



Billing and Coding Guide

Step-by-step guide to coverage determination, claim submission, and reimbursement

TEPEZZA J-Code: J3241, 10 mg

TEPEZZA[®]
teprotumumab-trbw



Welcome

TEPEZZA is indicated for the treatment of Thyroid Eye Disease (TED) regardless of Thyroid Eye Disease activity or duration.¹

Amgen is committed to assisting patients throughout their access and treatment journeys. We developed this guide to provide the information you may need to help with the coverage and reimbursement process for TEPEZZA.



Amgen By Your Side is a support program for patients prescribed TEPEZZA. Our dedicated team is your patient's partner, committed to providing nonmedical support to help patients as they start and continue on treatment as prescribed. Call **1-833-583-7399** or visit **[AmgenByYourSide.com](https://www.AmgenByYourSide.com)** to initiate enrollment for your patient by submitting the Patient Enrollment Form (PEF).



Payer coding requirements may vary. Consult individual payer policies for specific coding and documentation requirements.

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CPT® is a registered trademark of the American Medical Association.
CPT®, Current Procedural Terminology.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Infusion Reactions: TEPEZZA may cause infusion reactions. Infusion reactions have been reported in approximately 4% of patients treated with TEPEZZA.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit [TEPEZZAhcp.com](https://www.TEPEZZAhcp.com).



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The information in this guide is intended for informational purposes only and does not represent legal or billing advice. For specific guidance in this area, consult your own legal/billing advisor and billing/coding specialist because it remains your responsibility to ensure the accuracy of the claims your site of care submits.

Responsibility for properly submitting claims lies with the healthcare provider. We make no representations about the eligibility or guarantee of coverage, coding, or reimbursement for any particular claim. It is the responsibility of the healthcare provider to choose the most appropriate code as documented in the patient’s medical chart and submit the appropriate codes, charges, and modifiers for services or items rendered or applied. Your patient’s enrollment in Amgen By Your Side will in no way guarantee reimbursement.

The content herein is based on information current as of September 2025, and may have changed. Any product, ancillary supplies, or services received free of charge cannot be billed to third-party payers because doing so could be a violation of federal and/or state laws and/or third-party payer requirements.

Physician office and office-based infusion center billing and coding

A medical group, or other entity entitled to bill and receive payment for physician services, uses the current ASC X12 professional claim billing format or Form CMS-1500 to submit claims to Medicare A/B MACs Part B and all other payers.

This section provides general physician office coding information for TEPEZZA. The final coverage determination is not made until the payer receives and reviews the claim. Coding for TEPEZZA may vary by payer type (eg, Medicare, Medicaid, commercial payer) and plan type. **Contact payers for specific coding requirements for billing TEPEZZA.**

POS codes

POS codes identify the location where a service was performed. The following POS codes may be appropriate when TEPEZZA is administered in the physician office or office-based infusion center:

POS Code	POS Name	Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only

NDC

Payer requirements regarding the use of the 10- or 11-digit NDC may vary. Electronic data interchange (EDI) generally requires the use of the 11-digit NDC. Check payer requirements for appropriate reporting of the NDC. You may need to add the NDC for TEPEZZA to your EMR system if it is not already included.

TEPEZZA (teprotumumab-trbw) for injection is a sterile, preservative-free, white to off-white lyophilized powder available as follows:

10-digit NDC	11-digit NDC	Description
75987-130-15	75987-0130-15	Carton containing one 500-mg single-dose vial (lyophilized powder for intravenous infusion)

ICD-10-CM diagnosis codes

The following may be appropriate ICD-10-CM diagnosis codes for prescribing TEPEZZA:

ICD-10-CM Diagnosis Code	Description
E05.00	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
H05.831	Thyroid orbitopathy, right orbit
H05.832	Thyroid orbitopathy, left orbit
H05.833	Thyroid orbitopathy, bilateral
H05.839	Thyroid orbitopathy, unspecified orbit

Clinical Activity Score (CAS)-related ICD-10-CM diagnosis codes may be necessary to fully describe the patient’s condition and associated manifestations. It is important to include CAS within your clinical documentation. Please [click here](#) for a listing of CAS-related ICD-10-CM diagnosis codes that you may want to include in a claim.

HCPCS code

TEPEZZA has a permanent, product-specific HCPCS code: J3241.

HCPCS Drug Code	Description
J3241	Injection, teprotumumab-trbw, 10 mg

When billing for TEPEZZA using J3241:

- One unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

CMS, Centers for Medicare & Medicaid Services; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; MAC, Medicare Administrative Contractor.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Infusion Reactions (cont’d): Reported infusion reactions have usually been mild or moderate in severity. Signs and symptoms may include transient increases in blood pressure, feeling hot, tachycardia, dyspnea, headache, and muscular pain. Infusion reactions may occur during an infusion or within 1.5 hours after an infusion. In patients who experience an infusion reaction, consideration should be given to premedicating with an antihistamine, antipyretic, or corticosteroid and/or administering all subsequent infusions at a slower infusion rate.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit [TEPEZZAhcp.com](#).



Modifiers

Modifiers are typically alphanumeric 2-character indicators that provide payers with additional information regarding the services rendered. If appropriate, more than 1 modifier may be used with a single procedure code.

Certain payers require the “JW” modifier to be used in order to obtain payment for a discarded amount of drug for single-dose or single-use packaging. For claims submitted with J3241, providers should use multiple lines to identify the amount administered and the amount wasted. One line of the claim should include J3241 and number of units administered. A separate line should include J3241 with the “JW” modifier and the number of units wasted.

Effective January 1, 2023, modifier “JZ” may be reported on claims to note zero discarded amounts from single-use vials or single-use packages. CMS requires the reporting of modifier “JZ” effective July 1, 2023. Claims processing edits will be implemented by the MACs effective October 1, 2023.

Contact payers for specific coding requirements for billing wastage and modifiers.

