# Niktimvo<sup>™</sup> (axatilimab-csfr) Example CMS-1500 Claim Form Physician Office Setting

This example form is provided for guidance and reference only.

Niktimvo and the associated services provided in a physician's office are billed on the CMS-1500 Claim Form. It is always the provider's responsibility to determine the appropriate healthcare setting, and to submit true and correct claims for the products and services rendered. Incyte cannot guarantee payment of any claim and providers should contact third-party payers for specific information on their coding, coverage, and payment policies as needed.

#### **Box 19**

Some payers may require additional information for proper processing. This may include\*: Drug name, strength, route of administration, dosage administered, amount wasted (if applicable), and NDC

#### Box 21

Enter the ICD-10-CM diagnosis code

### Box 24 A-B

Enter the date of service and appropriate place of service code. Each unique NDC used should be listed as its own line item If NDC reporting is required, include the following in the shaded portion of Box 24A\*: N4+11-Digit NDC+ML+Unit Quantity (administered or discarded)

## Box 24 D

Enter the appropriate HCPCS, modifier, and  $\mbox{CPT}^{\circledast}$  codes. For example:

- Drug J9038 (Injection, axatilimab-csfr, 0.1 mg)<sup>†</sup>
- Modifier JW (Discarded product should be reported on a separate line with the JW modifier. If no wastage, include the JZ modifier inline with the HCPCS code)
- Administration 96413

#### **Box 24 E**

Refer to the diagnosis (Box 21), relating to the drug or procedure listed in Box 24D

#### Box 24 G

Enter number of units for each line item. If a separate line was created for wastage, clearly indicate number of units discarded

- J9038 Billing Unit = 0.1 mg
- Single Dose Vial = 9 mg or 22 mg
- 9 mg Vial = 90 Units
- 22 mg Vial = 220 Units

EALTH INSURANCE CLAIM FORM		
PICA MEDICARE MEDICAID TRICARE CHAMPV	A GROUP FECA OTHER	PICA PICA 14. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member k		
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Y STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	CITY STATE
CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a, INSURED'S DATE OF BIRTH SEX
	YES NO	a. INSURED'S DATE OF BIRTH SEX
SERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
SERVED FOR NUCC USE	c. OTHER ACCIDENT?	i c. INSURANCE PLAN NAME OR PROGRAM NAME
SURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
SURANCE PEAN NAME OF PROGRAM NAME	Tod. CEAIM CODES (Designated by NOCC)	YES NO <i>If yes</i> , complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Tauthorize the	elease of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
) process this claim. I also request payment of government benefits either elow.	o myselt or to the party who accepts assignment	services described below.
IGNED	DATE	SIGNED
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IAME OF REFERRING PROVIDE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM D TO TO TO THE T
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	ICD IIId.	E OR AUTHO 24 G
24 A-B 24 D	н. Ц.	E OR AUTHC 24 G
J. K. K. L M. DATE(S) OF SERVICE B. C. D. PROCE From To PLACEOF (Expli	L. DURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. B. H. I. J. DAYS ESSIT ID. RENDERING
DD YY MM DD YY SERVICE EMG CPT/HCP		CHARGES UNITS Family D. RENDERING OR Pamily Du. PROVIDER ID. #
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EDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	CCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC
20. FAILENT ON LIT 20. FAILENT OF	YES NO	\$ \$
		33. BILLING PROVIDER INFO & PH # (
IGNATURE OF PHYSICIAN OR SUPPLIER VCLUDING DEGREES OR CREDENTILS cortly that the statements on the reverse	CILITY LOCATION INFORMATION	33. BILLING PHOVIDER INFO & PH # ( )

CPT®, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NDC, National Drug Code.

\*Always refer to specific payer policies as billing requirements may vary by payer, including use of the 10- or 11-digit NDC. \*The permanent Niktimvo J-code applies from April 1, 2025. For earlier dates, verify coding with payers.



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