briumvi®
ublituximab-xiiy 150 mg/6 mL injection for IV

BILLING AND CODING GUIDE

PRIOR TO CLAIM SUBMISSION

- Keep up to date with payer coverage policies and contracts
- Confirm health plan billing and coding requirements (e.g., billing units)
- Confirm patient benefits are active

DURING CLAIM COMPLETION AND SUBMISSION

- Submit claims according to the health plan timeline
- Verify the accuracy of patient information
- Include the prior authorization number (if applicable)
- Identify required and appropriate codes (e.g., CPT®, HCPCS, ICD-10-CM, NDC)
- Follow the health plan requirements for:
  - Additional information (e.g., medical records)
  - Infusion only administration
- Confirm the claim has been received by the health plan

ONLINE SUBMISSION[1,2]

As online submission becomes more prominent, your dedicated Access and Reimbursement Manager (ARM) is available to answer questions. Additionally, here are some helpful reminders:

- Verify that the respective payer for each claim accepts online submission directly from the specific EMR system
- Ensure that the correct codes (e.g., CPT, NDC) and unit of measure are loaded into the EMR system and are appropriate for the respective payer
- Confirm that a manual paper claim has not already been submitted for the particular patient/claim

If you have questions about BRIUMVI coding and reimbursement, contact your local Access and Reimbursement Manager or BRIUMVI Patient Support by calling 1-833-BRIUMVI (1-833-274-8684), Monday-Friday 8 AM to 8 PM ET

CPT, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases-Tenth Revision-Clinical Modification; NDC, National Drug Code; EMR, Electronic Medical Record.

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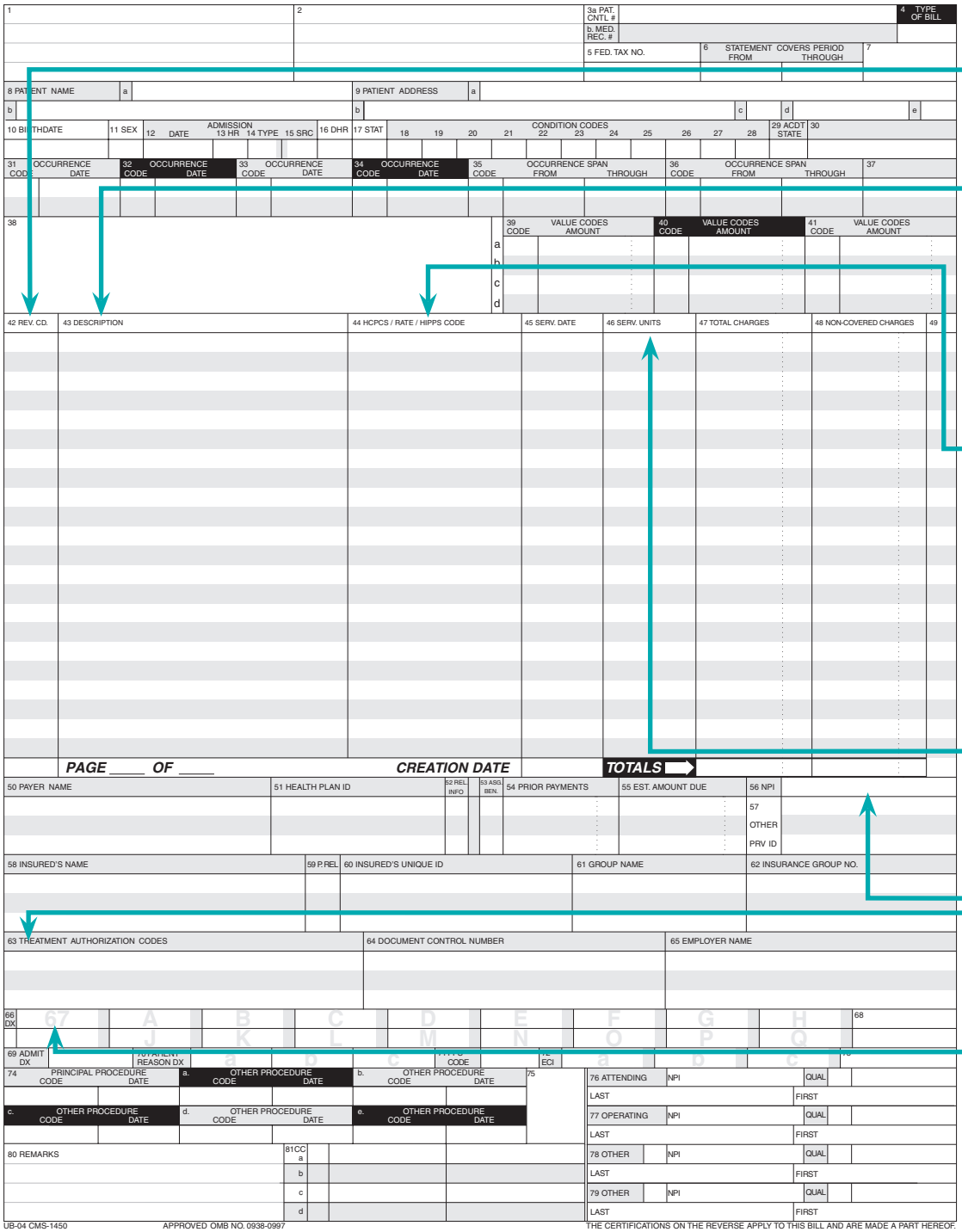
Annotated CMS-1450/UB-04[1]



