Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
EFFECTIVE JANUARY 1, 2019
EXPAREL APPROVED BY CMS FOR REIMBURSEMENT IN ASCs

On November 2, 2018, the Centers for Medicare & Medicaid Services (CMS) published the final ambulatory surgery center (ASC) Medicare rules and regulations for 2019.

Under the new rules, the Healthcare Common Procedure Coding System (HCPCS) code C9290 that is assigned to EXPAREL was assigned a payment status of “allowed” when used in a surgical procedure on Medicare patients in Medicare-certified ASCs.

• The “allowed” payment status enables EXPAREL to be reimbursed separately by Medicare and, potentially, other commercial payers

• In 2015, the payment status for C9290 was defined as “packaged,” which meant that EXPAREL was considered packaged into the pricing of the surgical procedure and, therefore, NOT eligible for separate reimbursement. The new rule changes the payment status from “packaged” to “allowed” in the ASC

• Effective October 1, 2019, EXPAREL is priced at $1.25/mg and should be billed using HCPCS code C9290*
  —For the 266 mg (20 mL) dose, the allowed amount† for reimbursement is $332.50
  —For the 133 mg (10 mL) dose, the allowed amount† for reimbursement is $166.25

• Acute care hospitals, hospital outpatient departments (HOPDs), and hospital-based same-day surgery centers are NOT included in the rule; therefore, they will not be reimbursed separately for EXPAREL

As a result of the new payment status for C9290, which has been approved as “allowed,” ASCs can provide greater patient access to EXPAREL, an opioid-free option for postsurgical pain management.

Reminder: EXPAREL reimbursement is based on mg (ie, units) not vials. Always make sure to bill units as the mg dosage.

Why is this so important?
Within the past 5 years, >90% of the Medicare population was reported to be in good health.1 Advanced age is considered a risk factor when undergoing surgical procedures; 1 in 10 people who have surgery are aged ≥65 years.2 Opioid-based postsurgical pain management may cause significant side effects.3

In one study of elderly patients undergoing low-risk surgical procedures, 10% of patients were still taking opioids 1 year later.4 Minimizing exposure to opioids and providing long-lasting pain control are key elements of a multimodal postsurgical pain management protocol.5 EXPAREL, a non-opioid, provides significant long-lasting pain control while reducing opioid use.1

The table on the following page provides an example of surgical procedures performed in the HOPD and ASC settings in 2014 and 2016 on Medicare patients.

• The table highlights Medicare ASC procedural trends, including the shift in site of service

• Postsurgical pain management is a key consideration when choosing surgical procedures performed in an ambulatory setting. EXPAREL has a broad indication for infiltration across surgical procedures and as an interscalene brachial plexus nerve block for rotator cuff repair and shoulder arthroplasty

*Pricing is subject to CMS Medicare updates.
†The allowed amount for reimbursement is based on the full dose being used for the surgical procedure and is subject to CMS Medicare updates.
‡The clinical benefit of the decrease in opioid consumption was not demonstrated in the pivotal trials.

Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
With the “allowed” payment status for C9290 and thus, separate reimbursement for EXPAREL, financial considerations or supply cost concerns to use EXPAREL on Medicare patients in an ASC are now eliminated. It also provides the necessary momentum for commercial payers to follow CMS policy, which is aimed at supporting the use of non-opioid-based postsurgical pain management in an ASC.

For details and guidance on how to access Medicare reimbursement and engage your commercial payers, please visit www.EXPAREL.com/reimbursement.

For additional information about reimbursement for EXPAREL, please contact 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com.


<table>
<thead>
<tr>
<th>MEDICARE PROCEDURE</th>
<th>HOPD utilization*</th>
<th>ASC utilization†</th>
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</thead>
<tbody>
<tr>
<td>Spine</td>
<td>46,248</td>
<td>82,824</td>
</tr>
<tr>
<td>Rotator cuff/shoulder repair</td>
<td>64,867</td>
<td>55,196</td>
</tr>
<tr>
<td>Hernia repair</td>
<td>37,644</td>
<td>50,336</td>
</tr>
<tr>
<td>Breast reconstruction</td>
<td>55,812</td>
<td>37,376</td>
</tr>
<tr>
<td>Bunionectomy</td>
<td>17,559</td>
<td>9939</td>
</tr>
<tr>
<td>Joint replacement (eg, TKA)</td>
<td>6827</td>
<td>9664</td>
</tr>
<tr>
<td>Hemorrhoidectomy</td>
<td>8121</td>
<td>7607</td>
</tr>
</tbody>
</table>


*HOPD utilization from OPPS CPT cost statistics files.

†ASC utilization from Medicare provider utilization and payment public use files for physician and other suppliers where provider type is an ASC.

‡Rotator cuff includes CPT codes 23412 and 29827; shoulder repair includes CPT codes 23130, 23410, 23420, 29807, and 29824.

§Bunionectomy includes CPT codes 28292, 28296, 28297, 28298, and 28299.
What can you do to prepare for reimbursement?

**Surgeons and Anesthesiologists**

- If EXPAREL is currently used in your ASC,
  - Provide the ASC Administrator with a list of surgical procedures performed on Medicare patients who may immediately benefit from a non-opioid postsurgical pain management option
  - Ask the ASC Administrator today to confirm there is a process in place to ensure that C9290 is billed for all patients who receive EXPAREL
  - Follow up with your ASC Administrator to confirm all commercial payers have been contacted to determine which payers will reimburse for EXPAREL
  - Request that the ASC Administrator provide a list of all commercial payers that have confirmed access to reimbursement for EXPAREL

For details and guidance (referred to as **C9290 Implementation Guidance**) on how to access Medicare reimbursement and engage your commercial payers, please visit [www.EXPAREL.com/reimbursement](http://www.EXPAREL.com/reimbursement).