Modifier	Description	Appropriate Use
JW	Drug amount discarded/not administered to any patient	Append to J3241 when there was discarded drug amount
JZ	Zero drug amount discarded/not administered to any patient	Append to J3241 when there was NO discarded drug amount

CPT® codes

When billing for TEPEZZA in the physician office, the following CPT® codes may be appropriate:

Chemotherapy Administration and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

CPT® Code	Description
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
96415	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug; each additional hour <i>List separately in addition to code for primary procedure</i>

Therapeutic, Prophylactic, and Diagnostic Injections and Infusions

CPT® Code	Description
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); initial, up to 1 hour; each additional hour <i>List separately in addition to code for primary procedure</i>

Other relevant testing considerations

Glucose testing codes

CPT® Code	Description
82945	Glucose, body fluid, other than blood
82947 (QW)*	Glucose, quantitative, blood (except reagent strip)
82948	Glucose, blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use

Consult individual payers on any coding and documentation preferences

*To show as a Clinical Laboratory Improvement Amendments (CLIA) waived test, HCPCS code 82947 must have the modifier "QW".

CPT®, Current Procedural Terminology; FDA, US Food and Drug Administration; HCPCS, Healthcare Common Procedure Coding System.

Sample CMS-1500 claim form for use in physician offices

The following is an example of how to fill out the CMS-1500 paper form for a patient who received TEPEZZA (two 500-mg vials of teprotumumab-trbw) via intravenous infusion.

In this example, the provider administered 900 mg via intravenous infusion and 100 mg was wasted. As shown below, providers report J3241 for TEPEZZA, 90 units for the amount administered, and J3241 with “JW” modifier, 10 units for the amount wasted, in Items 24A-24G. To report two 500-mg vials administered with no wastage, TEPEZZA would be reported on 1 line with J3241-JZ, 100 units.

Sample CMS-1500 with wastage

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.															
A. XXXXX										B.		C.		D.															
E.										F.		G.		H.															
I.										J.		K.		L.															
23. PRIOR AUTHORIZATION NUMBER										24. A.		B.		C.		D.		E.		F.		G.		H.		I.		J.	
DATE(S) OF SERVICE										PLACE OF SERVICE		EMG		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS POINTER		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		ID. QUAL.		RENDERING PROVIDER ID. #			
From To																													
MM DD YY MM DD YY																													
1										11		96365		A		90				NPI									
2										11		96365 JW		A		10				NPI									
3										11		96365		A		1				NPI									
4										11		96366		A		1				NPI									

Sample CMS-1500 with no drug wastage

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.															
A. XXXXX										B.		C.		D.															
E.										F.		G.		H.															
I.										J.		K.		L.															
23. PRIOR AUTHORIZATION NUMBER										24. A.		B.		C.		D.		E.		F.		G.		H.		I.		J.	
DATE(S) OF SERVICE										PLACE OF SERVICE		EMG		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS POINTER		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		ID. QUAL.		RENDERING PROVIDER ID. #			
From To																													
MM DD YY MM DD YY																													
1										11		96365		A		100				NPI									
2										11		96365		A		1				NPI									
3										11		96366		A		1				NPI									

Providers submitting claims for TEPEZZA via electronic software systems will need to translate claim information into compatible formats for input into their software systems. To view a crosswalk between **CMS-1500** and **X12N Health Care Claim: Professional (837)**, visit <https://x12.org/codes>

- 1 Item 21:**
 - Enter the appropriate ICD-10-CM diagnosis code(s)
 - The “ICD Ind.” field identifies the ICD code set being reported. Enter “0” between the dotted vertical lines for ICD-10-CM codes
- 2 Item 23:** If required, report PA number.
- 3 Item 24A:** Some payers may require NDC information. If required, enter information in the shaded field above the date of service, including:
 - Qualifier “N4” before the 11-digit NDC, followed by 3 spaces, the unit of measure (UN for units), and the quantity of drugs
 - Confirm with the payer how NDC numbers should be noted on the claim form
- 4 Item 24B:** Enter 11 for physician offices.
- 5 Item 24D:** Enter the appropriate HCPCS (J3241) and CPT® codes. Include any additional modifiers required by the payer (eg, to indicate wastage). See page 5 of this guide for more information about using modifiers.
 - **5a:** Use HCPCS code J3241 to report the drug and use JW to report waste (J3241-JW)
 - **5b:** Use HCPCS code J3241 to report the drug and use JZ to indicate no drug waste (J3241-JZ)
- 6 Item 24E:** Enter the letter that corresponds to the ICD-10-CM code recorded in Item 21. Only enter 1 diagnosis pointer per service line.
- 7 Item 24G:** Document the number of units used for each line item.
 - When billing for TEPEZZA with J3241, 1 unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

Special billing circumstances in the physician office

Referring patients to alternative sites of care

Providers who wish to prescribe TEPEZZA but do not have in-office infusion capabilities to administer it to patients refer patients to sites of care to receive treatment (eg, provider-owned infusion suite, home infusion, or independently-owned infusion suite). When referring patients to alternate providers for TEPEZZA treatment, the prescribing or referring HCP should be prepared to supply a variety of information and documentation to the provider administering TEPEZZA to assist with fulfilling payer requirements. Necessary documentation may include:

- Prescription/infusion order
- Diagnosis and supporting documentation (eg, the 7-point Clinical Activity Score)
- Letter of medical necessity
- Chart notes

Please refer to the [Payer Access Guide](#) for more information on payer access concerns.

Referring HCPs should coordinate closely with the site of care to ensure all necessary documentation is accurate, thorough, and complete.

Specialty pharmacy use in the physician office

To bill for administering TEPEZZA procured through a specialty pharmacy, include the appropriate ICD-10-CM diagnosis code(s) and CPT® code for the drug administration on the CMS-1500 form or the electronic equivalent. Payer requirements vary. Confirm with the patient's insurer if they require information about TEPEZZA to be included on the claim with "0" (zero) units or a modifier to indicate that a specialty pharmacy supplied the drug.

