

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**

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.A RELAPSING-REMITTING
MULTIPLE SCLEROSIS (ICD-10-CM)
OR

G35.C1 ACTIVE SECONDARY
PROGRESSIVE MULTIPLE SCLEROSIS
(ICD-10-CM)

OR

G37.9 CLINICALLY ISOLATED
SYNDROME (ICD-10-CM)



J2329 J-CODE



73150-0150-06 NDC

*Some health plans may need different diagnosis codes

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).

1		2		3a PAT. CONTL. # b. MED. REC. # 5 FED. TAX NO.		4 TYPE OF BILL	
8 PATIENT NAME		9 PATIENT ADDRESS		6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		100		101	

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.'

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 (e.g., G35.A, G35.C1).

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.

REFERENCES

- 1. Electronic Billing CMS-1450. CMS.gov. Accessed September 22, 2025. 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 22, 2025. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf>

Field 17b: Indicate the appropriate NPI number.

Field 21: Indicate the appropriate diagnosis code (e.g., G35.A, G35.C1).

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BENEFIT OTHER
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)

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)

8. RESERVED FOR NUCC USE

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

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.*

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.

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

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

15. OTHER DATE MM DD YY QUAL

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. NAME 17b. NPI

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

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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. SPOT Fee/Flat Rate I. ID. QUAL J. RENDERING PROVIDER ID. #

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. 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.)

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. NPI

33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMS-0938-1197 FORM 1500 (02-12)

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REFERENCES

1. CMS Forms CMS-1500. CMS.gov. Accessed September 22, 2025. <https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1188854>
2. Centers for Medicare & Medicaid Services. Medicare program discarded drugs and biologicals—JW modifier and JZ modifier policy. Accessed September 22, 2025. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf>

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 October 2025. 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.A		Relapsing-remitting multiple sclerosis
	G35.C1		Active secondary progressive multiple sclerosis
	G37.9		Clinically Isolated Syndrome
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 September 22, 2025. <https://palmettogba.com/jjb/did/8eelkq7002~claims~denial%20resolution>
2. 10 Common Medical Billing Mistakes That Cause Claim Denials. Maryland Local Health Department. September 22, 2025. <https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/PDF%20Manual/Section%20III/Common%20Claim%20Denials.pdf>
3. Find-A-Code. September 22, 2025. <https://www.findacode.com/index.html>
4. CMS.gov. Physician Fee Schedule - December 2024 release. Accessed September 22, 2025. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1807-f>