Field 42: Include appropriate revenue codes.

Field 43: In the shaded area, list the N4 indicator, the 11-digit NDC (e.g., 73150015006), and the unit of measure qualifier (e.g., ML6, ML18). In the non-shaded area, list the date of service.

Field 44: Enter the appropriate HCPCS code J2329 for BRIUMVI and/or CPT codes for administration as required by the payer. If applicable, include 'JZ' modifier to indicate 'zero drug amount discarded/ not administered to any patient.[2]

Field 46: Indicate the appropriate units (e.g., 150 for 150 mg, 450 for 450 mg).

Field 56: Indicate the appropriate NPI number.

Field 63: If applicable, report the PA number here.

Field 67: Indicate the appropriate diagnosis code.

The suggestions contained on this form are compiled from sources believed to be accurate for payers, including the Medicare Part B program, but TG makes no representation that the information is accurate or that it will comply with the requirements of any particular payer or MAC. You are solely responsible for determining the billing and coding requirements applicable to any particular payer or MAC. Diagnosis codes should be selected only by a healthcare professional. The information provided here is not intended to be conclusive or exhaustive, and is not intended to replace the guidance of a qualified professional advisor. Billing and coding requirements may vary or change over time, so it is important to regularly check these requirements with each payer or MAC. TG and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use and caution that changes in public and private payer billing requirements occur frequently. The use of this information does not guarantee payment or that any payment received will cover your costs.

CMS, Centers for Medicare & Medicaid Services; MAC, Medicare Administrative Contractor; NPI, National Provider Identifier; PA, Prior Authorization.

REFERENCE

1. Electronic Billing CMS-1450. CMS.gov. Accessed June 8, 2023. https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450
2. Centers for Medicare & Medicaid Services. Medicare program discarded drugs and biologicals—JW modifier and JZ modifier policy. Accessed September 17, 2024. https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

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Annotated CMS-1500[1]

Field 17b: Indicate the appropriate NPI number.

Field 21: Indicate the appropriate diagnosis code.