Patients who have traditional FFS Medicare typically do not have access to specialty pharmacy benefits

Physician office claims submission checklist

The following checklist provides an overview of requirements that may be necessary from payers when submitting claims for TEPEZZA. **Please check with individual payers for specific coding requirements.**



Use **J3241** for TEPEZZA and include supporting information when necessary



Have the **PA** or predetermination approval on file



Confirm with the payer how **NDC numbers** should be noted on the claim form



Include any **documentation required** by the payer

Hospital outpatient department (HOPD) and hospital-based infusion center billing and coding

The products and services provided in the hospital outpatient department are billed using the CMS-1450/UB-04 claim form or its electronic claim equivalent.

This section provides general hospital outpatient coding information for TEPEZZA. The final coverage determination is not made until the payer receives and reviews the claim. Coding for TEPEZZA may vary by payer type (eg, Medicare, Medicaid, commercial payer) and plan type. **Contact payers for specific coding requirements for billing TEPEZZA.**

POS codes

POS codes identify the location where a service was performed. The following POS codes may be appropriate when TEPEZZA is administered in the HOPD (on and off campus) and hospital-based infusion center:

POS Code	POS Name	Description
22	On-campus outpatient hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
19	Off-campus outpatient hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

On-campus vs off-campus HOPD designation

The Medicare reimbursement policies vary for HOPDs that are on campus (POS 22) vs off campus (POS 19). To bill and be reimbursed appropriately, facilities must understand the nuances of what is considered on and off campus for outpatient hospital departments. Centers for Medicare & Medicaid Services (CMS) defines HOPD on-campus locations as the physical area immediately adjacent to the healthcare provider's main buildings, as well as other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings. HOPD off-campus locations are paid under the Medicare Physician Fee Schedule (MPFS) rate, which is triggered when modifier "PN" is added to the claim form. HOPDs that are on campus are reimbursed at the facility rate.

NDC

Payer requirements regarding the use of the 10- or 11-digit NDC may vary. EDI generally requires the use of the 11-digit NDC. Check payer requirements for appropriate reporting of the NDC. You may need to add the NDC for TEPEZZA to your EMR system, if it is not already included.

10-digit NDC	11-digit NDC	Description
75987-130-15	75987-0130-15	Carton containing one 500-mg single-dose vial) (lyophilized powder for intravenous infusion)

ICD-10-CM diagnosis code

The following may be appropriate ICD-10-CM diagnosis codes for TEPEZZA:

ICD-10-CM Diagnosis Code	Description
E05.00	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
H05.831	Thyroid orbitopathy, right orbit
H05.832	Thyroid orbitopathy, left orbit
H05.833	Thyroid orbitopathy, bilateral
H05.839	Thyroid orbitopathy, unspecified orbit

Clinical Activity Score (CAS)-related ICD-10-CM diagnosis codes may be necessary to fully describe the patient's condition and associated manifestations. It is important to include CAS within your clinical documentation. Please [click here](#) for a listing of CAS-related ICD-10-CM diagnosis codes that you may want to include in a claim.

HCPCS code

TEPEZZA has a permanent, product-specific HCPCS code: J3241.

HCPCS Code	Description
J3241	Injection, teprotumumab-trbw, 10 mg

When billing for TEPEZZA using J3241:

- One unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

Revenue codes

Revenue codes are used on the CMS-1450 claim form to map a specific charge to a cost center. Examples of revenue codes that a hospital outpatient department may use to track costs for services associated with TEPEZZA include:

Revenue Code	Description
0250	General pharmacy
0636	Drugs requiring detailed coding
0260	Intravenous therapy; general

CMS, Centers for Medicare & Medicaid Services; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Inflammatory Bowel Disease: TEPEZZA may cause an exacerbation of inflammatory bowel disease (IBD). IBD has been reported in some patients without a prior diagnosis of IBD. Monitor patients for signs and symptoms of IBD. If IBD exacerbation is suspected, discontinue use of TEPEZZA.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit TEPEZZAhcp.com.



Modifiers

Modifiers are typically alphanumeric 2-character indicators that provide payers with additional information regarding the services rendered. If appropriate, more than one modifier may be used with a single procedure code.

Certain payers require the “JW” modifier to be used in order to obtain payment for a discarded amount of drug for single-dose or single-use packaging. For claims submitted with J3241, providers should use multiple lines to identify the amount administered and the amount wasted. One line of the claim should include J3241 and number of units administered. A separate line should include J3241 with the “JW” modifier and the number of units wasted.

Effective January 1, 2023, modifier “JZ” may be reported on claims to note zero discarded amounts from single-use vials or single-use packages. CMS requires the reporting of modifier “JZ” effective July 1, 2023. Claims processing edits will be implemented by the MACs effective October 1, 2023.

Contact payers for specific coding requirements for billing wastage and modifiers.

Modifier	Description	Appropriate Use
JW	Drug amount discarded/not administered to any patient	Append to J3241 when there was discarded drug amount
JZ	Zero drug amount discarded/not administered to any patient	Append to J3241 when there was NO discarded drug amount

Modifier guidance on drugs acquired through 340B Drug Discount Program

Beginning January 1, 2025, CMS will require the reporting of the “TB” modifier on all claim lines for drugs acquired through the 340B program. This applies to all 340B covered entities, including hospital-based and non-hospital-based entities, that submit claims for separately payable Part B drugs and biologicals.

Modifiers “PN” and “PO” are used to report services provided at an off-campus, outpatient, provider-based department (PBD) of a hospital.

Modifier	Description	Appropriate Use
TB	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities	Effective January 1, 2025, the “TB” modifier must be reported by all 340B covered entity hospitals paid under OPPS, even if the hospital previously reported the “JG” modifier
PN	Non-expected service provided at an off-campus, outpatient, provider-based department of a hospital	Services from non-expected off-campus PBD of a hospital
PO	Expected service provided at an off-campus, outpatient, provider-based department of a hospital	Services from expected off-campus PBD of a hospital

CPT® codes

When billing for TEPEZZA in the hospital outpatient department, the following CPT® codes may be appropriate:

Chemotherapy Administration and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

CPT® Code	Description
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
96415	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug; each additional hour <i>List separately in addition to code for primary procedure</i>

Therapeutic, Prophylactic, and Diagnostic Injections and Infusions

CPT® Code	Description
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); initial, up to 1 hour; each additional hour <i>List separately in addition to code for primary procedure</i>

Other relevant testing considerations

Glucose testing codes

CPT® Code	Description
82945	Glucose, body fluid, other than blood
82947 (QW)*	Glucose, quantitative, blood (except reagent strip)
82948	Glucose, blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use

Consult individual payers on any coding and documentation preferences

*To show as a Clinical Laboratory Improvement Amendments (CLIA) waived test, HCPCS code 82947 must have the modifier "QW".

