Clinical Policy: Factor VIII (Human, Recombinant)

Reference Number: CP.PHAR.215
Effective Date: 06.01.16
Last Review Date: 02.22
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are factor VIII products requiring prior authorization: human – Hemofil M®, Koate-DVI®; recombinant – Advate®, Adynovate®, Afstyla®, Eloctate®, Esperoct®, Helixate FS®, Jivi®, Kogenate FS®, Kovaltry®, Novoeight®, Nuwiq®, Obizur®, Recombinate®, Xyntha®, and Xyntha® Solofuse®.

FDA Approved Indication(s)

Factor VIII products are indicated for patients with hemophilia A for the following uses:

- Control and prevention of bleeding episodes:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Esperoct, Helixate FS, Hemofil M, Jivi (in previously treated patients ≥ 12 years of age only), Koate-DVI, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha
- Perioperative management:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Esperoct, Helixate FS, Hemofil M, Jivi (in previously treated patients ≥ 12 years of age only), Koate-DVI, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes:
  - Adults only: Kogenate FS
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Esperoct, Helixate FS, Jivi (in previously treated patients ≥ 12 years of age only), Kovaltry, Novoeight, Nuwiq, Xyntha
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes and to reduce the risk of joint damage in children without pre-existing joint damage:
  - Children: Helixate FS, Kogenate FS
- On-demand treatment and control of bleeding episodes in acquired hemophilia A:
  - Adults: Obizur

Limitation(s) of use:

- Factor VIII products are not indicated for treatment of von Willebrand disease.
- Obizur is not indicated for the treatment of congenital hemophilia A.
- Safety and efficacy of Obizur have not been established in patients with a baseline anti-porcine factor VIII inhibitor titer of > 20 Bethesda units (BU).
- Jivi is not indicated for use in children < 12 years of age due to a greater risk for hypersensitivity reactions.
- Jivi is not indicated for use in previously untreated patients.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that factor VIII products are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hemophilia A (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Congenital hemophilia A (factor VIII deficiency) (all products except Obizur);
   b. Acquired hemophilia A (Obizur only);
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following uses (a, b, or c):
   a. Control and prevention of bleeding episodes;
   b. Perioperative management (all products except Obizur);
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes;
4. For routine prophylaxis requests: Request is for Advate, Adynovate, Eloctate, Esperoct, Helixate FS, Jivi, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Xyntha, and member meets one of the following (a or b):
   a. Member has severe hemophilia (defined as factor VIII level of < 1%);
   b. Member has experienced at least one life-threatening or serious spontaneous bleed (*see Appendix D*);
5. For all products except Obizur: If factor VIII coagulant activity levels are > 5%, failure of desmopressin acetate, unless contraindicated, clinically significant adverse effects are experienced, or an appropriate formulation of desmopressin acetate is unavailable;
6. For Jivi: Member meets both of the following (a and b):
   a. Age ≥ 12 years;
   b. Has previously been treated for hemophilia A;
7. Documentation of member's body weight (in kg);
8. Dose does not exceed the FDA-approved maximum recommended dose for the relevant indication.

Approval duration: 3 months (surgical/acute bleeding) or 6 months (prophylaxis)

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hemophilia A (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Documentation of member's body weight (in kg);
4. If request is for a dose increase, new dose does not exceed the FDA-approved

maximum recommended dose for the relevant indication.
Approval duration: 3 months (surgical/acute bleeding) or 6 months (prophylaxis)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents;

B. Von Willebrand disease.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
BU: Bethesda units
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
desmopressin acetate (Stimate® nasal spray; generic injection solution)	When Factor VIII coagulant activity levels are > 5% Injection: 0.3 mcg/kg IV every 48 hours Nasal spray: < 50 kg: 1 spray intranasally in one nostril only; may repeat based on laboratory response and clinical condition ≥ 50 kg: 1 spray intranasally in each nostril; may repeat based on laboratory response and clinical condition	Injection: 0.3 mcg/kg IV every 48 hours Nasal spray: 1 spray intranasally in each nostril
Hemlibra (emicizumab-kxwh)	3 mg/kg per week IV during the first four weeks of therapy, followed by either 1.5 mg/kg per week, 3 mg/kg once every two weeks, or 6 mg/kg once every four weeks thereafter	6 mg/kg/month