- If you are currently an EXPAREL user in an acute care setting and would like to learn more about how EXPAREL can be used in the ASC setting, please contact 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com and you will be contacted by your local Pacira representative

- If you are not currently an EXPAREL user and are interested in a non–opioid-based postsurgical pain management option, please contact 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com and you will be contacted by your local Pacira representative

**Administrators**

- If EXPAREL is currently used in your ASC,
  - Discuss the potential benefits of Medicare’s reimbursement of EXPAREL with surgeons and anesthesiologists who work in your ASC
  - Educate the business office staff about the new rule and process to ensure they are aware that charges for EXPAREL should be billed with HCPCS code C9290
  - Contact your commercial payers to determine how EXPAREL can be added to your contracts to access reimbursement as a result of the Medicare rule

- If surgeons and/or anesthesiologists who work in your ASC are using EXPAREL in the acute care hospital setting, Medicare’s ASC reimbursement for EXPAREL may serve as an opportunity to determine if they can perform additional surgical procedures on Medicare patients in the ASC

- If surgeons and/or anesthesiologists who work in your ASC are not currently using EXPAREL, the ASC Medicare reimbursement should prompt a discussion on how a non–opioid-based postsurgical pain management option can provide clinical benefits and economic value

For details and guidance on how to access Medicare reimbursement and engage your commercial payers, please visit [www.EXPAREL.com/reimbursement](http://www.EXPAREL.com/reimbursement).

For additional information about reimbursement for EXPAREL, please contact 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com.
IMPLEMENTATION GUIDANCE

In engaging with commercial payers, there are 3 common scenarios:

Scenario 1: The commercial payer follows Medicare policy AND uses the Medicare reimbursement methodology as the basis for payment.

Scenario 2: The commercial payer follows Medicare policy but does NOT use the Medicare reimbursement methodology as the basis for payment.

Scenario 3: The commercial payer does not follow Medicare policy OR use the Medicare reimbursement methodology as the basis for payment.

Below is guidance for discussion with your commercial payers regarding C9290 for EXPAREL under the above scenarios.

Scenario 1: Commercial payers that follow Medicare policy AND use the Medicare reimbursement methodology as the basis for payment (ie, the Outpatient Prospective Payment System [OPPS]), may reimburse the ASC for EXPAREL for patients who are insured with those payers.

For example, if the ASC has a contract at 150% of current Medicare (ie, 2019), the EXPAREL rate of reimbursement is expected at a value equivalent to $1.25\times 1.5 = $1.875/mg.

- It is necessary that the payer add C9290 to the ASC-Approved list with a reimbursement rate so that the ASC will be able to access reimbursement under their current commercial contract
- The reimbursement rate will be subject to the ASC contract payment methodology and the terms in the ASC agreement with the payer
- ASCs should confirm with the payer when they will add C9290 to the ASC-Approved list and confirm the reimbursement rate in accordance with their contract terms

Scenario 2: Many commercial payers who follow Medicare policies but do NOT use the Medicare reimbursement methodology as the basis for payment will issue updates to their reimbursement methodologies within 30 to 90 days following the effective date of the rule changes; however, some could take longer.

Scenario 3: Commercial payers that do not follow Medicare policies NOR use the Medicare reimbursement methodology as the basis for payment typically need to institute changes to their own policy and update their reimbursement methodologies in order for EXPAREL to be reimbursed.

- The process will require the commercial payer to add EXPAREL to the payer’s ASC-Approved list and to establish a reimbursement rate. The timing of commercial payers implementing policy and reimbursement changes is unknown and varies across commercial payers
- The ASC may be required to renegotiate their contract with the payer to obtain approval to add C9290 to their contract and obtain reimbursement

How can your ASC bill Medicare for EXPAREL?

C9290 MUST be billed in addition to the surgical Current Procedural Terminology (CPT) codes billed for the surgical procedure. Drug codes (eg, C9290) that are covered under Medicare Part B are submitted by the ASC to the appropriate Medicare Administrative Contractor for reimbursement as part of a surgical claim.

Under the new rules, what follows on the next page is an example of the Medicare reimbursement-approved amounts and application of the OPPS methodology for reimbursement for a rotator cuff repair with capsulorrhaphy and biceps tenodesis. The 2 dosages are presented in each scenario to illustrate the implications on reimbursement. PLEASE NOTE THAT THE CPT PAYMENT RATES ARE FOR ILLUSTRATIVE PURPOSES ONLY.

Reminder: EXPAREL reimbursement is based on mg (ie, units) not vials. Always make sure to bill units as the mg dosage.

*Pricing is subject to CMS Medicare updates.

Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
Scenario 1: EXPAREL 266 mg/20 mL

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
<th>MEDICARE ALLOWED AMOUNT</th>
<th>MULTIPLE PROCEDURE ADJUSTMENT</th>
<th>MEDICARE PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>29827</td>
<td>Arthroscopy, shoulder, surgical; with rotator cuff repair</td>
<td>$2721.00</td>
<td>100%</td>
<td>$2721.00</td>
</tr>
<tr>
<td>29806</td>
<td>Arthroscopy, shoulder, surgical; capsulorrhaphy</td>
<td>$2721.00</td>
<td>50%</td>
<td>$1360.50</td>
</tr>
<tr>
<td>29828</td>
<td>Arthroscopy, shoulder, surgical; biceps tenodesis</td>
<td>$2721.00</td>
<td>50%</td>
<td>$1360.50</td>
</tr>
</tbody>
</table>

