

EYLEA® (aflibercept) Injection Receives Permanent J-Code J0178

May help streamline reimbursement

- Effective for dates of service (DOS) on or after January 1, 2013, the Centers for Medicare & Medicaid Services (CMS) has issued a new permanent HCPCS billing code for EYLEA® (aflibercept) Injection

HCPCS code	Description	Billing unit	Effective date
J0178	Injection, aflibercept, 1 mg*	2	January 1, 2013

*With the 1 mg descriptor, it is important to indicate “2” billing units on the claim form for each 2 mg injection.

For DOS on or after January 1, 2013

- CMS will discontinue the HCPCS code Q2046 for EYLEA
- Providers should no longer bill using miscellaneous J3490/J3590
- Implementation times may vary for other payer types (e.g., Medicaid and commercial payers)

See reverse side for a sample CMS 1500 form.



Sample CMS 1500 Form—Physician Office

Note: The information presented below is based on the paper claim format; **please adopt this information to electronic equivalent fields in your software systems.** The coding information discussed in this document and sample form is provided for informational purposes only, is subject to change, and should not be construed as legal advice. The codes listed below may not apply to all patients or to all health plans; providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient.

Box 21. Diagnosis Code

Enter the appropriate ICD-9-CM code for the patient's diagnosis/condition.

Box 24D. Procedure Code

Enter the appropriate CPT* code to denote intravitreal injection.

Box 24D. Product Code

Enter HCPCS code J0178 to represent EYLEA product for dates of service on or after January 1, 2013.

Note: State Medicaid agencies, secondaries, and some private payers may require providers to report EYLEA's NDC (61755-0005-02) in addition to HCPCS code J0178; however, the NDC is not required for Medicare claims.

Box 24G, Units Administration

J0178 has a unit descriptor of 1 mg; report 2 units of the code when billing for a 2 mg injection EYLEA.

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UMMC CLAIM COMMITTEE 08/05															PICA																																																																					
1. MEDICARE (Medicare #) ☐ 2. MEDICAID (Medicaid #) ☐ 3. TRICARE CHAMPUS (Sponsor's SSN) ☐ 4. CHAMPVA (Member ID) ☐ 5. GROUP HEALTH PLAN (SSN or ID) ☐ 6. FECA BOX (LUNG) (SSN) ☐ 7. OTHER (ID) ☐ 1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐ 4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																				
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ 7. INSURED'S ADDRESS (No., Street)																																																																																				
CITY 8. PATIENT STATUS Single ☐ Married ☐ Other ☐ CITY																																																																																				
STATE 9. PATIENT STATUS Employed ☐ Full-Time Student ☐ Part-Time Student ☐ STATE																																																																																				
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																				
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b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) _____ b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																				
c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES ☐ NO ☐ c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																				
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.																																																																																				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																																																																																				
SIGNED _____ DATE _____																																																																																				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pregnancy) (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																				
19. RESERVED FOR LOCAL USE 17b. NPI 20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO.																																																																																				
2. _____ 23. PRIOR AUTHORIZATION NUMBER																																																																																				
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES ☐ NO ☐ 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$																																																																																				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()																																																																																				
SIGNED _____ DATE _____ a. NPI b. _____ a. NPI b. _____																																																																																				

NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Have a billing or reimbursement question related to EYLEA® (aflibercept) Injection?

Call EYLEA4U® at 1-855-EYLEA4U (1-855-395-3248) and select option 4.

Reimbursement Specialists are available Monday–Friday 9 AM–8 PM Eastern Time.

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EYLEA®
(aflibercept) Injection




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F4U-0146

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