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): life-threatening hypersensitivity reactions, including anaphylaxis, to the product and its constituents*
  **Including bovine, mouse, or hamster protein for Advate, Adynovate, Afstyla, Esperoct, Helixate FS, Hemofil M, Jivi, Kogenate FS, Kovaltry, Novoeight, Obizur, Recombinate, and Xyntha*
- Boxed warning(s): none reported

Appendix D: General Information

- Life-threatening bleeding episodes include, but are not limited to, bleeds in the following sites: intracranial, neck/throat, or gastrointestinal.
- Serious bleeding episodes include bleeds in the following site: joints (hemarthrosis).
- Spontaneous bleed is defined as a bleeding episode that occurs without apparent cause and is not the result of trauma.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – recombinant (Advate, Adynovate, Afstyla, Kovaltry, Novoeight, Nuwiq, Recombinate, ReFacto, Xyntha)	Control and prevention of bleeding episodes	Minor episodes: 10-20 IU/kg IV every 12-24 hours (Advate: 8-24 hours for age < 6 years) Moderate episodes: 15-30 IU/kg IV every 12-24 hours (Advate: 8-24 hours for age < 6 years) Major episodes: 30-50 IU/kg IV every 8-24 hours (Advate: 6-12 hours for age < 6 years)	50 IU/kg every 6 hours until the bleeding episode is resolved
Antihemophilic factor – recombinant (Eloctate)	Control and prevention of bleeding episodes	Minor and moderate episodes: 20-30 IU/kg every 24-48 hours (12-24 hours for age < 6 years) Major episodes: 40-50 IU/kg every 12-24 hours (8 to 24 hours for age < 6 years)	50 IU/kg every 8 hours until the bleeding episode is resolved
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Control and prevention of bleeding episodes	Minor episodes: 10- 20 IU/kg IV; repeat dose if there is evidence of further bleeding	50 IU/kg single dose or 30 IU/kg/repeated dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Moderate episodes: 15-30 IU/kg IV every 12-24 hours Major episodes: initial 40-50 IU/kg IV, followed by 20-25 IU/kg every 8-24 hours (Kogenate FS: every 8-12 hours)	
Antihemophilic factor – recombinant, glycopegylated (Esperoct)	Control and prevention of bleeding episodes	Minor to moderate episodes: 40-65 IU/kg IV; one dose should be sufficient for minor episodes; additional dose may be administered after 24 hours for moderate episodes. Major episodes: 50-65 IU/kg IV; additional doses may b eadministered approximately every 24 hours.	At least 12 years old: 40 IU/kg < 12 years old: 65 IU/kg
Antihemophilic factor – recombinant (Advate, Adynovate)	Perioperative management	Minor surgery: 30-50 IU/kg IV as a single dose within 1 hour of the operation and every 12-24 hours (Adynovate: 24 hours) thereafter as needed to control bleeding Major surgery: 40-60 IU/kg IV as a single dose preoperatively to achieve 100% activity and every 8- 24 hours thereafter to keep factor VIII activity in desired range (Advate: every 6-24 hours for age < 6 years; Adynovate: every 6-24 hours if age < 12 years)	Minor surgery: 50 IU/kg/dose Major surgery: 60 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – recombinant (Eloctate)	Perioperative management	Minor surgery: 25-40 IU/kg every 24 hours (12-24 hours age < 6 years) Major surgery: pre-operative dose of 40-60 IU/kg followed by a repeat dose of 40-50 IU/kg after 8-24 hours (6-24 hours for age < 6 years) and then every 24 hours to maintain Factor VIII activity within the target range	Minor surgery: 40 IU/kg/dose Major surgery: 60 IU/kg/dose
Antihemophilic factor – recombinant, glycopegylated (Esperoct)	Perioperative management	Minor and major surgery: 50-65 IU/kg IV; additional doses can be administered after 24 hours if necessary for minor surgeries; additional doses can be administered approximately every 24 hours for the first week and then approximately every 48 hours until wound healing has occurred for major surgeries	At least 12 years old: 50 IU/kg < 12 years old: 65 IU/kg
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Perioperative management	Minor surgery: 15- 30 IU/kg IV every 12-24 hours Major surgery: pre-operative dose of 50 IU/kg IV followed by a repeat dose every 6- 12 hours to maintain Factor VIII activity within the target range	Minor surgery: 30 IU/kg/dose Major surgery: 50 IU/kg/dose
Antihemophilic factor – recombinant (Afstyla, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha)	Perioperative management	Minor surgery: 15-30 IU/kg IV every 24 hours (Xyntha: every 12-24 hours) (Recombinate: 30- 40 IU/kg as a single infusion)	Minor surgery: 30 IU/kg/dose (Recombinate: 40 IU/kg/dose)