SUBTOTAL | $5442.00 |

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<tr>
<th>HCPCS</th>
<th>DESCRIPTION</th>
<th>MEDICARE ALLOWED AMOUNT*</th>
<th>MULTIPLE PROCEDURE ADJUSTMENT</th>
<th>2019 MEDICARE PAYMENT RATE</th>
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<tbody>
<tr>
<td>C9290</td>
<td>EXPAREL (266 mg/20 mL)</td>
<td>$332.50</td>
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TOTAL | $5766.52 |

Scenario 2: EXPAREL 133 mg/10 mL

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<th>DESCRIPTION</th>
<th>MEDICARE ALLOWED AMOUNT</th>
<th>MULTIPLE PROCEDURE ADJUSTMENT</th>
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SUBTOTAL | $5442.00 |

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<thead>
<tr>
<th>HCPCS</th>
<th>DESCRIPTION</th>
<th>MEDICARE ALLOWED AMOUNT*</th>
<th>MEDICARE PROCEDURE ADJUSTMENT</th>
<th>2019 MEDICARE PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9290</td>
<td>EXPAREL (133 mg/10 mL)</td>
<td>$166.25</td>
<td>100%</td>
<td>$166.25</td>
</tr>
</tbody>
</table>

TOTAL | $5604.26 |

How will your ASC be paid by Medicare for EXPAREL?

The Medicare-allowed amount (expected reimbursement) for EXPAREL in ASCs is based on the published rate of $1.25/mg effective October 1, 2019.† The patient will be responsible for their co-insurance, which is typically 20% but may vary, especially with Medicare Advantage Plans.†

- EXPAREL is not subject to a wage index adjustment, as it is considered a “pass-through” under the OPPS and, as such, it is a drug that is separately payable.

Reminder: EXPAREL reimbursement is based on mg (ie, units) not vials. Always make sure to bill units as the mg dosage.

*The allowed amount for reimbursement is based on the full dose being used for the surgical procedure and is subject to CMS Medicare updates.
†Pricing is subject to CMS Medicare updates.

Will Medicare reimbursement for EXPAREL be different for a Medicare Advantage Plan?

Medicare Advantage Plans typically follow Medicare policy and reimbursement methodology and would be expected to pay for EXPAREL separately.

- From time to time, a Medicare Advantage Plan may differ in reimbursement methodology as well as reimbursement rate; therefore, the ASC must verify with the Medicare Advantage Plan that there is coverage for EXPAREL and if the expected reimbursement rate is consistent with the Medicare reimbursement rate. If the approved reimbursement amount differs from the Medicare reimbursement rate, it may be subject to the contracted rate with the Medicare Advantage Plan.
How does my ASC verify if a commercial payer has added reimbursement rates for EXPAREL?

- Each commercial payer typically has an ASC-Approved list of codes that includes all procedures, drug, lab, and other ancillary codes that are allowed for reimbursement by the payer in the ASC setting.
- Contact your commercial payer’s Provider Network Representative to confirm the process for adding EXPAREL to their ASC-Approved list and verify the ASC code list will be updated and applied to your respective contract.
- It is also recommended that you check your commercial payer’s provider portal on the payer’s website, which may include updates to the payer’s ASC-Approved list to determine if EXPAREL has been added to the list and allowed for reimbursement.
- All commercial payers should be contacted, regardless of the reimbursement methodology in the ASC contract, to determine if the payers will reimburse EXPAREL and what steps are required to obtain approval if they do not reimburse EXPAREL. This includes the addition of EXPAREL as an approved code to the payer’s ASC reimbursement methodology as it relates to your contract, or adding the code as a “carve out” to the ASC’s existing contract.

The following information will be needed as part of your payer discussions:

**C9290** assigned to EXPAREL and approved by Medicare for separate reimbursement.

The Medicare reimbursement rate approved for EXPAREL for each dosage is $332.50 for 266 mg (20 mL) and $166.25 for 133 mg (10 mL).†

- Seek confirmation from the commercial payer regarding the time line for adding **C9290** to the payer-specific ASC-Approved list.
- Once the payer has confirmed the code will be added, verify the reimbursement rate for **C9290**.
- Once a contract has been updated (ie, EXPAREL has been added to the payer’s ASC-Approved list and assigned a reimbursement rate), ensure that your insurance verification process is updated to include EXPAREL. Specifically, the ASC verification of benefits process should determine if there is a preauthorization requirement and the amount the patient is responsible for out of pocket, if any.
- It is important to notify the surgeons, anesthesiologists, and their office staff by providing a list of payers and the applicable benefit plan that will reimburse EXPAREL in the ASC. The list should include Medicare and all commercial payers that have confirmed access to reimbursement effective January 1, 2019. As commercial payers approve EXPAREL for reimbursement, updates should be provided to the surgeons, anesthesiologists, and their office staff regarding expanded access to EXPAREL for commercially insured patients.

What should the ASC do if the commercial payer does not follow the Medicare reimbursement system or does not have a reimbursement rate for EXPAREL?

In the event the commercial payer does not approve **C9290** for separate reimbursement, the ASC should seek approval for additional reimbursement by following these steps:

- The ASC should request reimbursement that is equivalent to
  —At least the cost of EXPAREL, OR
  —Medicare’s approved reimbursement rate ($1.25/mg)

The negotiated reimbursement amount can be added to an existing contract as a carve out or as part of the contracted reimbursement rate for the surgical CPT codes that are performed with EXPAREL.

- The ASC should provide the payer with **C9290** for EXPAREL, verify the cost with a copy of the invoice, and provide the Medicare reimbursement rate to the payer.
- This scenario will likely require renegotiation of the ASC contract with the commercial payer.

