THE FIRST AND ONLY 2-DOSE HEPATITIS B VACCINE
FOR ADULTS ≥18 YEARS\(^1,2\)

**INDICATION**
HEPLISAV-B is indicated for prevention of infection caused by all known subtypes of hepatitis B virus in adults 18 years of age and older.

**IMPORTANT SAFETY INFORMATION**
Do not administer HEPLISAV-B to individuals with a history of severe allergic reaction (eg, anaphylaxis) after a previous dose of any hepatitis B vaccine or to any component of HEPLISAV-B, including yeast.

Please see additional Important Safety Information on page 3 and accompanying full Prescribing Information.
CONTENTS

- Indication and Important Safety Information ................................................. 3
- Quick-reference coding guide ........................................................................ 4
- Submitting claim forms .................................................................................. 5
- Tips for submitting claims .............................................................................. 6
- Appeals information ....................................................................................... 7
- HEPLISAV-B Access Navigator™ ................................................................. 8

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Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of HEPLISAV-B.

Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to HEPLISAV-B.

Hepatitis B has a long incubation period. HEPLISAV-B may not prevent hepatitis B infection in individuals who have an unrecognized hepatitis B infection at the time of vaccine administration.

The most common patient-reported adverse reactions reported within 7 days of vaccination were injection site pain (23%-39%), fatigue (11%-17%), and headache (8%-17%).
### QUICK-REFERENCE CODING GUIDE

The table below provides a brief overview of relevant billing and coding information for HEPLISAV-B, presented in greater detail with the sample CMS-1500 form.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT** Drug Code</td>
<td>90739</td>
<td>Hepatitis B vaccine, adult dosage 2-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>CPT Administration Code</td>
<td>90471</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)</td>
</tr>
<tr>
<td>HCPCS (Administration code for Medicare Part B)</td>
<td>G0010</td>
<td>Administration of hepatitis B vaccine</td>
</tr>
</tbody>
</table>

#### 10-Digit NDC Number
- 43528-002-01: Single vial, 1 dose, 0.5 mL
- 43528-002-05: Package of 5 single-dose vials
- 43528-003-01: Prefilled Syringe, 1 dose (0.5 mL)
- 43528-003-05: Package of 5 single-dose prefilled syringes

#### 11-Digit NDC Number
- 43528-0002-01: Single vial, 1 dose, 0.5 mL
- 43528-0002-05: Package of 5 single-dose vials
- 43528-0003-01: Prefilled Syringe, 1 dose (0.5 mL)
- 43528-0003-05: Package of 5 single-dose prefilled syringes

#### ICD-10-CM
- Z23: Encounter for immunization

#### MVX Code
- DVX: Dynavax

#### CVX Code
- 189: Hepatitis B vaccine (recombinant), adjuvant

Please note for TRICARE:
- The correct NDC number for reimbursement is on the package, not the vial/prefilled syringe
- Be sure to enter the 11-digit NDC number (the one with the extra ‘0’) on the claim form

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### SUBMITTING CLAIM FORMS

Use this guidance when submitting claims for HEPLISAV-B in the office/noninstitutional setting (CMS-1500 form). First, complete the top half of the claim form with the patient’s information. Then, fill in the product and diagnosis codes in the sections indicated in the sample form below.

- **Box 17B:** Include the NPI number for the ordering/referring physician
- **Box 21:** Report the diagnosis codes along with any other diagnoses relevant to the patient’s episode of care on this Date of Service
- **Box 24A:** Include the NDC within the shaded area above the Date of Service
- **Box 24D:** Include the CPT code for HEPLISAV-B: 90739
  - Append any necessary modifiers (check for ICD-10 code and diabetes) for proper claim processing
- **Box 24E:** Include the ICD-10 code linked to the CPT code to support medical necessity
- **Box 31:** Sign if necessary and submit the claim form per the insurance carrier’s/insurer’s instructions

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Please see Important Safety Information on page 3 and accompanying full Prescribing Information.
TIPS FOR SUBMITTING CLAIMS

- Verifying that CPT code 90739 has been added to your payer contracts
- Ensuring that your NPI number is verified against CPT code 90739
- Keeping complete, legible, and easily accessible records
- Confirming the accuracy of both clinician- and patient-supplied information
- Rationale for services should be documented or easily inferred
- When reporting NDCs per individual payer requirements, NDCs must be documented in an 11-digit format. For HEPLISAV-B, this involves adding a “0” immediately after the first hyphen in each NDC. Please note that on the CMS-1500 claim form, no spaces or hyphens should be used when adding an NDC
- Communicate with appropriate payer contacts to determine plan-specific requirements
- Monitor the first few claims submitted to each plan to learn about the plan’s claim and reimbursement processes, and apply the knowledge to future claims

Private payer reimbursement varies and is based on the rate contracted with the provider

- Review your contracts to understand how each of the payers you work with reimburses
- Consider setting up your electronic medical records system to prepopulate appropriate claims information by payer

Additional tips for Medicare patients

- Medicare pays for hepatitis B vaccinations for individuals considered to be at high or intermediate risk. Consult Medicare’s coverage criteria for high or intermediate risk to determine your patient’s eligibility for HEPLISAV-B
- If your Medicare patient does not fall within the Medicare coverage criteria, an Advanced Beneficiary Notice prior to administering treatment may be required

ADDITIONAL RESOURCES

- Sample CMS-1500 forms can be accessed and downloaded from the CMS website: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
- Please see the CMS website for information on adult immunization resources for providers, coverage, billing, and more: CMS.gov or https://www.cms.gov/Medicare/Prevention/Immunizations/Providerresources.html

APPEALING DENIED CLAIMS

The Affordable Care Act grants the right to ask insurers to reconsider a denied claim or to appeal their decision. Make sure to take these important steps before beginning a formal appeals process:

- Understand the reason for denial
- Investigate the appeals guidelines
- Verify eligibility and reimbursement amounts with the health plan
- Get the phone contact information

APPEALS CHECKLIST

You may need to include certain forms and documents in an appeals package if an insurer denies treatment to your patient

- Each insurer and each patient might need different information

Please review each denial and the insurer’s guidelines to determine what to include in your patient’s appeals package

- Letter of Medical Necessity
  - Download sample letter at HeplisavB.com
- Copy of the patient’s health plan or prescription card (front and back)
- Letter of Appeal
  - Download sample letter at HeplisavB.com
- Denial information, including the patient’s denial letter or Explanation of Benefits (EOB) letter
- Supporting documentation

If the patient’s insurer has not responded within 30 to 60 days of receipt of the appeals package, contact the insurer to find out its status

- Keep a copy of everything you send with the patient’s appeal
- Keep a log of every phone call you make to the patient’s insurer
- Write down the date and the name of the person you spoke with

Call HEPLISAV-B Access Navigator™

at 1-844-HEPLISAV (1-844-375-4728) for coverage and reimbursement support
8 AM to 8 PM, ET, Monday through Friday
HeplisavB.com
HEPLISAV-B™
Hepatitis B Vaccine (Recombinant), Adjuvanted
ACCESS NAVIGATOR

HERE TO HELP WITH YOUR COVERAGE AND REIMBURSEMENT QUESTIONS, INCLUDING:

- Billing and coding guidelines
- Sample claim form information
- Tips for submitting claims
- Information on payer coverage and reimbursement
- Guidance on payer authorization and appeal process

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