CPT®, Current Procedural Terminology; FDA, US Food and Drug Administration; HCPCS, Healthcare Common Procedure Coding System.

Sample CMS-1450 claim form for use in hospital outpatient departments

The following is an example of how to fill out the CMS-1450 paper form for a patient who received TEPEZZA (two 500-mg vials of teprotumumab-trbw) via intravenous infusion.

In this example, the provider administered 900 mg via intravenous infusion and 100 mg was wasted. As shown below, providers report J3241 for TEPEZZA, 90 units for the amount administered, and J3241 with “JW” modifier, 10 units for the amount wasted, in Boxes 42-47. To report two 500-mg vials administered with no wastage, TEPEZZA would be reported on 1 line with J3241-JZ, 100 units.

Sample CMS-1450 with wastage

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0636	Drugs requiring detailed coding (brand)	J3241	XX-XX-XX	90	XXX XX		1
2 0636	Drugs requiring detailed coding (brand)	J3241-JW	XX-XX-XX	10	XXX XX		2
3 0260	Intravenous infusion; initial, up to 1 hour	96365	XX-XX-XX	1	XXX XX		3
4 0260	Intravenous infusion; each additional hour	96366	XX-XX-XX	1	XXX XX		4
5 0260	Intravenous infusion; initial, up to 1 hour	96365	XX-XX-XX	1	XXX XX		5
6 0260	Intravenous infusion; each additional hour	96366	XX-XX-XX	1	XXX XX		6
7 0260	Intravenous infusion; each additional hour	96366	XX-XX-XX	1	XXX XX		7

Sample CMS-1450 with no drug wastage

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1 0636	Drugs requiring detailed coding (brand)	J3241-JZ	XX-XX-XX	100	XXXXX
2 0260	Intravenous infusion, initial, up to 1 hour	96365	XX-XX-XX	1	XXXXX
3 0260	Intravenous infusion, initial,	96366	XX-XX-XX	1	XXXXX

Providers submitting claims for TEPEZZA via electronic software systems will need to translate claim information into compatible formats for input into their software systems. To view a crosswalk between **CMS-1450** and **ASC X12 8371 v5010A2**, visit <https://www.cms.gov/files/document/8371-Form-CMS-1450-MLN006926.pdf>

- 1 **Boxes 42-43:** Enter the appropriate revenue code and description corresponding to the HCPCS code listed in Box 44.
 - Confirm with the payer how NDC numbers should be noted on the claim form
- 2 **Box 44:** Enter the appropriate HCPCS (J3241) and CPT® codes. Include any additional modifiers (eg, to indicate wastage) required by the payer. See page 13 of this guide for more information about using modifiers.
 - **2a:** Use HCPCS code J3241 to report the drug and use JW to report waste (J3241-JW)
 - **2b:** Use HCPCS code J3241 to report the drug and use JZ to indicate no drug waste (J3241-JZ)
- 3 **Box 46:** Document the number of units used for each line item.
 - When billing for TEPEZZA with J3241, 1 unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

Hospital outpatient department claims submission checklist

The following checklist provides an overview of payer requirements that may be necessary when submitting claims for TEPEZZA. Please check with individual payers for specific coding requirements.



Use J3241 for TEPEZZA and include supporting information when necessary

Have the PA or predetermination approval on file

Confirm with the payer how NDC numbers should be noted on the claim form

Include any documentation required by the payer

Specialty pharmacy provider (SPP) infusion center billing and coding

Patients may receive TEPEZZA in an SPP infusion center. In this setting, commercial payers reimburse facilities for services and procedures. The products and services provided at the SPP infusion center are billed using the CMS-1500 claim form or its electronic claim equivalent.

This section provides general SPP infusion center coding information for TEPEZZA. The final coverage determination is not made until the payer receives and reviews the claim. Coding for TEPEZZA may vary by commercial payer and plan type. **Contact payers for specific coding requirements for billing TEPEZZA.**

POS codes

POS codes identify the location where a service was performed. The following POS code may be appropriate when TEPEZZA is administered in an SPP infusion center:

POS Code	POS Name	Description
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence

NDC

Payer requirements regarding the use of the 10- or 11-digit NDC may vary. EDI generally requires use of the 11-digit NDC as listed below. Some payers may require each NDC number on the claim. Check payer requirements for appropriate reporting of the NDC.

10-digit NDC	11-digit NDC	Description
75987-130-15	75987-0130-15	Carton containing one 500-mg single-dose vial (lyophilized powder for intravenous infusion)

ICD-10-CM diagnosis codes

The following may be appropriate ICD-10-CM diagnosis codes for TEPEZZA:

ICD-10-CM Diagnosis Code	Description
E05.00	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
H05.831	Thyroid orbitopathy, right orbit
H05.832	Thyroid orbitopathy, left orbit
H05.833	Thyroid orbitopathy, bilateral
H05.839	Thyroid orbitopathy, unspecified orbit

Clinical Activity Score (CAS)-related ICD-10-CM diagnosis codes may be necessary to fully describe the patient’s condition and associated manifestations. It is important to include CAS within your clinical documentation. Please [click here](#) for a listing of CAS-related ICD-10-CM diagnosis codes that you may want to include in a claim.