For additional information about reimbursement for EXPAREL, please contact 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com.

†The allowed amount for reimbursement is based on the full dose being used for the surgical procedure and is subject to CMS Medicare updates.

Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
BILLING GUIDANCE

Bill for EXPAREL with HCPCS code C9290

Effective January 1, 2019, EXPAREL is eligible for separate Medicare reimbursement in a Medicare-certified ASC setting.

- Effective October 1, 2019, EXPAREL is priced at $1.25/mg* and should be billed using HCPCS code C9290. Based on the $1.25/mg* pricing
  - For the 266 mg (20 mL) dose, the allowed amount† for reimbursement is $332.50*
  - For the 133 mg (10 mL) dose, the allowed amount† for reimbursement is $166.25*

✓ Document the amount of EXPAREL administered in the patient’s medical record. The amount must be expressed in mg (ie, units)

✓ Medicare will reimburse EXPAREL in the 2 doses that are available: 266 mg (20 mL) and 133 mg (10 mL)

✓ Commercial payers that follow the current (2019) Medicare payment methodology and policy are also expected to reimburse EXPAREL when billed with HCPCS code C9290. Check with your payer’s Provider Network Representative to confirm

✓ Check your ASC contracts to verify the reimbursement amount if your commercial contract reimburses at a percentage of the current Medicare payment rate. Contact your payer’s Provider Network Representative to confirm

✓ In the event that your ASC successfully negotiates reimbursement for EXPAREL with any of its commercial payers, it is important that your insurance verification process is updated to include EXPAREL

✓ It is important to notify the surgeons, anesthesiologists, and their office staff by providing a list of payers and the applicable benefit plan that will reimburse EXPAREL in an ASC setting

Important information about billing for EXPAREL that can impact opportunities for payment and successful negotiations with commercial payers.

- When EXPAREL is used, document it in the operative note
- Always bill with HCPCS C9290 whenever EXPAREL is used, unless it is contractually prohibited
  - Read your contracts to determine if there are any provisions that do not allow the ASC to bill for drugs and/or HCPCS C9290
  - There may be state-specific tax implications for the ASC if a non-contracted supply is billed. It is important for the ASC to determine their specific state regulations

- Notify the payer that you would like to pursue contractual options to include reimbursement for EXPAREL

Why bill for EXPAREL?

- It increases opportunities for payers to add EXPAREL to their approved ASC list and/or your contract
- Payers do not know EXPAREL was used or is in demand unless it is billed
- Payer contract policies sometimes include provisions that allow for a drug, such as EXPAREL, to be covered even if it is not included in the ASC fee schedule
- It demonstrates the added cost to the procedure, so that payers have the necessary information to substantiate the cost of EXPAREL
- The payer can see the types of procedures that benefit from EXPAREL, which increases the likelihood of success in securing reimbursement for EXPAREL

*Pricing is subject to CMS Medicare updates.
†The allowed amount for reimbursement is based on the full dose being used for the surgical procedure and is subject to CMS Medicare updates.

Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
Capture reimbursement when EXPAREL is used in a surgical case

For Medicare and commercial payers that require the CMS 1500 form or the electronic 837P form, follow these steps:

STEP 1: DOCUMENTATION

✔️ The amount of EXPAREL used in a surgery case is to be documented in the patient’s medical record.

✔️ If any amount of EXPAREL is not used, known as drug wastage, it must also be documented in the medical record and indicated that the unused amount was discarded. EXPAREL drug wastage may be billed using the HCPCS modifier “JW” on a separate line of the form.

STEP 2: BILLING FOR EXPAREL

✔️ Bill for EXPAREL using HCPCS code C9290.

✔️ Document and bill the dosage as units (266 mg or 133 mg).

✔️ Enter the number of units given in box 24G.

STEP 3: BILLING FOR DRUG WASTAGE

✔️ Drug amounts that are unused and discarded may be billed separately using the HCPCS modifier “JW”.

✔️ The modifier is noted as “C9290 JW” and is billed on a separate line. In order for the drug wastage to be reimbursed, providers must report 2 claim lines to represent both the used and unused amount of the drug.

Check with your Provider Network Representative regarding the appropriate claim form and process to bill for EXPAREL if they do not use the CMS 1500 form or the electronic 837P form.

For reimbursement questions, please call 1-855-RX-EXPAREL (793-9727), email reimbursement@pacira.com, or visit www.EXPAREL.com/reimbursement.
Question: What is the HCPCS code for EXPAREL?

Answer: The HCPCS code for EXPAREL is C9290. Below is specific information about the reimbursement amount for Medicare-certified ASCs that use EXPAREL for surgical procedures performed on Medicare patients.

Question: Since C9290 was already the billing code for EXPAREL, what changed with the November 2, 2018 ruling?

Answer: To better understand the significance of the November 2nd ruling, it is important to understand the history of C9290. (Also refer to HCPCS in the Key Terms and Definitions section.)