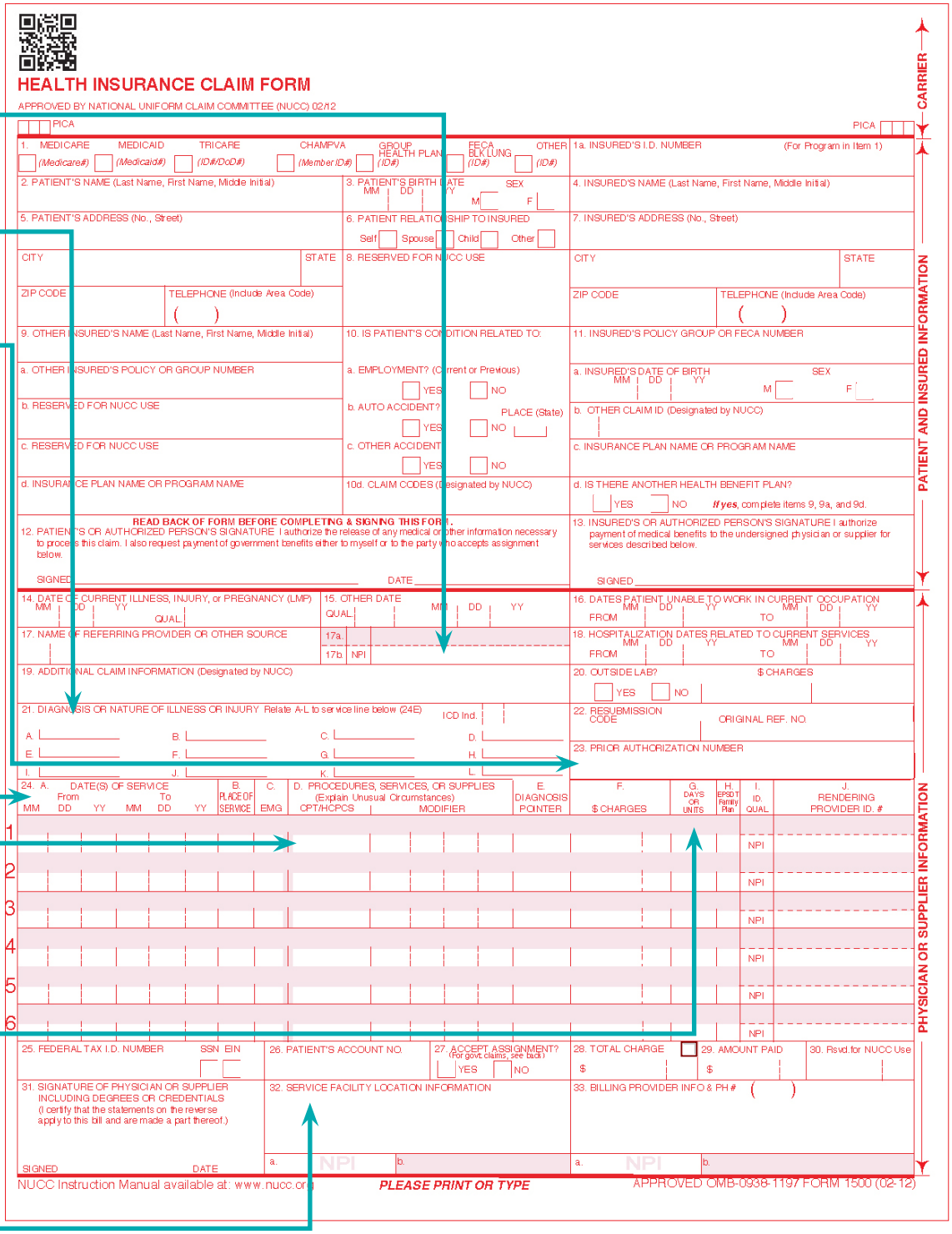
Field 23: If applicable, report the PA number here.

Field 24a: In the shaded area, list the N4 indicator, the 11-digit NDC (e.g., 73150015006), and the unit of measure qualifier (e.g., ML6, ML18). In the non-shaded area, list the date of service.

Field 24D: Enter the appropriate HCPCS code J2329 for BRIUMVI and/or CPT codes as required by the payer. If applicable, include 'JZ' modifier to indicate 'zero drug amount discarded/not administered to any patient.[2] NOTE: For BRIUMVI obtained through a specialty pharmacy, report the drug administration codes here. Check with the payer to identify how to report the drug that was administered if needed.

Field 24G: Include the appropriate number of units for J2329 (i.e., 150 for 150 mg, 450 for 450 mg) and/or CPT code required by the payer and administration duration.