CMS, Centers for Medicare & Medicaid Services; EDI, electronic data interchange; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NDC, National Drug Code; POS, place of service.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hyperglycemia: Increased blood glucose or hyperglycemia may occur in patients treated with TEPEZZA. In clinical trials, 10% of patients (two-thirds of whom had preexisting diabetes or impaired glucose tolerance) experienced hyperglycemia. Hyperglycemic events should be controlled with medications for glycemic control, if necessary.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit TEPEZZAhcp.com.



HCPCS code

TEPEZZA has a permanent, product-specific HCPCS code: J3241.

HCPCS Drug Code	Description
J3241	Injection, teprotumumab-trbw, 10 mg

When billing for TEPEZZA using J3241:

- One unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

Modifiers

Modifiers are typically alphanumeric 2-character indicators that provide payers with additional information regarding the services rendered. If appropriate, more than one modifier may be used with a single procedure code.

Certain payers require the “JW” modifier to be used in order to obtain payment for a discarded amount of drug for single-dose or single-use packaging. For claims submitted with J3241, providers should use multiple lines to identify the amount administered and the amount wasted. One line of the claim should include J3241 and the number of units administered. A separate line should include J3241 with the “JW” modifier and the number of units wasted.

Effective January 1, 2023, modifier “JZ” may be reported on claims to note zero discarded amounts from single-use vials or single-use packages. CMS requires the reporting of modifier “JZ” effective July 1, 2023. Claims processing edits will be implemented by the MACs effective October 1, 2023.

The “SS” modifier may also be used to identify the setting of the administration.

Contact payers for specific coding requirements for billing wastage and modifiers.

Modifier	Description	Appropriate Use
JW	Drug amount discarded/not administered to any patient	Append to J3241 when there was discarded drug amount
JZ	Zero drug amount discarded/not administered to any patient	Append to J3241 when there was NO discarded drug amount
SS	Home infusion services provided in the infusion suite of the intravenous therapy provider	Append to CPT/HCPCS code for drug administration when home infusion services are provided in the infusion suite of the intravenous therapy provider

CPT® and HCPCS codes

When billing for TEPEZZA in the SPP facility, the following CPT® and HCPCS codes may be appropriate:

CPT®/HCPCS Code for Drug Administration	Description
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 (list separately in addition to code for primary procedure)
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
S9810	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)

Other relevant testing considerations

Glucose testing codes

CPT® Code	Description
82945	Glucose, body fluid, other than blood
82947 (QW)*	Glucose; quantitative, blood (except reagent strip)
82948	Glucose, blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use

Consult individual payers on any coding and documentation preferences

*To show as a Clinical Laboratory Improvement Amendments (CLIA) waived test, HCPCS code 82947 must have the modifier "QW".

CPT®, Current Procedural Terminology; FDA, US Food and Drug Administration; HCPCS, Healthcare Common Procedure Coding System; SPP, specialty pharmacy provider.

Sample CMS-1500 claim form for use in SPP infusion centers

The following is an example of how to fill out the CMS-1500 paper form for a patient who received TEPEZZA (two 500-mg vials of teprotumumab-trbw) via intravenous infusion.

In this example, the provider administered 900 mg via intravenous infusion and 100 mg was wasted. As shown below, providers report J3241 for TEPEZZA, 90 units for the amount administered, and J3241 with “JW” modifier, 10 units for the amount wasted, in Items 24A-24G. To report two 500-mg vials administered with no wastage, TEPEZZA would be reported on 1 line with J3241-JZ, 100 units.

Sample CMS-1500 with wastage

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____												22. RESUBMISSION CODE _____		ORIGINAL REF. NO. _____				
A. XXXXX			B. _____			C. _____			D. _____			23. PRIOR AUTHORIZATION NUMBER _____						
E. _____			F. _____			G. _____			H. _____			I. _____						
J. _____			K. _____			L. _____			M. _____			N. _____						
24. A.		DATE(S) OF SERVICE				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. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	SUPPLIER INFORMATION
1	XX	XX	XX	XX	XX	XX	49	J3241				A		90			NPI	
2	XX	XX	XX	XX	XX	XX	49	J3241 JW				A		10			NPI	
3	XX	XX	XX	XX	XX	XX	49	99601 SS				A		1			NPI	

Sample CMS-1500 with no drug wastage





21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____												22. RESUBMISSION CODE _____		ORIGINAL REF. NO. _____				
A. XXXXX			B. _____			C. _____			D. _____			23. PRIOR AUTHORIZATION NUMBER _____						
E. _____			F. _____			G. _____			H. _____			I. _____						
J. _____			K. _____			L. _____			M. _____			N. _____						
24. A.		DATE(S) OF SERVICE				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. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	SUPPLIER INFORMATION
1	XX	XX	XX	XX	XX	XX	49	J3241 JZ				A		100			NPI	
2	XX	XX	XX	XX	XX	XX	49	99601 SS				A		1			NPI	
3																NPI		

Providers submitting claims for TEPEZZA via electronic software systems will need to translate claim information into compatible formats for input into their software systems. To view a crosswalk between **CMS-1500** and **X12N Health Care Claim: Professional (837)**, visit <https://x12.org/codes>

- 1 **Item 21:**
 - Enter the appropriate ICD-10-CM diagnosis code(s)
 - The “ICD Ind.” field identifies the ICD code set being reported. Enter “0” between the dotted vertical lines for ICD-10-CM codes
- 2 **Item 23:** If required, report PA number.
- 3 **Item 24B:** Enter 49 for independent clinic.
- 4 **Item 24D:** Enter the appropriate HCPCS (J3241) and CPT® codes. Include any additional modifiers (eg, to indicate wastage) required by the payer. See page 18 of this guide for more information about using modifiers.
 - **4a:** Use HCPCS code J3241 to report the drug and use JW to report waste (J3241-JW)
 - **4b:** Use HCPCS code J3241 to report the drug and use JZ to indicate no drug waste (J3241-JZ)
 - Confirm with the payer how NDC numbers should be noted on the claim form
- 5 **Item 24E:** Enter the letter that corresponds to the ICD-10-CM code recorded in Item 21. Only enter 1 diagnosis pointer per service line.
- 6 **Item 24G:** Document the number of units used for each line item.
 - When billing for TEPEZZA with J3241, 1 unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

SPP infusion center claims submission checklist

The following checklist provides an overview of requirements that may be necessary from payers when submitting claims for TEPEZZA:

-  **Use J3241 for TEPEZZA and include supporting information when necessary**
-  **Have the PA or predetermination approval on file**
-  **Confirm with the payer how NDC numbers should be noted on the claim form**
-  **Include any documentation required by the payer**

Home infusion billing and coding

Patients may receive TEPEZZA in a home setting. In this setting, commercial payers reimburse providers separately for services and procedures. The products and services provided in the home setting are billed using the CMS-1500 claim form or its electronic claim equivalent.

