpatient departments.

TYPE	CODE	DESCRIPTION
Diagnosis: ICD-10-CM	G35	Multiple sclerosis
Drug: HCPCS	**J2351**	**Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq**
Drug: NDC	10-digit	Ocrelizumab, 920 mg and hyaluronidase 23,000 units single-dose vial
	50242-554-01	
	11-digit	
	50242-0554-01	
Administration Procedures: CPT	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
Home Injection: HCPCS	G0089 (initial)	Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes
	G0069 (subsequent)	Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes
HCPCS Modifier*	JZ	Zero drug amount discarded/not administered to any patient
	25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service

Check your billable units on the claim: Generally, a 920-mg dose of OCREVUS ZUNOVO is billed at 920 units.

*The JZ modifier is required on claims for all single-dose containers or single-use drugs when no drug is discarded/administered to any patient as of July 1, 2023. For more information on the JZ modifier, visit CMS.gov.

The codes on pages 2 and 3 are not all-inclusive; appropriate codes can vary by patient, setting of care and payer. Correct coding is the responsibility of the provider submitting the claim for the item or service. Please check with the payer to verify codes and special billing requirements. Genentech does not make any representation or guarantee concerning reimbursement or coverage for any item or service.

Many payers will not accept unspecified codes. If you use an unspecified code, please check with your payer.

PERMANENT J-CODE FOR **OCREVUS ZUNOVO® (ocrelizumab and hyaluronidase-ocsq)**

The Centers for Medicare & Medicaid Services has assigned a permanent J-code for OCREVUS ZUNOVO effective April 1, 2025. Check with individual payers for specific requirements.

J2351: Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq

- Can be used as you complete forms for government and commercial payers
- Bill 920 units for 920 mg of OCREVUS ZUNOVO
- Update billing software and EMRs to include the permanent J-code

For additional information or resources, please scan or click the QR code or visit **OCREVUS.com/Access**.

CONSIDERATIONS FOR **CLAIMS SUBMISSION**

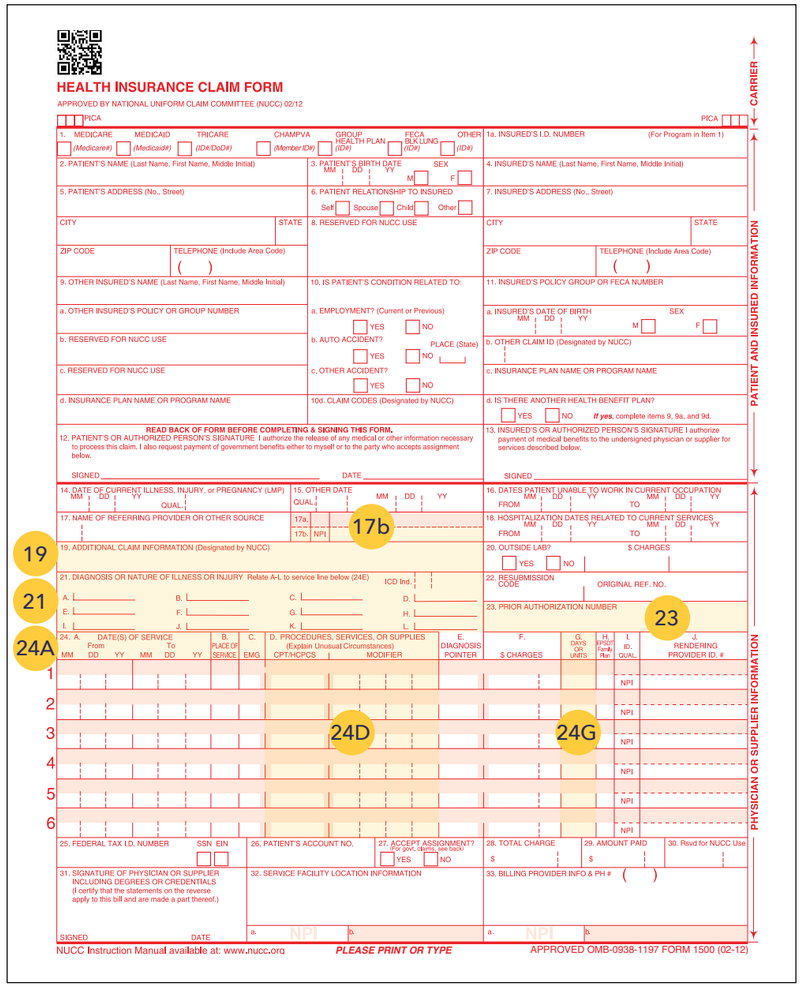
CONSIDERATIONS FOR **BOTH OCREVUS® (ocrelizumab) AND OCREVUS ZUNOVO**

