

Medical Benefit Updates for Members

Health care items or services available to you that are covered by your plan.

Starting **December 21, 2026**, the changes listed in the table below will go into effect. Please see the list below for the updated drug(s).

Drug Name (Brand Name)	CPT code ¹	Used in	Line of Business		Drug Limits ²	Prior Authorization (PA) Criteria ³	Specialist Needed ⁴
			Medi-Cal	Medicare			
ONDANSETRON HCL, PER 1 MG (ZOFTRAN)	J2405	Nausea		X	None	No PA required.	No
PALONOSETRON HCL, 25 MCG	J2469						
METOCLOPRAMIDE HCL TO 10MG	J2765						
AMISULPRIDE, 1 MG	J0184						
APREPITANT, 1 MG (APONVIE)	J8502	Nausea	X	X	None	No PA required. This code replaces the expired code, C9145.	No
ZOPAPOGENE IMADENOVEC-DRBA (PAPZIMEOS)	J3404	Viral Infection	X		Maximum of 4 injections per treatment course. 1 course of treatment.	Zopapogene imadenovec-drba (Papzimeos) is for patients who meet ALL of these: [A] Age 18 years or older [B] Histologically confirmed diagnosis of recurrent respiratory papillomatosis (RRP) [C] Documented HPV (Human papillomavirus) serotype 6 or 11 [D] Surgery before the first dose to remove any lumps that can be seen so that the smallest amount remains [E] Proof of laryngotracheal papillomas [F] Patient has received or is planning to get the HPV shot as indicated	No
DEPEMOKIMAB-ULAA, 1 MG (EXDENSUR)	J2361	Asthma	X		None	Exdensur needs the following: (1) You must be 12 years of age or older. (2) You have a type of severe asthma. This type has high levels of a white blood cell. This is called an "eosinophil." This asthma type has high levels of this white blood cell. You need to	Yes



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						have ≥ 150 cells/μL when you start treatment. You can also have ≥ 300 cells/μL in the last 12 months. (3) You have severe asthma that is not well controlled. This can mean you had 2 or more severe asthma flare-ups in the last 12 months while on other meds. (4) You must have tried other meds. You should fill these meds regularly. You should take these meds on time. These should also be at a medium or high dose. This might include at least two of the following: inhaled steroids with another controller med. (4) This med is ordered by an allergy doctor or immune doctor. (5) This should not be used alone. You must keep taking your other asthma controller meds.	
MEPOLIZUMAB 1 MG (NUCALA)	J2182	Asthma	X		None	Nucala needs the following: (1) You must be 6 years of age or older. (2) You have a type of severe asthma. This type has high levels of a white blood cell. This is called an "eosinophil." This asthma type has high levels of this white blood cell. You need to have ≥ 150 cells/μL when you start treatment. You can also have ≥ 300 cells/μL in the last 12 months. (3) You have severe asthma that is not well controlled. This can mean you had 2 or more severe asthma flare-ups in the last 12 months while on other meds. (4) You must have tried other meds. You should fill these meds regularly. You should take these meds on time. These should also be at a medium or high dose. This might include at least two of	Yes



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						the following: inhaled steroids with another controller med. (4) This med is ordered by an allergy doctor or immune doctor. (5) This should not be used alone. You must keep taking your other asthma controller meds.	
BENRALIZUMAB, 1 MG (FASENRA)	J0517	Asthma	X		None	Fasenra needs the following: (1) You must be 6 years of age or older. (2) You have a type of severe asthma. This type has high levels of a white blood cell. This is called an "eosinophil." This asthma type has high levels of this white blood cell. You need to have ≥ 150 cells/ μ L when you start treatment. You can also have ≥ 300 cells/ μ L in the last 12 months. (3) You have severe asthma that is not well controlled. This can mean you had 2 or more severe asthma flare-ups in the last 12 months while on other meds. (4) You must have tried other meds. You should fill these meds regularly. You should take these meds on time. These should also be at a medium or high dose. This might include at least two of the following: inhaled steroids with another controller med. (4) This med is ordered by an allergy doctor or immune doctor. (5) This should not be used alone. You must keep taking your other asthma controller meds.	Yes
RESLIZUMAB, 1 MG (CINQAIR)	J2786	Asthma	X		None	Cinqair needs the following: (1) You must be 18 years of age or older. (2) You have a type of severe asthma. This type has high levels of a white blood cell. This is called an "eosinophil." This asthma type has	Yes