This section provides general home infusion coding information for TEPEZZA. Coding for TEPEZZA may vary by commercial payer type and plan type. **Contact payers for specific coding requirements for billing TEPEZZA.**

POS codes

POS codes identify the location where a service was performed. The following POS code may be appropriate when TEPEZZA is administered in the home:

POS Code	POS Name	Description
12	Home	Location, other than hospital or other facility, where the patient receives care in a private residence

NDC

Payer requirements regarding use of the 10- or 11-digit NDC vary. EDI generally requires use of the 11-digit NDC as listed below. Note that some payers may require each NDC number to be listed on the claim. Check payer requirements for appropriate reporting of the NDC.

10-digit NDC	11-digit NDC	Description
75987-130-15	75987-0130-15	Carton containing one 500-mg single-dose vial (lyophilized powder for intravenous infusion)

ICD-10-CM diagnosis codes

The following may be appropriate ICD-10-CM diagnosis codes for TEPEZZA:

ICD-10-CM Diagnosis Code	Description
E05.00	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
H05.831	Thyroid orbitopathy, right orbit
H05.832	Thyroid orbitopathy, left orbit
H05.833	Thyroid orbitopathy, bilateral
H05.839	Thyroid orbitopathy, unspecified orbit

Clinical Activity Score (CAS)-related ICD-10-CM diagnosis codes may be necessary to fully describe the patient's condition and associated manifestations. It is important to include CAS within your clinical documentation. Please [click here](#) for a listing of CAS-related ICD-10-CM diagnosis codes that you may want to include in a claim.

CMS, Centers for Medicare & Medicaid Services; EDI, electronic data interchange; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NDC, National Drug Code; POS, place of service.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hyperglycemia (cont'd): Assess patients for elevated blood glucose and symptoms of hyperglycemia prior to infusion and continue to monitor while on treatment with TEPEZZA. Ensure patients with hyperglycemia or preexisting diabetes are under appropriate glycemic control before and while receiving TEPEZZA.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit TEPEZZAhcp.com.

TEPEZZA
teprotumumab-trbw

HCPCS code

TEPEZZA has a permanent, product-specific HCPCS code: J3241.

HCPCS Drug Code	Description
J3241	Injection, teprotumumab-trbw, 10 mg

When billing for TEPEZZA using J3241:

- One unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

Modifiers

Modifiers are typically alphanumeric 2-character indicators that provide payers with additional information regarding the services rendered. If appropriate, more than one modifier may be used with a single procedure code.

Certain payers require the “JW” modifier to be used in order to obtain payment for a discarded amount of drug for single-dose or single-use packaging. For claims submitted with J3241, providers should use multiple lines to identify the amount administered and the amount wasted. One line of the claim should include J3241 and number of units administered. A separate line should include J3241 with the “JW” modifier and the number of units wasted.

Effective January 1, 2023, modifier “JZ” may be reported on claims to note zero discarded amounts from single-use vials or single-use packages. CMS requires the reporting of modifier “JZ” effective July 1, 2023. Claims processing edits will be implemented by the MACs effective October 1, 2023.

Contact payers for specific coding requirements for billing wastage and modifiers.

Modifier	Description	Appropriate Use
JW	Drug amount discarded/not administered to any patient	Append to J3241 when there was discarded drug amount
JZ	Zero drug amount discarded/not administered to any patient	Append to J3241 when there was NO discarded drug amount

CPT® and HCPCS codes

When billing for TEPEZZA in the home, the following CPT® and HCPCS codes may be appropriate:

CPT®/HCPCS Code for Drug Administration	Description
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 (list separately in addition to code for primary procedure)
S5035	Home infusion therapy, routine service of infusion device (eg, pump maintenance)
S5520	Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion

CPT® and HCPCS codes continue on next page.

CPT® and HCPCS codes (continued)

CPT®/HCPCS Code for Drug Administration	Description
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
S9810	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)

Other relevant testing considerations

Glucose testing codes

CPT® Code	Description
82945	Glucose, body fluid, other than blood
82947 (QW)*	Glucose; quantitative, blood (except reagent strip)
82948	Glucose, blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use

Consult individual payers on any coding and documentation preferences

*To show as a Clinical Laboratory Improvement Amendments (CLIA) waived test, HCPCS code 82947 must have the modifier “QW”.

Sample CMS-1500 claim form for use in the home infusion setting

The following is an example of how to fill out the CMS-1500 paper form for a patient who received TEPEZZA (two 500-mg vials of teprotumumab-trbw) via intravenous infusion.

In this example, the provider administered 900 mg via intravenous infusion and 100 mg was wasted. As shown below, providers report J3241 for TEPEZZA, 90 units for the amount administered, and J3241 with “JW” modifier, 10 units for the amount wasted, in Items 24A-24G. To report two 500-mg vials administered with no wastage, TEPEZZA would be reported on 1 line with J3241-JZ, 100 units.