- Since OCREVUS and OCREVUS ZUNOVO are administered only twice a year,* a benefits investigation (BI) is recommended prior to each subsequent treatment to ensure there have not been changes to payer coverage, prior authorization (PA) requirements, site-of-care restrictions or out-of-pocket costs for the patient
- Keep complete, legible and easily accessible records
- Communicate with appropriate payer contacts to determine plan-specific requirements
- Double-check to make sure all coding information is accurate, including NDC units of measure if the payer requires this method*
- Review each claim to avoid simple errors, such as misspellings
- File the claim promptly after the service has been rendered
- Conduct follow-ups with payers in the interest of timely claims processing
- Be sure to include any PA or predetermination information, along with relevant clinical information, on your claim
- If you are considering scheduling administration on the same day as a patient office visit, first check the requirements of your payer's policies about same day billing. This may require:
  - Additional codes or modifiers
  - Clear documentation of patient evaluation and management (E/M) above what is included in the injection or infusion CPT code

*The first dose of OCREVUS [IV] is administered as two 300-mg IV infusions 2 weeks apart. Subsequent doses are administered as a single 600-mg infusion every 6 months.

SAMPLE CLAIM FORM
CMS-1500

The CMS-1500 claim form is used by some payers to bill for services provided in the noninstitutional (physician office) setting.



The form shown here is for informational purposes only. Completion of other fields on this claim form or completion of different claim forms might be required. Check with individual payers for specific requirements.

Please see additional Important Safety Information throughout and click here for full OCREVUS Prescribing Information and Medication Guide. For OCREVUS ZUNOVO, click here for full Prescribing Information and Medication Guide.

WHERE TO DOCUMENT INFORMATION ON PAPER AND ELECTRONIC BILLING FORMS[1]

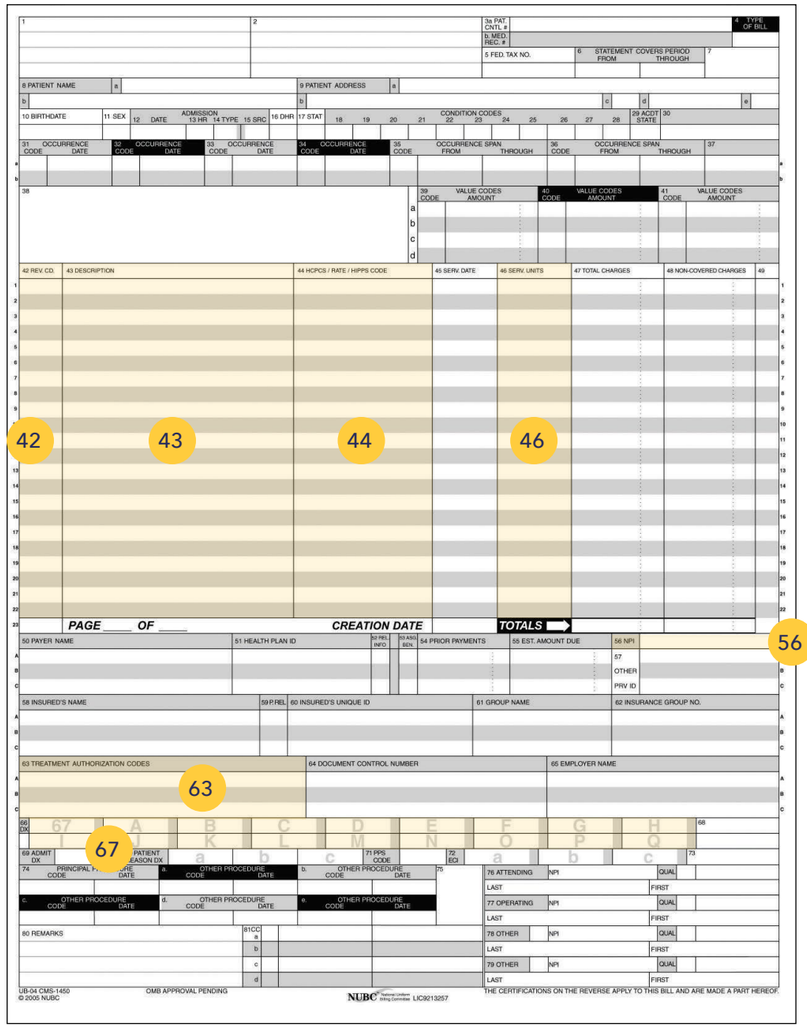
The table below shows where specific claim information can be recorded on a paper claim (as shown to the left) as well as on electronic claims.