Field 32: Indicate the place of service.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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 STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd.for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

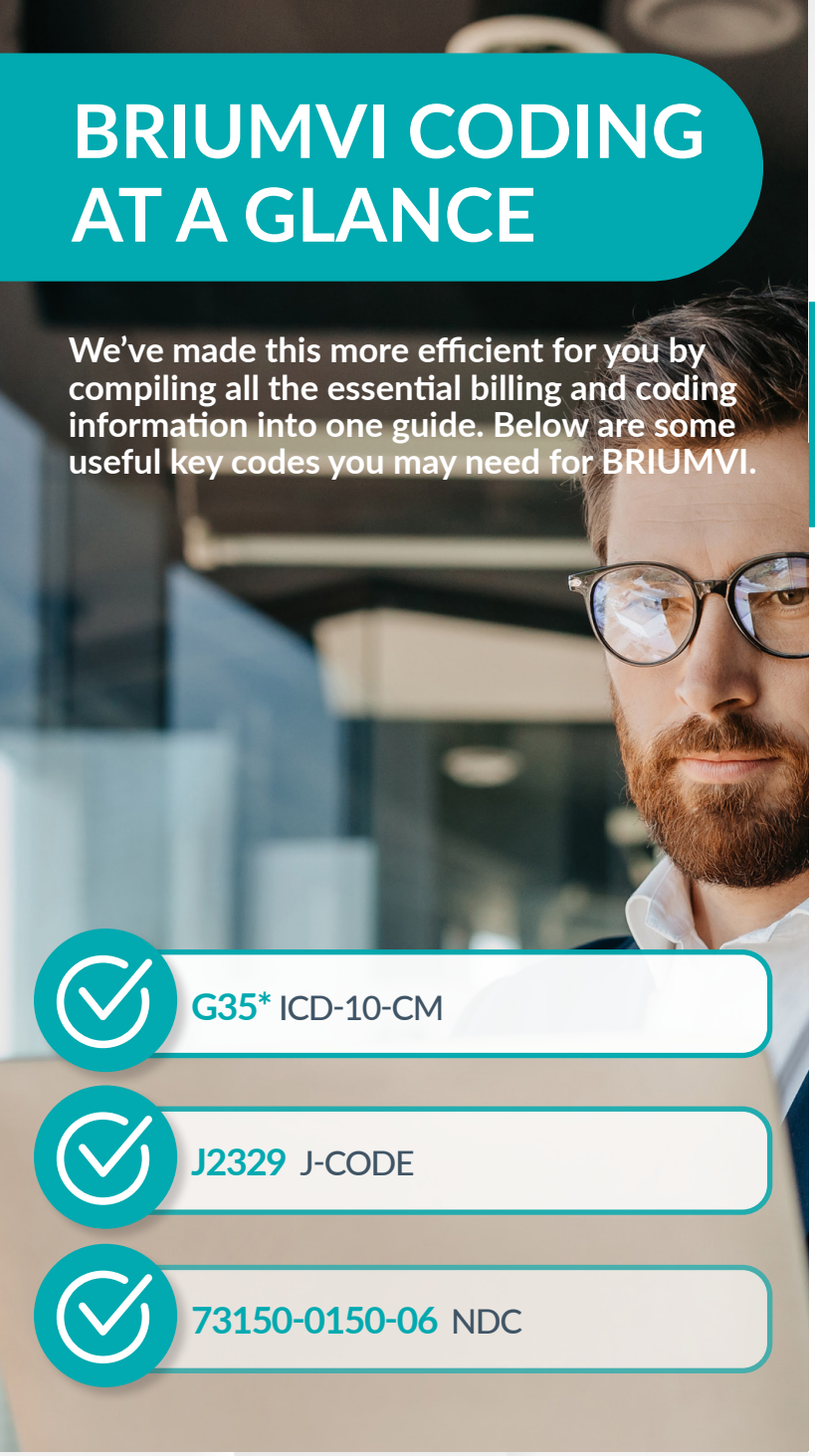
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

REFERENCE

1. CMS Forms CMS-1500. CMS.gov. Accessed June 8, 2023. https://www.cms.gov/Medicare/CMS-Forms/
2. Centers for Medicare & Medicaid Services. Medicare program discarded drugs and biologicals—JW modifier and JZ modifier policy. Accessed September 17, 2024. https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

BRIUMVI CODING AT A GLANCE



We've made this more efficient for you by compiling all the essential billing and coding information into one guide. Below are some useful key codes you may need for BRIUMVI.