• In April 2012, C9290 was initially established for EXPAREL and added to the approved list of billing codes for the HOPD and ASC sites of service
  — C9290 was classified as “allowed” for payment as a pass-through drug for HOPDs, which enabled separate reimbursement for EXPAREL. The payment was based on the OPPS rate for HOPDs
  — C9290 was classified as “allowed” for separate payment in ASCs and based on the OPPS rate
• In 2015, C9290 was no longer considered a pass-through and was reclassified from “allowed” to “packaged” for BOTH HOPDs and ASCs. This meant that EXPAREL was no longer eligible for separate reimbursement in either site of service
• The November 2nd ruling changed the payment status to “allowed” for C9290 in the ASC and, thus, EXPAREL became available for separate reimbursement
• The November 2nd ruling maintained the “packaged” payment status for C9290 in the HOPD, so there is NO separate reimbursement for EXPAREL in HOPDs
• The CMS reviews all codes on an annual basis
• Effective January 1, 2019, C9290 can be billed for Medicare patients receiving EXPAREL as part of a surgical procedure performed in a Medicare-certified ASC
  — The “allowed” payment status for billing C9290 will enable EXPAREL to be reimbursed at $1.25/mg* effective October 1, 2019
  — For the 266 mg (20 mL) dose, the Medicare allowed amount† for reimbursement is $332.50*
  — For the 133 mg (10 mL) dose, the Medicare allowed amount† for reimbursement is $166.25*

*Pricing is subject to CMS Medicare updates.
† The allowed amount for reimbursement is based on the full dose being used for the surgical procedure and is subject to CMS Medicare updates.

Question: Aren’t C-codes considered temporary? If so, why wasn’t a J-code, which is supposed to be considered permanent, assigned?

Answer: While C-codes are defined as temporary, they do not have an expiration date. There are C-codes that have been in place for over 10 years and retain an “allowed” payment status.

• Also, there are instances when a J-code is on the ASC- or HOPD-Approved lists but have a “packaged” payment status and, thus, are not eligible for separate reimbursement
• The designation of a C-code or a J-code does not dictate the payment status (eg, “allowed” or “packaged”)
• CMS reviews all codes on an annual basis
• The most important aspect of the November ruling is that EXPAREL will be reimbursed when C9290 is billed for Medicare patients in a Medicare-certified ASC

Reminder: EXPAREL reimbursement is based on mg (ie, units) not vials. Always make sure to bill units as the mg dosage.
Question: What is the definition of an ASC?
Answer: An ASC is a distinct entity that primarily provides outpatient procedures to patients who do not require an overnight stay after the procedure (no more than 23.59 hours). ASCs are either independent/freestanding, physician owned (90%), hospital owned, or corporate systems.

Question: What if my ASC does not treat Medicare patients?
Answer: The CMS ruling is specific to EXPAREL being reimbursed for Medicare patients undergoing surgical procedures in the ASC; however, commercial payers may follow Medicare policy and reimbursement methodologies. The ASC Administrator should inquire with their commercial payer as to how EXPAREL may be reimbursed under current commercial contracts or, potentially, seek other avenues to secure reimbursement.

Question: If the ASC Administrator, biller, or coding staff needs more information about how to bill for EXPAREL using C9290, who can they call?
Answer: They can reach a dedicated Reimbursement Specialist by contacting 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com.

Question: If my ASC Administrator, biller, or coding staff is unsure if EXPAREL can be reimbursed, who can they call?
Answer: They can reach a dedicated Reimbursement Specialist by contacting 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com.

Question: Why can’t C9290 be used to pay for EXPAREL for an acute care hospital currently using or wanting to use EXPAREL?
Answer: Acute care hospitals and HOPDs that operate as surgery centers are NOT eligible for separate reimbursement of EXPAREL under the new CMS rules. Thus, there is no separate reimbursement for EXPAREL when provided to Medicare patients in any hospital setting, including inpatient, outpatient, and same-day surgery (SDS) centers.

Question: What is the difference between an HOPD, an SDS center, and an ASC?
Answer: HOPDs and SDS centers are part of an acute care hospital’s operation and may be a department in the hospital or a freestanding facility located on the hospital campus within 250 yards of the hospital. The hospital owns 100% of these facilities. Physicians cannot have an ownership stake in an HOPD or SDS center.

Question: Are all ASCs certified by Medicare? How does state licensure impact Medicare certification?
Answer: Not all ASCs are Medicare certified. An ASC that is not Medicare certified and services Medicare patients will not be paid by Medicare. In addition, some states require state licensure for ASCs and others do not. In a state that requires licensure, the ASC must be licensed in order to obtain Medicare certification. If the state does not require licensure, then the ASC may be Medicare certified without a state ASC license; however, in order for an ASC to be eligible for Medicare reimbursement, it must be Medicare certified.

Question: Why does the ASC have to check with their payer about Medicare updates? Won’t EXPAREL be automatically reimbursed on January 1, 2019?
Answer: C9290’s “allowed” payment status and allowed reimbursement amount for Medicare patients will be automatically updated in the Medicare system effective January 1, 2019; however, C9290 MUST be billed as part of the Medicare claim submission in order for the ASC to be reimbursed.

For commercial payers, Medicare updates applied to their ASC-Approved code list or payment systems do not necessarily take place immediately on the effective date of the CMS ruling. Commercial payer contracts may require changes (such as adding C9290 to the ASC-Approved list) to be formally established. They are not mandated to make changes on a particular date so it is important to check the Provider portal of the payer website or contact the payer’s Provider Network Representative for updates. It is also recommended that the ASC contact their commercial payer’s Provider Network Representative regarding Medicare updates.
**Question:** Does the administration of EXPAREL get reimbursed?

**Answer:** C9290 is specific to reimbursing the cost of EXPAREL, NOT the actual administration of the drug by either the surgeon or anesthesiologist. ASCs are not accustomed to receiving separate reimbursement for drugs, supplies, or services used or performed as part of a surgical procedure. Most payers, including Medicare, package these elements into their reimbursement methodology.

There may be instances where an anesthesiologist can bill for “services.” In the interim, if there are questions regarding professional service reimbursement, please contact 1-855-RX-EXPAREL (1-855-793-9727) or reimbursement@pacira.com.

**Question:** Products such as bupivacaine are also considered non-opioids and are used for postsurgical pain management. Will they now be reimbursed as a result of the CMS ruling?