INFORMATION TO BE INCLUDED ON CLAIM	CMS-1500	ELECTRONIC LOOP	EQUIVALENT SEGMENT
Provider-specific National Provider Identifier (NPI) number	17b	2310A (referring) 2420E (ordering) 2310D (supervising)	NM109
OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq) only **Additional claim information Include the following:** • Drug name (both brand and generic names) • Dosage • NDC **Payers may also require:** • Route of administration • Amount administered • Drug strength **Note:** When submitting claims using the electronic version of the CMS-1500 claim form, make sure the character limits in Box 19 are set to let you include all of the required information. An attachment might be needed if Box 19 is not large enough for the required information. If necessary, contact your software vendor for assistance.	19	2300	NTE PWK (Paperwork)
ICD-10-CM diagnosis code(s)	21	2300	HI01-2
Payer-specific PA number	23	2300	REF02
List the dates of service	24A	2400	DTP03
HCPCS code, NDC with N4 qualifier (if required) and appropriate CPT administration code(s) and required modifier(s) on separate lines	24D	2400	SV101
Number of units for each line item: Generally, a 300-mg dose of OCREVUS [IV] is billed at 300 units and a 600-mg dose of OCREVUS [IV] is billed at 600 units. Generally, a 920-mg dose of OCREVUS ZUNOVO is billed at 920 units.	24G	2400	SV104

SAMPLE CLAIM FORM

CMS-1450/UB-04

The CMS-1450/UB-04 claim form is used by some payers to bill for services provided in the institutional (hospital) setting.



The form shown here is for informational purposes only. Completion of other fields on this claim form or completion of different claim forms might be required. Check with individual payers for specific requirements.

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WHERE TO DOCUMENT INFORMATION ON PAPER AND ELECTRONIC BILLING FORMS[2,3]

The table below shows where specific claim information can be recorded on a paper claim (as shown to the left) as well as on electronic claims.

INFORMATION TO BE INCLUDED ON CLAIM	CMS-1450/ UB-04	ELECTRONIC LOOP	EQUIVALENT SEGMENT
Revenue code	42	2400	SV201
NDC with N4 qualifier (if required)	43	2410	LIN03
HCPCS code on one line and appropriate CPT administration code(s) with required modifier(s) on a separate line	44	2400	SV202-2
Number of units for each line item: Generally, a 300-mg dose of OCREVUS [IV] is billed at 300 units and a 600-mg dose of OCREVUS [IV] is billed at 600 units. Generally, a 920-mg dose of OCREVUS ZUNOVO is billed at 920 units.	46	2400	SV205
Provider-specific NPI number	56	2010AA	MB1/85/09
Treatment authorization codes	63	2300	REF/G1/02
ICD-10-CM diagnosis code(s) Enter the appropriate diagnosis code.	67	2300	HI01-2

FREQUENTLY ASKED **QUESTIONS**

Q How does Medicare reimburse for drugs?

A Medicare generally reimburses for drugs based on a percentage of the average sales price (ASP). CMS calculates ASP on a quarterly basis. The percentage varies based on the treatment setting.[3]

Note: Please visit **www.cms.gov** to learn about current reimbursement rates.

Q How does Medicaid reimburse for drugs?

A Medicaid reimbursement varies by state. Often, payment methodologies follow Medicare and are based on a percentage of ASP, WAC, AWP, invoice pricing or another means. However, payments could be lower or higher than Medicare in any particular state.[4]

Q How do commercial payers reimburse for drugs?

