

Sample UB-04 (also known as CMS 1450) Claim Form for Hospital Outpatient Department Billing: RENFLEXIS® (infliximab-abda) for Injection, for Intravenous Use 100 mg

Before prescribing RENFLEXIS, please read the [Prescribing Information](#), including the **Boxed Warning** about serious infections and malignancies. The [Medication Guide](#) also is available.

Note: See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html> for additional guidance from CMS on billing for RENFLEXIS (infliximab-abda), including important information about differences between claims with dates of service on or after April 1, 2018 versus claims with dates of service before April 1, 2018. For questions on billing if a portion of a package is wasted, consult the applicable payer's policy regarding wastage. Record the amount of drug administered and the amount wasted in the patient's medical record. Medicare requires the use of the JW modifier on all claims that include wasted product.

1	2	3a PAT. CNTL. # B. MED. REC. #	4 TYPE OF BILL
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%; border: 2px solid black; padding: 10px; background-color: #333; color: white;"> <h3>Locator 42</h3> <ul style="list-style-type: none"> Enter appropriate revenue code for each line item. Drugs that are billed with HCPCS codes usually require revenue code 0636—<i>Drugs requiring detailed coding.</i> </div> <div style="width: 30%; border: 2px solid black; padding: 10px; background-color: #333; color: white;"> <h3>Locator 43</h3> <ul style="list-style-type: none"> For each line item, enter the description of the revenue code used. For the line item for RENFLEXIS (infliximab-abda), also enter the drug's brand and generic names. </div> <div style="width: 30%; border: 2px solid black; padding: 10px; background-color: #333; color: white;"> <h3>Locator 46</h3> <ul style="list-style-type: none"> Enter the number of units administered in this field. Note that 1 unit equals 10 mg of RENFLEXIS for both Q5104 (used to bill for RENFLEXIS [infliximab-abda] for dates of service on or after April 1, 2018) as well as Q5102 (used to bill for RENFLEXIS [infliximab-abda] for dates of service before April 1, 2018). </div> </div>			
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
<div style="border: 2px solid black; padding: 10px; background-color: #333; color: white; margin: 10px auto; width: 80%;"> <h3>Locator 44</h3> <p>Please note that different payers may have different coding requirements for RENFLEXIS (infliximab-abda). Check with the payer for information on billing and coding if you have questions. The guidance below applies to Medicare Part B claims. Check with the payer for billing and coding information for commercial claims.</p> <p>For claims with dates of service on or after April 1, 2018:</p> <ul style="list-style-type: none"> Use Q5104 to bill for RENFLEXIS (infliximab-abda). <p>For claims with dates of service before April 1, 2018:</p> <ul style="list-style-type: none"> Use Q5102 to bill for RENFLEXIS (infliximab-abda), and Under MODIFIER, insert ZC to indicate that RENFLEXIS (infliximab-abda) was used. <p>For infusion procedure:</p> <ul style="list-style-type: none"> The infusion time corresponds to CPT® codes 96413 and 96415. (Some payers may prefer use of 96365 and 96366. Check with the applicable payer.) </div>			
PAGE OF			
50 PAYER NAME			
59 P. REL.			
60 INSURED'S UNIQUE ID		61 GROUP NAME	
62 INSURANCE GROUP NO.		57 OTHER PRV ID	
63 TREATMENT AUTHORIZATION CODES			
64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX			
67 A B C D E F G H			
68			
69 ADMIT DX	70 PATIENT REASON DX	71 FPS CODE	72 ECI
73	74 PRINCIPAL PROCEDURE CODE	75	76 ATTENDING NPI
77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 REMARKS
81CC a	b	c	d

Locator 67

- Enter appropriate diagnosis code(s).

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Merck makes no representation that the information is accurate or that it will comply with the requirements of any particular MAC or payer. You are solely responsible for determining the billing and coding requirements applicable to any payer or MAC. Diagnosis codes should be selected only by a health care 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 or any instructions provided by a payer or MAC. Billing and coding requirements may vary or change over time, so it is important to regularly check these requirements with each payer or MAC. Merck makes no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use and cautions 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.