**Answer:** Because these products/drug supplies do not have an “allowed” payment status nor a Medicare-designated billing code (such as a C- or J-code), they CANNOT be reimbursed separately. They are deemed part of the procedure and are paid based on the reimbursement methodology associated with the payer (governmental [ie, Medicare] or commercial).

**Question:** Is there a special form or process for Medicare reimbursement?

**Answer:** Typically, ASCs file a surgical claim using electronic form 837P or paper form CMS 1500. Claims must be submitted to Medicare electronically unless certain exceptions are met. Medicare has several resources available through the Medicare website to assist ASCs.

**Question:** Does CMS require providers to document if a full vial of EXPAREL is unused and discarded during a procedure? Can unused drugs that are discarded be billed for reimbursement?

**Answer:** Yes. CMS requires unused drugs that are discarded to be documented in the patient’s medical record. Unused drugs that are discarded are also known as drug wastage, and may be billed separately using the HCPCS modifier “JW.” The modifier is noted as “C9290 JW” and is billed on a separate line. In order for the drug wastage to be reimbursed, providers must report 2 claim (electronic form 837P or paper form CMS 1500) lines per discarded drug.

Please refer to the Billing Guidance section of this brochure for more information.

**Question:** What is the National Drug Code (NDC) for EXPAREL?

**Answer:** The NDC for EXPAREL is the universal identifier for all medications and their doses.

<table>
<thead>
<tr>
<th>Item</th>
<th>NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 mL Single-dose vial</td>
<td>65250-0133-10</td>
</tr>
<tr>
<td>10 mL 4 pack</td>
<td>65250-0133-04</td>
</tr>
<tr>
<td>10 mL 10 pack</td>
<td>65250-0133-09</td>
</tr>
<tr>
<td>20 mL Single-dose vial</td>
<td>65250-0266-20</td>
</tr>
<tr>
<td>20 mL 4 pack</td>
<td>65250-0266-04</td>
</tr>
<tr>
<td>20 mL 10 pack</td>
<td>65250-0266-09</td>
</tr>
</tbody>
</table>

Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
Question: What procedures can EXPAREL be used and reimbursed for?

Answer: First, EXPAREL can be administered in most surgical procedures in accordance with its indication. Specifically, EXPAREL is indicated for single-dose infiltration in adults for postsurgical local analgesia and as an interscalene brachial plexus nerve block to produce postsurgical regional analgesia. Safety and efficacy have not been established in other nerve blocks.

CMS reimburses EXPAREL using HCPCS C9290 for Medicare patients receiving EXPAREL as part of a Medicare-approved surgical procedure performed in a Medicare-certified ASC. There are over 5000 Medicare-approved CPT codes (denotes procedures).

Medicare has a transparency tool that the ASC Administrator or health care provider can access to identify specific Medicare ASC-approved procedures and the payment amount. To use the tool, go to https://www.medicare.gov/procedure-price-lookup.

In addition, if your ASC is a member of the Ambulatory Surgery Center Association (ASCA), they can access a Medicare calculator, which provides the Medicare-approved procedure and the associated payment amount.

The following chart is a list of some of the Medicare-approved procedures:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
<th>Description</th>
<th>Medicare-approved ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Reconstruction</td>
<td>19301</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)</td>
<td>Yes</td>
</tr>
<tr>
<td>Breast Reconstruction</td>
<td>19302</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy</td>
<td>Yes</td>
</tr>
<tr>
<td>Breast Reconstruction</td>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
<td>Yes</td>
</tr>
<tr>
<td>Breast Reconstruction</td>
<td>19357</td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
<td>Yes</td>
</tr>
<tr>
<td>Breast Reconstruction</td>
<td>19366</td>
<td>Breast reconstruction with other technique</td>
<td>Yes</td>
</tr>
<tr>
<td>Breast Reconstruction</td>
<td>19380</td>
<td>Revision of reconstructed breast</td>
<td>Yes</td>
</tr>
<tr>
<td>Spine - Kyphoplasty</td>
<td>22513</td>
<td>Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic</td>
<td>Yes</td>
</tr>
<tr>
<td>Spine - Kyphoplasty</td>
<td>22514</td>
<td>Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar</td>
<td>Yes</td>
</tr>
<tr>
<td>Spine - Fusion</td>
<td>22551</td>
<td>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2</td>
<td>Yes</td>
</tr>
<tr>
<td>Spine - Fusion</td>
<td>22558</td>
<td>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
<td>No</td>
</tr>
<tr>
<td>Spine - Fusion</td>
<td>22612</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)</td>
<td>Yes</td>
</tr>
<tr>
<td>Spine - Fusion</td>
<td>22630</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
<td>No</td>
</tr>
<tr>
<td>Spine - Fusion</td>
<td>22633</td>
<td>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar</td>
<td>No</td>
</tr>
<tr>
<td>Spine - Disc Arthroplasty</td>
<td>22856</td>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical</td>
<td>Yes</td>
</tr>
<tr>
<td>Procedure Description</td>
<td>Code</td>
<td>Details</td>
<td>Allowable</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Spine - Disc Arthroplasty, Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar</td>
<td>22857</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Orthopedic - Rotator Cuff, Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic</td>
<td>23412</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Orthopedic - Rotator Cuff, Arthroscopy, shoulder, surgical; with rotator cuff repair</td>
<td>29827</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ortho - anterior cruciate ligament (ACL)/posterior cruciate ligament (PCL), Arthroscopically aided anterior cruciate ligament repair/ augmentation or reconstruction</td>
<td>29888</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hemorrhoidectomy, Hemorrhoidectomy, external, ≥2 columns/groups</td>
<td>46250</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hemorrhoidectomy, Hemorrhoidectomy, internal and external, single column/group</td>
<td>46255</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hemorrhoidectomy, Hemorrhoidectomy, internal and external, ≥2 columns/groups</td>
<td>46260</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hemorrhoidectomy, Hemorrhoidectomy, internal and external, ≥2 columns/groups; with fissurectomy</td>
<td>46261</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Laparoscopic Cholecystectomy, Laparoscopy, surgical; cholecystectomy</td>
<td>47562</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Laparoscopic Cholecystectomy, Laparoscopy, surgical; cholecystectomy with cholangiography</td>
<td>47563</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Laparoscopic Cholecystectomy, Laparoscopy, surgical; cholecystectomy with exploration of common duct</td>
<td>47564</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hernia Repair, Repair initial incisional or ventral hernia; reducible</td>
<td>49560</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hernia Repair, Repair initial incisional or ventral hernia; incarcerated or strangulated</td>
<td>49561</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hernia Repair, Laparoscopy, surgical; repair initial inguinal hernia</td>
<td>49650</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hernia Repair, Laparoscopy, surgical; repair recurrent inguinal hernia</td>
<td>49651</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>General Surgery - Hernia Repair, Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible</td>
<td>49652</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Spine - Laminectomy, Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical</td>
<td>63020</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Spine - Laminectomy, Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar</td>
<td>63030</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Spine - Laminectomy, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar</td>
<td>63045</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Spine - Laminectomy, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar</td>
<td>63046</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Spine - Laminectomy, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar</td>
<td>63047</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Spine - Laminectomy, Tranpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)</td>
<td>63056</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
**Question:** If an ASC has an issue with processing a Medicare claim related to billing EXPAREL or EXPAREL is denied Medicare payment, what can they do?