A Commercial payer reimbursement varies and is based on the contracted rate with the provider. Review your contracts to understand your specific reimbursement rates.

Q How do I submit a claim for OCREVUS® (ocrelizumab) or OCREVUS ZUNOVO® if I did not purchase the drug?

A If you did not purchase OCREVUS or OCREVUS ZUNOVO directly (e.g., you used a specialty pharmacy or the Genentech Patient Foundation), you may bill for the administration only. Some payers may require you to enter the HCPCS code on the claim form with a zero charge to identify the drug that was administered, but you should check with individual payers for specific requirements. Note that including the HCPCS code on the claim form will make it easier to use the OCREVUS Co-pay Program, since the HCPCS code will then appear on the patient's Explanation of Benefits (EOB).

Q What happens if I have to replace a vial of OCREVUS or OCREVUS ZUNOVO?

A The Genentech Spoilage Program provides for replacement of infused, injected and self-administered products, which are prescribed and prepared for a labeled indication, yet not administered due to unforeseen patient or clinical circumstances, subject to certain limitations and conditions set forth by Genentech. The purpose of the program is to support our commitment to protecting patient safety by preventing the use of spoiled, damaged or contaminated products.

Please contact Genentech Customer Service at **(800) 551-2231** to submit a request for replacement of spoiled product or to obtain additional information about the Program.

Please see additional Important Safety Information throughout and click here for full OCREVUS **Prescribing Information** and **Medication Guide**. For OCREVUS ZUNOVO, click here for full **Prescribing Information** and **Medication Guide**.

Q What happens if my claim was denied?

A If a plan issues a denial, the denial should be reviewed, along with the health insurance plan's guidelines, to determine what to include in your patient's appeal submission.

Your Field Reimbursement Manager (FRM) or an OCREVUS Patient Navigator has local payer coverage expertise and can help you determine specific requirements for your patient. Additionally, considerations for composing an appeal letter and a sample appeal letter are available at **OCREVUS.com/Access**.

Some considerations for appealing a denial include:

- Determine payer-specific appeals processes and deadlines
- Review the EOB and/or denial letter, paying particular attention to any remark codes
- Document discussions and correspondence with payers regarding the denial
- If there was a documentation error, contact the payer to adjust or correct the form

Commonly requested documentation for denials includes:

- Appeal letter
- EOB and/or denial letter
- Medical documentation, including patient history, chart notes, records of prior treatments and outcomes, and lab data or other test results
- Other supporting documentation, including journal articles, practice guidelines and compendia indications

YOUR DIRECT CONNECTION **TO GENENTECH**

Visit **OCREVUS.com/Access**

Call your **Patient Navigator** at **(844) OCREVUS** (844-627-3887) Monday through Friday, 9 a.m.–8 p.m. ET

Get support from your **Field Reimbursement Manager** or **Therapeutic Area Manager**

Please see additional Important Safety Information throughout and click here for full OCREVUS Prescribing Information and Medication Guide. For OCREVUS ZUNOVO, click here for full Prescribing Information and Medication Guide.

References: 1. CMS-1500 claim form crosswalk to EMC loops and segments. Noridian Healthcare Solutions. Updated April 23, 2024. Accessed February 14, 2025. https://med.noridianmedicare.com/web/jeb/topics/claim-submission/cms-1500-crosswalk-emc-loops-segments **2.** ASC 837I version 5010A2 institutional health care claim to the CMS-1450 claim form crosswalk. Palmetto GBA. Accessed February 14, 2025. https://www.palmettogba.com/Palmetto/Providers.Nsf/files/EDI_837I_v5010A2_crosswalk.pdf/$File/EDI_837I_v5010A2_crosswalk.pdf **3.** Centers for Medicare & Medicaid Services. Medicare claims processing manual. Chapter 17 – drugs and biologicals. Published February 15, 2024. Accessed February 14, 2025. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf **4.** Medicaid covered outpatient prescription drug reimbursement information by state. Medicaid.gov. Updated November 16, 2022. Accessed February 14, 2025. https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/medicaid-covered-outpatient-prescription-drug-reimbursement-information-state/index.html

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