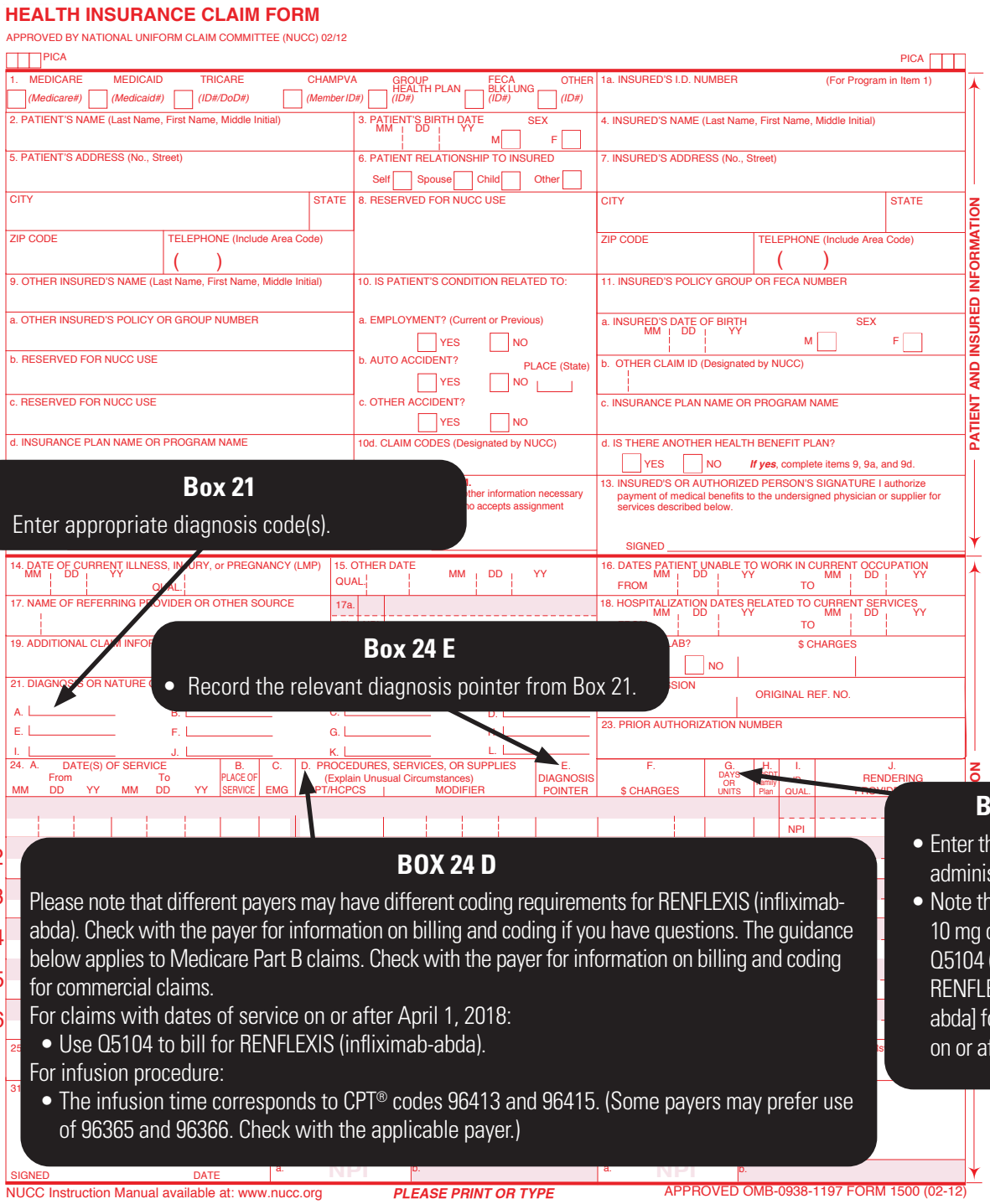
Sample CMS-1500 Claim Form for Office Billing: RENFLEXIS® (infliximab-abda) for Injection, for Intravenous Use 100 mg

Before prescribing RENFLEXIS, please read the accompanying 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.



Box 21

- Enter appropriate diagnosis code(s).

Box 24 E

- Record the relevant diagnosis pointer from Box 21.

BOX 24 D

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 information on billing and coding for commercial claims.

For claims with dates of service on or after April 1, 2018:

- Use Q5104 to bill for RENFLEXIS (infliximab-abda).

For infusion procedure:

- The infusion time corresponds to CPT® codes 96413 and 96415. (Some payers may prefer use of 96365 and 96366. Check with the applicable payer.)

BOX 24 G

- Enter the number of units administered in this field.
- Note that 1 unit equals 10 mg of RENFLEXIS for Q5104 (used to bill for RENFLEXIS [infliximab-abda] for dates of service on or after April 1, 2018).

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Organon 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. Billing and coding requirements may vary or change over time, so it is important to regularly check these requirements with each payer or MAC. Organon 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.