Sample CMS-1500 with wastage

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.:										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. XXXXX		B.		C.		D.		E.		23. PRIOR AUTHORIZATION NUMBER									
E.		F.		G.		H.		I.		J.									
I.		J.		K.		L.													
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER										
1	XX XX XX	XX XX XX	12				J3241		A		90			NPI					
2	XX XX XX	XX XX XX	12				J3241	JW	A		10			NPI					
3	XX XX XX	XX XX XX	12				99601		A		1			NPI					

Sample CMS-1500 with no drug wastage

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.:										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. XXXXX		B.		C.		D.		E.		23. PRIOR AUTHORIZATION NUMBER									
E.		F.		G.		H.		I.		J.									
I.		J.		K.		L.													
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER										
1	XX XX XX	XX XX XX	12				J3241	JZ	A		100			NPI					
2	XX XX XX	XX XX XX	12				99601		A		1			NPI					

Providers submitting claims for TEPEZZA via electronic software systems will need to translate claim information into compatible formats for input into their software systems. To view a crosswalk between **CMS-1500** and **X12N Health Care Claim: Professional (837)**, visit <https://x12.org/codes>

- 1 Item 21:**
 - Enter the appropriate ICD-10-CM diagnosis code(s)
 - The “ICD Ind.” field identifies the ICD code set being reported. Enter “0” between the dotted vertical lines for ICD-10-CM codes
- 2 Item 23:** If required, report PA number.
- 3 Item 24A:** Some payers may require NDC information. If required, enter information in the shaded field above the date of service, including:
 - Qualifier “N4” before the 11-digit NDC, followed by 3 spaces, the unit of measure (UN for units), and the quantity of drug
 - Confirm with the payer how NDC numbers should be noted on the claim form
- 4 Item 24B:** Enter 12 for home.
- 5 Item 24D:** Enter the appropriate HCPCS (J3241) and CPT® codes. Include any additional modifiers (eg, to indicate wastage) required by the payer. See page 23 of this guide for more information about using modifiers.
 - **5a:** Use HCPCS code J3241 to report the drug and use JW to report waste (J3241-JW)
 - **5b:** Use HCPCS code J3241 to report the drug and use JZ to indicate no drug waste (J3241-JZ)
- 6 Item 24E:** Enter the letter that corresponds to the ICD-10-CM code recorded in Item 21. Only enter 1 diagnosis pointer per service line.
- 7 Item 24G:** Document the number of units used for each line item.
 - When billing for TEPEZZA with J3241, 1 unit represents 10 mg of TEPEZZA. TEPEZZA should be billed based on units, not the number of milligrams

Home infusion claims submission checklist

The following checklist provides an overview of payer requirements that may be necessary when submitting claims for TEPEZZA. Please check with individual payers for specific coding requirements:



Use J3241 for TEPEZZA and include supporting information when necessary

Have the PA or predetermination approval on file

Confirm with the payer how NDC numbers should be noted on the claim form

Include any documentation required by the payer

Reimbursement considerations by payer type

Commercial health plans

For commercial payers, reimbursement for drugs and professional services depends significantly on the contracts negotiated between healthcare providers and the payer. The following list provides some important information you need to consider regarding your commercial payer contracts:



Identify your site of care's top payers



Locate copies of your site of care's contracts with these payers



Review the contracts to determine payment methodology for:

- Administration of infusion therapies with permanent billing codes
- Other related services (eg, laboratory monitoring, pregnancy testing)



Determine how frequently the rates are updated

- If the rates are based on Medicare, are they updated annually, biannually, quarterly, or more frequently?



Review any product acquisition terms



Determine the contract term, renewal date, and termination time frame



Document contact information for the payer and your site of care's designated payer relations representative



Store the contracts in a central location for easy access

Medicare Fee-for-Service (FFS)

Hospital outpatient department

- TEPEZZA: J3241-Injection, teprotumumab-trbw, 10 mg
 - TEPEZZA has status indicator “K” non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals, paid under OPPS; separate APC payment, effective July 1, 2023
- Drugs and biologicals with status indicator K are reimbursed as separately payable under OPPS Addendum B and currently have a payment rate of 106% of ASP

For the drug and professional services associated with drug administration:

- Medicare Part B covers drugs that are administered by infusion or injection in HCP offices and HOPDs if they: (a) meet the statutory definition of a drug or a biological, (b) are usually not self-administered, (c) are incident to an HCP’s service, (d) are reasonable and necessary for the diagnosis or treatment of an illness or injury, and (e) have not been determined by the US Food and Drug Administration to be less than effective
 - Typically, HCPs are reimbursed 80% of the allowed amount of most covered Part B drugs like TEPEZZA and the associated administration
- A policy of Medicare FFS claims incurring a 2% reduction (sequestration) in HCP payments has been reimplemented beginning July 1, 2022

Medicaid

Reimbursement for TEPEZZA can vary based on whether a patient enrolls in an FFS Medicaid plan or in a managed Medicaid plan. In many states, reimbursement for Medicaid is based on a uniform, publicly available fee schedule. However, reimbursement methodologies for managed Medicaid plans will vary and may not be publicly accessible.

Drug reimbursement for traditional Medicaid and managed Medicaid may include:

- Percentage (±) of AWP
- Percentage (±) of WAC
- Percentage (±) of ASP
- Invoice price

Medicaid programs may also use a variety of methods to determine the reimbursement for drug administration associated with TEPEZZA, which include:

- Fee schedule-based reimbursement
- Percentage of the Medicare Physician Fee Schedule
- Usual, customary, and reasonable reimbursement
- Percentage of billed charges

It is particularly important to conduct patient-specific benefits investigations for Medicaid beneficiaries before each scheduled appointment, because in many states, enrollees have the option to switch their plans every month. Therefore, eligibility for these patients can change frequently. Verify benefits each month prior to infusion and check authorization at the start of each new plan year and for any patients turning 26 years of age

Dual-eligible beneficiaries who receive both Medicare and Medicaid benefits may require prior authorization for payment by their specific Medicaid plan

Considerations for appealing underpaid or denied claims

After checking your contract, if you still believe a claim for TEPEZZA has been improperly reimbursed or denied, you may consider submitting an appeal.

