



## MASSACHUSETTS

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# Pharmacy Medical Policy

## B-Type Natriuretic Peptide

### Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [References](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [Coding Information](#)
- [Forms](#)

### Policy Number: 031

BCBSA Reference Number: None

### Related Policies

None

### Policy

#### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

**Note:** All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document.

This medication is not covered by the pharmacy benefit. It is covered by the Medical Benefit or as a Home Infusion Therapy.

We may cover Natrecor® (nesiritide) when ALL of the following criteria are met<sup>1</sup>:

- Patients with a diagnosis of acutely decompensated congestive heart failure who have dyspnea at rest or with minimal activity
- The medication is being administered as an inpatient (Place of Service 1- in the hospital) or in the *emergency room* treatment, only. (Place of Service 2).

Nesiritide is not covered for any other indication, including<sup>1</sup>:

- Intermittent outpatient infusion
- Scheduled repetitive use
- To improve renal function
- To enhance diuresis.

### CPT Codes / HCPCS Codes / ICD Codes

*Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.*

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above **medical necessity criteria MUST** be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

### HCPCS Codes

HCPCS codes:	Code Description
J2325	Injection, nesiritide, 0.1 mg (Natrecor®)

### ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
3E063VH	Introduction of Human B-type Natriuretic Peptide into Central Artery, Percutaneous Approach
3E033VH	Introduction of Human B-type Natriuretic Peptide into Peripheral Vein, Percutaneous Approach
3E043VH	Introduction of Human B-type Natriuretic Peptide into Central Vein, Percutaneous Approach
3E053VH	Introduction of Human B-type Natriuretic Peptide into Peripheral Artery, Percutaneous Approach

The following ICD Diagnosis Codes are considered medically necessary when submitted with the codes above if **medical necessity criteria** are met:

### ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.1	Left ventricular failure, unspecified
I50.20	Unspecified systolic (congestive) heart failure
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.30	Unspecified diastolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.9	Heart failure, unspecified

### Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts  
 Pharmacy Operations Department  
 25 Technology Place  
 Hingham, MA 02043  
 Tel: 1-800-366-7778  
 Fax: 1-800-583-6289

### Managed Care Authorization Instructions

- Prior authorization is required for all out patient sites of service
- For all outpatient sites of service, physicians may fax or mail the attached form to the address above.

### PPO and Indemnity Authorization Instructions

- Prior authorization **is** required when this medication is processed under the home infusion therapy benefit.
- Prior authorization **is not** required when this medication is purchased by the physician and administered in the office in accordance with this medical policy.
- Physicians may also fax or mail the attached form to the address above.

### Policy History

Date	Action
7/2018	Clarified coding information.
6/2017	Updated address for Pharmacy Operations.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
1/2014	Updated ExpressPath language.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/1/2006	New policy, effective 1/1/2006, describing covered and non-covered indication.

### References

1. Natrecor® [package insert]. Fremont, CA: Scios Inc; April 2005
2. Yancy CW et al. Safety and feasibility of using serial infusions of nesiritide for heart failure in an outpatient setting (from the FUSION I trial). Am J Cardiol 2004;94:595-601.
3. Peacock WF, et al. Observation unit treatment of heart failure with nesiritide: results from the PROACTION trial. J Emerg Med 2005;29(3):243-252.
4. Publication Committee for the VMAC Investigators. Intravenous nesiritide vs. nitroglycerin for treatment of decompensated heart failure. JAMA 2002; 287: 1531 - 40.
5. Burger AJ, et al. Effect of nesiritide (B-Type Natriuretic Peptide) and dobutamine on ventricular arrhythmias in the treatment of patients with acutely decompensated CHF: The PRECEDENT study. Am Heart J 2002; 144 (6):1102-8.
6. Colucci, WS et al. Intravenous nesiritide, a natriuretic peptide, in the treatment of decompensated congestive heart failure. NEJM. 2000;343(4):246-53.
7. Mills RM, et al. Sustained hemodynamic effects of an infusion of nesiritide (human b-type natriuretic peptide) in heart failure. J Am Coll Cardiol 1999; 34(1):155-62
8. Marcus LS et al. Hemodynamic and renal excretory effects of human brain natriuretic peptide infusion in patients with congestive heart failure: a double-blind, placebo-controlled, randomized crossover trial. Circulation 1996;94:3184-3189.
9. Braunwald E, Burnett JC, Colucci WS, et al. Natrecor Advisory Panel Report. In: Panel of cardiology experts provides recommendations to Scios regarding Natrecor. Healthcare Professional Letter. Fremont, CA: Scios; June 13, 2005. Available at: <http://www.natrecor.com/>. Accessed December 19, 2005.

**To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:**

<http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf>

**Home Infusion Therapy**  
Prior Authorization Form



Please complete and fax with the physician's prescription to: (888) 641-5355. If the patient is a BCBSMA employee, please fax the form to: (617)246-4013.  
**FOR TPN THERAPY, USE MEDICAL POLICY #296 REQUEST FORM**

Company name:		Contact Name:	
Phone #:		Provider #:	
Fax#		Address:	
Patient name:		Address:	
Patient ID#:		DOB: ___/___/___	Diagnosis:
Prescribing Physician/addr:	_____		Telephone:
PCP name/address:	_____		Telephone:

Is this fax number 'secure' for PHI receipt/transmission per HIPAA requirements? (circle one) Yes No

**Place of Service**     Home     SNF     MD office     other (specify) \_\_\_\_\_

**Primary Therapy**

Primary drug name: \_\_\_\_\_      Approximate duration: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
Dose: \_\_\_\_\_  
Frequency: \_\_\_\_\_      Route of Administration: \_\_\_\_\_      pump: Y N

**Other Therapy**

Other drug name: \_\_\_\_\_      Approximate duration: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
Dose: \_\_\_\_\_  
Frequency: \_\_\_\_\_      Route of Administration: \_\_\_\_\_      pump: Y N

If this is a "drug only" authorization request, indicate other services the nursing agency is providing:

\_\_\_\_\_  
Nursing provided by: \_\_\_\_\_      Contact: \_\_\_\_\_

Phone: \_\_\_\_\_      Fax: \_\_\_\_\_

Request for 7 Day Coverage : Date of occurrence: \_\_\_\_\_ request dates: \_\_\_\_\_

Occurrence type:     Hospitalization     Death     Change of Therapy

**Physician signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**OR Copy of prescription REQUIRED with this request**