Immunomodulators for Inflammatory Conditions (for Indiana Only)

Policy Number: CSIND0150.07
Effective Date: December 1, 2024

Instructions for Use

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Related Policies
None

Application

This Medical Benefit Drug Policy only applies to the state of Indiana.

Coverage Rationale

This policy addresses the following immunomodulator agents for inflammatory conditions:

- Cimzia® (certolizumab pegol)
- Ilumya™ (tildrakizumab-asmn)

The following immunomodulator agents are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline:

- Cimzia® (certolizumab pegol): CP: Specialty Rx Non-Oncology, Certolizumab pegol (Cimzia)
- Ilumya™ (tildrakizumab-asmn): CP: Specialty Rx Non-Oncology, Tildrakizumab-asmn (Ilumya)

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

CPT® is a registered trademark of the American Medical Association

HCPCS Code	Description
J0717	Injection, certolizumab pegol, 1 mg (code may be used when drug administered under the direct supervision of a physician, not for use when drug is self-administered)

HCPCS Code	Description
J3245	Injection, tildrakizumab, 1 mg

Policy History/Revision Information

Date	Summary of Changes
12/01/2024	• Routine review; no content changes • Archived previous policy version CSIND0150.06

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.