1. Review the remittance advice to determine what has been denied or underpaid (eg, drug, administration, both) and the reason for it.
 - If the underpayment or denial was due to a technical billing error, verify/obtain specific directions from the payer and submit a corrected claim
2. If necessary to appeal, verify the appeals process with the payer:
 - Is there a particular form that must be completed?
 - Can the appeal be conducted over the phone or must it be in writing?
 - To whom should the appeal be directed?
 - What information must be included with the appeal (eg, copy of original claim, EOB, PA number, other supporting documentation)?
 - How long does the appeals process usually take?
 - How will the payer communicate the appeal decision?
3. Review the appeal request for accuracy, including the patient identification numbers, coding, and requested information.
4. File the appeal as soon as possible and within filing time limits.
5. Request that the payer have a specialist who has experience with TED and TEPEZZA review the claim for medical necessity.
6. Reconcile claims appeal responses promptly and thoroughly to ensure appeal has been processed appropriately.
7. Record the appeal result (eg, payment amount or if further action is required).

If a claim is denied, some payers may use a process called “Same Specialist Review,” which provides adjudication by a medical reviewer specializing in a particular disease. Contact your Provider Relations representative to request this review.

If the second claim submission is denied, consider contacting the payer’s medical or claims director. A claim denial may be reversed upon a director’s review of an accurate and complete denial appeal request



To download a sample Letter of Appeal, click [here](#)

To download a sample Letter of Medical Necessity, click [here](#)

EOB, explanation of benefits; PA, prior authorization; TED, Thyroid Eye Disease.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hearing Impairment Including Hearing Loss: TEPEZZA may cause severe hearing impairment including hearing loss, which in some cases may be permanent. Assess patients’ hearing before, during, and after treatment with TEPEZZA and consider the benefit-risk of treatment with patients.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit [TEPEZZAhcp.com](#).

TEPEZZA
teprotumumab-trbw

Appendix

Additional ICD-10-CM codes

Clinical Activity Score (CAS)-related ICD-10-CM diagnosis codes may be necessary to fully describe the patient's condition and associated manifestations. It is important to include CAS within your clinical documentation. The following list is not inclusive of all codes that are available or related to TED, but rather codes related to CAS. It is the responsibility of the healthcare provider to choose the most appropriate codes.

ICD-10-CM Codes	Descriptor
H02.531-H02.539	Eyelid retraction
H02.841-H02.849	Edema of eyelid
H04.121-H04.129	Dry eye syndrome of lacrimal glands
H05.241-H05.249	Constant exophthalmos
H05.251-H05.259	Intermittent exophthalmos
H10.421-H10.429	Simple chronic conjunctivitis
H11.131-H11.139	Conjunctival pigmentations
H11.141-H11.149	Conjunctival xerosis, unspecified
H11.411-H11.419	Vascular abnormalities of conjunctiva
H11.421-H11.429	Conjunctival edema
H11.431-H11.439	Conjunctival hyperemia
H16.211-H16.219	Exposure keratoconjunctivitis
H46.8	Other optic neuritis
H47.011-H47.019	Ischemic optic neuropathy
H47.091-H47.099	Other disorders of optic nerve
H50.21-H50.22	Vertical strabismus
H50.69	Other mechanical strabismus
H53.2	Diplopia
H53.451-H53.459	Other localized visual field defect
H57.10-H57.13	Ocular pain

ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; TED, Thyroid Eye Disease.

IMPORTANT SAFETY INFORMATION

ADVERSE REACTIONS

The most common adverse reactions (incidence $\geq 5\%$ and greater than placebo) are muscle spasm, nausea, alopecia, diarrhea, fatigue, hyperglycemia, hearing impairment, dysgeusia, headache, dry skin, ear discomfort, weight decreased, nail disorders, and menstrual disorders.

Please see additional Important Safety Information on page 34 and see [Full Prescribing Information](#) or visit TEPEZZAhcp.com.

TEPEZZA
teprotumumab-trbw

INDICATION

TEPEZZA is indicated for the treatment of Thyroid Eye Disease regardless of Thyroid Eye Disease activity or duration.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Infusion Reactions: TEPEZZA may cause infusion reactions. Infusion reactions have been reported in approximately 4% of patients treated with TEPEZZA. Reported infusion reactions have usually been mild or moderate in severity. Signs and symptoms may include transient increases in blood pressure, feeling hot, tachycardia, dyspnea, headache, and muscular pain. Infusion reactions may occur during an infusion or within 1.5 hours after an infusion. In patients who experience an infusion reaction, consideration should be given to premedicating with an antihistamine, antipyretic, or corticosteroid and/or administering all subsequent infusions at a slower infusion rate.

Inflammatory Bowel Disease: TEPEZZA may cause an exacerbation of inflammatory bowel disease (IBD). IBD has been reported in some patients without a prior diagnosis of IBD. Monitor patients for signs and symptoms of IBD. If IBD exacerbation is suspected, discontinue use of TEPEZZA.

Hyperglycemia: Increased blood glucose or hyperglycemia may occur in patients treated with TEPEZZA. In clinical trials, 10% of patients (two-thirds of whom had preexisting diabetes or impaired glucose tolerance) experienced hyperglycemia. Hyperglycemic events should be controlled with medications for glycemic control, if necessary. Assess patients for elevated blood glucose and symptoms of hyperglycemia prior to infusion and continue to monitor while on treatment with TEPEZZA. Ensure patients with hyperglycemia or preexisting diabetes are under appropriate glycemic control before and while receiving TEPEZZA.

Hearing Impairment Including Hearing Loss: TEPEZZA may cause severe hearing impairment including hearing loss, which in some cases may be permanent. Assess patients' hearing before, during, and after treatment with TEPEZZA and consider the benefit-risk of treatment with patients.

ADVERSE REACTIONS

The most common adverse reactions (incidence \geq 5% and greater than placebo) are muscle spasm, nausea, alopecia, diarrhea, fatigue, hyperglycemia, hearing impairment, dysgeusia, headache, dry skin, ear discomfort, weight decreased, nail disorders, and menstrual disorders.

Please see [Full Prescribing Information](#) or visit [TEPEZZAhcp.com](https://www.tepezzaahcp.com) for more information.

Reference: 1. TEPEZZA (teprotumumab-trbw) [prescribing information] Amgen.