- **G35*** ICD-10-CM
- **J2329** J-CODE
- **73150-0150-06** NDC

*Some health plans may need different diagnosis codes

briumvi®
ublituximab-xiiy 150 mg/6 mL injection for IV

PATIENT SUPPORT HIGHLIGHTS

BRIUMVI Patient Support offers a flexible program designed to support the treatment journey in a way that works best for patients. Our program focuses on what matters most, with key features for eligible patients including:

- **Copay Assistance*:**
  - Medication costs - Eligible patients may pay as little as $0 copay per BRIUMVI treatment up to the annual maximum of $20,000
  - Infusion and Administration Costs - Eligible patients who have out-of-pocket costs may be covered up to $550 for the first infusion and then up to $350 per infusion thereafter
- **Quick Start:** Patients experiencing an insurance coverage delay may be eligible to receive their BRIUMVI infusion free of charge
- **Interim Dose:** Patients currently on BRIUMVI who experience a short-term, temporary insurance issue may be eligible for an interim dose at no cost. Additional terms, conditions, and eligibility criteria apply
- **Patient Assistance Program:** If eligible, patients may receive BRIUMVI at no charge if they are uninsured or underinsured and meet the financial eligibility criteria†

*For commercially insured patients only. Other eligibility requirements apply. Full terms and conditions available at www.briumvicopayterms.com.
†Financial eligibility criteria is based on fixed annual gross household income/household size, as follows: $100k/1, $125k/2, $150k/3, $175k/4 (+$25k for each additional household member).

SAMPLE CODING[3,4]

The information in this resource is provided as a reference only and may be relevant when billing for BRIUMVI and its administration. This information is current as of August 2024. For information about billing and coding products other than BRIUMVI, please contact the manufacturer of the product or the applicable payer. The information available here is compiled from sources believed to be accurate, but TG Therapeutics makes no representation that it is accurate. This information is subject to change. Payer coding requirements may vary or change over time, so it is important to regularly check with each payer as to payer-specific requirements. The information available here is not intended to be conclusive nor exhaustive, and is not intended to replace the guidance of a qualified professional advisor. TG Therapeutics and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for any party's particular use given the frequent changes in public and private payer billing. The use of this information does not guarantee payment or that any payment received will cover your costs.

You are solely responsible for determining the appropriate codes and for any action you take in billing. Information about HCPCS codes is based on guidance issued by the CMS applicable to Medicare Part B and may not apply to other public or private payers. Consult the relevant manual and/or other guidelines for a description of each code to determine the appropriateness of a particular code and for information on additional codes. Diagnosis codes should be selected only by a healthcare professional.

CODING CLASS	CODE		DESCRIPTION
Diagnosis: ICD-10-CM	G35		Multiple sclerosis
	G35.1		Relapsing remitting multiple sclerosis
Drug: NDC	10-digit	11-digit	BRIUMVI (ublituximab-xiiy)
	73150-150-06	73150-0150-06	
Drug: HCPCS Level II	J2329		Injection, ublituximab-xiiy, 1 mg
Administration: CPT	96413		Chemotherapy administration, intravenous infusion technique; up to 1 hour
	96415		Chemotherapy administration, intravenous infusion technique; each additional hour
	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
	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
Home infusion: HCPCS Level II	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

REFERENCES

1. Top Reasons for Claim Denials and Rejections. Palmetto GBA, LLC. Accessed May 15, 2024. https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/8EELKQ7002~Claims~Denial%20Resolution
2. 10 Common Medical Billing Mistakes That Cause Claim Denials. Maryland Local Health Department. Accessed May 15, 2024. https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/PDF%20Manual/Section%20III/Common%20Claim%20Denials.pdf
3. Find-A-Code. Accessed August 5, 2024. https://www.findacode.com/index.html
4. CMS.gov. Physician Fee Schedule - July 2024 release. Accessed August 5, 2024. https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu24c

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