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						high levels of this white blood cell. You need to have ≥ 150 cells/μL when you start treatment. You can also have ≥ 300 cells/μL in the last 12 months. (3) You have severe asthma that is not well controlled. This can mean you had 2 or more severe asthma flare-ups in the last 12 months while on other meds. (4) You must have tried other meds. You should fill these meds regularly. You should take these meds on time. These should also be at a medium or high dose. This might include at least two of the following: inhaled steroids with another controller med. (4) This med is ordered by an allergy doctor or immune doctor. (5) This should not be used alone. You must keep taking your other asthma controller meds.	
TEZEPELUMAB-EKKO, 1 MG (TEZSPIRE)	J2356	Asthma	X		None	This says what we need to approve Tezspire. Some of these things are: (1) You must be 12 years of age or older. (2) You have severe asthma that is not well controlled. This can mean you had 2 or more severe asthma flare-ups in the last 12 months while on other meds. (3) You must have tried other meds. You should fill these meds regularly. You should take these meds on time. These should also be at a medium or high dose. This might include at least two of the following: inhaled steroids with another controller med. (4) This med is ordered by an allergy doctor or immune doctor.	Yes

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						(5) Tezspire should not be used alone. You must keep taking your other asthma controller meds. (6) Tezspire should not be combined with other targeting meds that are similar to Tezspire.	
RANIBIZUMAB-LEYK, BIOSIMILAR, 0.1 MG (NUFYMCO)	Q5168	Eye Injection	X		Limit one dose per eye every four weeks.	Nufymco and Ranluspec need the following: (1) It must be for a use approved by the Food and Drug Administration (FDA). (2) You must not have other eye issues that need to be treated first. Other eye issues are eye infections that are not controlled. (3) You must be 18 years old or older. (4) You must have tried some other meds first, unless you have side effects or cannot use them. These meds are other eye injections like Avastin.	No
RANIBIZUMAB-HKDZ (RANLUSPEC)	J3490 J3590 C9399						No
AFLIBERCEPT, 1 MG (EYLEA)	J0178	Eye Injection	X		Limit to standard dosing of one 2 mg dose per eye every 4 weeks.	Eylea and Pavblu need the following: (1) It must be for a use approved by the Food and Drug Administration (FDA). (2) You must not have other eye issues that need to be treated first. Other eye issues are eye infections that are not controlled. (3) You must be 18 years old or older. (4) You must have tried some other meds first, unless you have side effects or cannot use them. These meds are other eye injections like Avastin. There are exceptions for this. For example, you can have poor vision with 20/50 or worse. You also need to have diabetic macular edema (DME). If you have both, you do not have to try Avastin.	No
AFLIBERCEPT-AYYH (PAVBLU), BIOSIMILAR, 1 MG	Q5147						



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AFLIBERCEPT HD, 1 MG (EYLEA HD)	J0177	Eye Injection	X		Limit to standard dosing of one 8 mg dose every 4 weeks for the first 3 doses, then 8 mg once every 8 to 16 weeks. Dosing for every 4 weeks may only be approved for those who have Eylea HD work for the first 3-5 monthly doses and then did not work after switching to every 8 to 16 weeks.	Eylea HD needs the following: (1) It must be for a use approved by the Food and Drug Administration (FDA). (2) You must not have other eye issues that need to be treated first. Other eye issues are eye infections that are not controlled. (3) You must be 18 years old or older. (4) You must have tried some other meds first, unless you have side effects or cannot use them. These meds are other eye injections like Lucentis or Eylea.	No
FARICIMAB-SVOA, 0.1 MG (VABYSMO)	J2777	Eye Injection	X		Does not exceed standard dosing per FDA package insert.	Vabysmo needs the following: (1) It must be for a use approved by the Food and Drug Administration (FDA). (2) You must not have other eye issues that need to be treated first. Other eye issues are eye infections that are not controlled. (3) You must be 18 years old or older. (4) You must have tried some other meds first, unless you have side effects or cannot use them. These meds are other eye injections like Lucentis or Eylea.	No