**Answer:** Medicare Administrator Contractors (MACs) are multistate, regional contractors that are responsible for administering Medicare claims and establishing fee schedules. They are considered intermediaries between the health care providers and Medicare. The MACs are regionally designated into jurisdictions.

If your ASC has an issue with a Medicare claim related to billing EXPAREL, they should contact their MAC.

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**Key Terms and Definitions**

1. **Ambulatory Surgery Center (ASC)**

   An ASC is a distinct entity that primarily provides outpatient procedures to patients who do not require an overnight stay. The length of stay in an ASC is typically limited to 23.59 hours; however, this may be more limited and is often stipulated by state rules. ASCs can also be referred to as a center or facility.

   ASCs are typically independent or freestanding and are owned and operated by physicians; however, ASCs may also have corporate partners that have ownership and hold a management agreement, and may also have a hospital partner that has ownership.

   ASCs may also be part of a group practice, are owned and operated by the group, and are only used by a specific group. Group practice ASCs are typically single specialty but may be multispecialty if they are part of a multispecialty practice.

   **The following is a list of the most common ASCs and their characteristics:**

   - **Licensed and Medicare-certified ASCs** are eligible for reimbursement from Medicare and they may also have access to commercial payer reimbursement. These ASCs are typically freestanding; part of a group practice; or may also be found in large ambulatory care centers or pavilions, such as an orthopedic institute or a large multispecialty clinic. They typically have physician owners and may also have an ASC management company and/or a hospital as a partner.

   - **Licensed and accredited ASCs** are ASCs that are licensed by a state and accredited by an organization, typically AAAHC, JCAHO, or AAAASF. **These ASCs will have access to Medicare reimbursement if they have obtained a “Medicare deemed” status with the accrediting agency.** If they do not, then they will not have access to Medicare reimbursement but may have access to reimbursement from a commercial payer, which is dependent on the ASC’s contract provisions with the commercial payer. These ASCs are typically physician owned, a group practice, or may also be cosmetic/plastic surgery centers.

   - **Hospital-based ASCs** that are freestanding and more than 250 yards from the hospital must be licensed as an ASC and cannot operate as an HOPD. **If these hospital-based ASCs are Medicare certified or have a deemed status accreditation, they will have access to reimbursement by Medicare under the new rule.**

   An HOPD, SDS center, or ASC may be physically located inside of a hospital, may be a freestanding facility located on the campus of a hospital, or may be outside of the campus of a hospital. These ASCs cannot have physician owners and are owned 100% by the hospital.

2. **Benefit plan**

   A benefit plan is a specifically designed plan of health insurance benefits for individuals, families, and/or employers.

3. **Centers for Medicare & Medicaid Services (CMS)**

   CMS is a federal agency within the US Department of Health and Human Services (HHS) that administers the Medicare program and works with state governments to administer Medicaid, the Children’s Health Insurance Program (CHIP), and comply with the Health Insurance Portability and Accountability Act (HIPAA). CMS is also responsible for quality standards for long-term care facilities and clinical laboratory quality standards. CMS also oversees HealthCare.gov.


   The CPT code is a 5-digit code given to a procedure by the American Medical Association (AMA) (eg, CPT code 64721 is the primary code for carpal tunnel surgery).
**Key Terms and Definitions (continued)**

5. Healthcare Common Procedure Coding System (HCPCS)

A system developed by CMS to report medical procedures and services.

- There are different levels of HCPCS codes
  - Level I—consists of the AMA’s CPT codes and are numeric
  - Level II—the alphanumeric (single alphabetical letter followed by 4 numeric digits) HCPCS codes primarily for non-physician products, supplies, and procedures that are not included in the CPT codes (eg, **C9290**). Below are examples of some of the definitions associated with the alphanumeric part of the HCPCS code
    - A-codes: transportation, medical and surgical supplies, miscellaneous, and experimental
    - B-codes: enteral and parenteral therapy
    - C-codes: temporary hospital OPPS
    - J-codes: drugs administered other than oral method, chemotherapy drugs
  - Level III is known as HCPCS local codes. These codes are developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions
  - CMS reviews all HCPCS codes on an annual basis

6. Hospital outpatient departments (HOPDs)

HOPDs are often called outpatient surgery centers, ambulatory surgery centers, or same-day surgery centers. **These surgery centers are not eligible for reimbursement under the new Medicare rules**; however, they may have access to reimbursement with commercial payers.

An HOPD, SDS center, or ASC may be physically located inside of a hospital, may be a freestanding facility located on the campus of a hospital, or may be outside of the campus of a hospital. These ASCs cannot have physician owners and are owned 100% by the hospital.

7. Medicare is the federal health insurance program for

- People aged ≥65 years
- Certain younger people with disabilities
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant)

The different parts of Medicare help cover specific services:

- Medicare Part A (Hospital Insurance)
  Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- Medicare Part B (Medical Insurance)
  Part B covers certain doctors’ services, outpatient care, ASCs, medical supplies, and preventive services.
- Medicare Part D (Prescription Drug Coverage)
  Part D adds prescription drug coverage to
    - Original Medicare
    - Some Medicare Cost Plans
    - Some Medicare Private Fee-for-Service Plans
    - Medicare Medical Savings Account Plans

These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

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Please see Indication and Important Safety Information on back cover and refer to accompanying full Prescribing Information.
8. Medicare Advantage

Medicare Advantage is also known as Part C and is an all-in-one alternative to original Medicare. These “bundled” plans include Part A, Part B, and usually Part D. Medicare Advantage is offered and administered by commercial payers approved by Medicare. Medicare contracts with these payers to manage and provide plan-enrolled Medicare beneficiaries with Medicare benefits. Commercial payers that offer Medicare Advantage products negotiate contracts and rates with providers specific to the Medicare Advantage patient population. The reimbursement rates may be different than traditional Medicare reimbursement rates and are subject to the contract negotiation between the payer and the provider.

9. Outpatient Prospective Payment System (OPPS)

CMS began using this prospective payment system in August 2000. Medicare uses this payment system to set rates for outpatient services (e.g., x-rays) provided in HOPDs, as well as payment of ASC services. OPPS includes 2 separate and distinct approved payment lists of codes that are allowed and potentially priced or packaged for reimbursement in an HOPD and an ASC. The HOPD-Approved list is different from the ASC-Approved list.

10. Payer

A payer is the health insurance company or entity paying the claim; also known as insurer, managed care organization, or carrier.

• Government payers—represent government-run health insurers such as Medicare, Medicaid, and Tricare
• Commercial payers—represent non-government, private companies providing insurance

11. Procedure

A specific surgical procedure as defined by the AMA and represented by a specific CPT code.

12. Provider

The person or facility that provides the health care service.

13. Reimbursement

The amount that is negotiated and that a payer is contractually obligated to pay to a provider for a service.

14. Workers’ Compensation

A form of insurance providing wage replacement and medical benefits to employees injured in the course of employment. They can be state funded, a self-insured plan, or a third-party insurer similar to group health coverage.
Indication
EXPAREL is indicated for single-dose infiltration in adults to produce postsurgical local analgesia and as an interscalene brachial plexus nerve block to produce postsurgical regional analgesia. Safety and efficacy have not been established in other nerve blocks.

Important Safety Information
EXPAREL is contraindicated in obstetrical paracervical block anesthesia.

Adverse reactions reported with an incidence greater than or equal to 10% following EXPAREL administration via infiltration were nausea, constipation, and vomiting; adverse reactions reported with an incidence greater than or equal to 10% following EXPAREL administration via interscalene brachial plexus nerve block were nausea, pyrexia, and constipation.

If EXPAREL and other non-bupivacaine local anesthetics, including lidocaine, are administered at the same site, there may be an immediate release of bupivacaine from EXPAREL. Therefore, EXPAREL may be administered to the same site 20 minutes after injecting lidocaine.

EXPAREL is not recommended to be used in the following patient population: patients <18 years old and/or pregnant patients.

Because amide-type local anesthetics, such as bupivacaine, are metabolized by the liver, EXPAREL should be used cautiously in patients with hepatic disease.

Warnings and Precautions Specific to EXPAREL
Avoid additional use of local anesthetics within 96 hours following administration of EXPAREL.

EXPAREL is not recommended for the following types or routes of administration: epidural, intrathecal, regional nerve blocks other than interscalene brachial plexus nerve block, or intravascular or intra-articular use.

The potential sensory and/or motor loss with EXPAREL is temporary and varies in degree and duration depending on the site of injection and dosage administered and may last for up to 5 days, as seen in clinical trials.

Warnings and Precautions for Bupivacaine-Containing Products
Central Nervous System (CNS) Reactions: There have been reports of adverse neurologic reactions with the use of local anesthetics. These include persistent anesthesia and paresthesia. CNS reactions are characterized by excitation and/or depression.

Cardiovascular System Reactions: Toxic blood concentrations depress cardiac conductivity and excitability which may lead to dysrhythmias, sometimes leading to death.

Allergic Reactions: Allergic-type reactions (eg, anaphylaxis and angioedema) are rare and may occur as a result of hypersensitivity to the local anesthetic or to other formulation ingredients.

Chondrolysis: There have been reports of chondrolysis (mostly in the shoulder joint) following intra-articular infusion of local anesthetics, which is an unapproved use.

Methemoglobinemia: Cases of methemoglobinemia have been reported with local anesthetic use.

Please refer to accompanying full Prescribing Information.
For more information, please visit www.EXPAREL.com or call 1-855-RX-EXPAREL (793-9727).