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BROLUCIZUMAB-DBLL, 1 MG (BEOVU)	J0179	Eye Injection	X		Does not exceed standard dosing per FDA package insert.	Beovu needs the following: (1) It must be for a use approved by the Food and Drug Administration (FDA). (2) You must not have other eye issues that need to be treated first. Other eye issues are eye infections that are not controlled. (3) You must be 18 years old or older. (4) You must have tried some other meds first, unless you have side effects or cannot use them. These meds are other eye injections like Lucentis or Eylea.	No
CEMIPLIMAB-RWLC, 1 MG	J9119	Cancer	X	X	None	Medical necessity criteria will be applied.	No
DOCETAXEL (HOSPIRA), NOT THERAPEUTICALLY EQUIVALENT TO J9171, 1 MG	J9232	Cancer	X	X	None	No PA Required	No
CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR	96401	Cancer		X	None	No PA Required	No
CHEMOTHERAPY INJECTION, HORMONAL ANTINEOPLASTIC	96402	Cancer		X	None	No PA Required	No
CHEMOTHERAPY ADMINISTRATION, IV PUSH	96409	Cancer		X	None	No PA Required	No
ADDITIONAL CHEMOTHERAPY IV PUSH	96411	Cancer		X	None	No PA Required	No
CHEMOTHERAPY ADMINISTRATION, IV	96413	Cancer		X	None	No PA Required	No

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INFUSION (INITIAL HOUR)							
ADDITIONAL HOUR OF CHEMOTHERAPY INFUSION	96415	Cancer		X	None	No PA Required	No
ADDITIONAL CHEMOTHERAPY INFUSION (UP TO 1 HOUR)	96417	Cancer		X	None	No PA Required	No
THERAPEUTIC/ DIAGNOSTIC INJECTION, SUBCUTANEOUS OR INTRAMUSCULAR	96372			X	None	No PA Required	No
THERAPEUTIC/ DIAGNOSTIC INJECTION, IV PUSH	96374			X	None	No PA Required	No
ADDITIONAL SEQUENTIAL IV PUSH	96375			X	None	No PA Required	No
ADDITIONAL IV PUSH (SAME DRUG)	96376			X	None	No PA Required	No
APPLICATION OF ON- BODY INJECTOR (E.G., FOR NEULASTA)	96377			X	None	No PA Required	No
IV INFUSION THERAPY/ PROPHYLAXIS /DX 1ST TO 1 HR	96365			X	None	No PA Required	No
IV INFUSION THERAPY PROPHYLAXIS/DX EA HOUR	96366			X	None	No PA Required	No
IV INFUSION THER PROPH ADDL SEQUENTIAL TO 1 HR	96367			X	None	No PA Required	No

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IV NFS THERAPY PROPHYLAXIS/DX CONCURRENT NFS	96368			X	None	No PA Required	No

You may contact our Customer Service Department with any questions or concerns.

For Medi-Cal only members: Monday through Friday, 8:00 am to 5:00 pm, at **1-888-936-7526 (PLAN)**, TDD/TTY 711.

For Medicare (D-SNP) members: 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30, at **1-888-361-7526 (PLAN)**, TDD/TTY 711.

The most recent information about Health Plan of San Joaquin/Mountain Valley Health Plan (“Health Plan”) and our services is always available on our website <https://www.hpsj.com/>.