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Major surgery: 40-50 IU/kg IV every 8-24 hours (Xyntha: 30-50 IU/kg)	Major surgery: 50 IU/kg every 8 hours
Antihemophilic factor – recombinant (Xyntha)	Routine prophylaxis	30 IU/kg IV 3 times weekly < 12 years of age: 25 IU/kg every other day.	30 IU/kg/dose
Antihemophilic factor – recombinant (Advate)	Routine prophylaxis	20-40 IU/kg IV every other day (3 to 4 times weekly) OR Use every third day dosing regimen targeted to maintain Factor VIII trough levels ≥ 1%	40 IU/kg every other day
Antihemophilic factor – recombinant (Adynovate)	Routine prophylaxis	≥ 12 years of age: 40-50 IU/kg IV 2 times per week < 12 years of age: 55 IU/kg IV 2 times per week	70 IU/kg/dose
Antihemophilic factor – recombinant (Afstyla)	Routine prophylaxis	≥ 12 years of age: 20-50 IU/kg IV 2-3 times per week < 12 years of age: 30-50 IU/kg IV 2-3 times per week	50 IU/kg/dose
Antihemophilic factor – recombinant (Eloctate)	Routine prophylaxis	50 IU/kg IV every 4 days For children < 6 years of age: 50 IU/kg IV twice weekly	65 IU/kg/dose
Antihemophilic factor – recombinant, glycopegylated (Esperoct)	Routine prophylaxis	At least 12 years old: 50 IU/kg IV every 4 days < 12 years old: 65 IU/kg IV twice weekly	At least 12 years old: 50 IU/kg < 12 years old: 65 IU/kg
Antihemophilic factor – recombinant	Routine prophylaxis	Adults: 25 IU/kg IV three times per week	25 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
(Helixate FS, Kogenate FS)		Children: 25 IU/kg every other day	
Antihemophilic factor – recombinant (Novoeight)	Routine prophylaxis	≥ 12 years of age: 20-50 IU/kg IV 3 times per week OR 20-40 IU/kg IV every other day < 12 years of age: 25-60 IU/kg IV 3 times per week OR 25-50 IU every other day	60 IU/kg/dose
Antihemophilic factor – recombinant (Nuwiq)	Routine prophylaxis	≥ 12 years of age: 30-40 IU/kg IV every other day < 12 years of age: 30-50 IU/kg IV every other day or 3 times/week	50 IU/kg/dose
Antihemophilic factor – recombinant (Kovaltry)	Routine prophylaxis	> 12 years of age: 20-40 IU/kg IV 2-3 times per week ≤ 12 years of age: 25-50 IU/kg twice or three times weekly or every other day according to individual requirements	50 IU/kg every other day
Antihemophilic factor – recombinant, porcine sequence (Obizur)	Treatment of bleeding episodes in acquired hemophilia A	200 IU/kg every 4-12 hours	200 IU every 4 hours
Antihemophilic factor – human (Hemofil M)	Control and prevention of bleeding episodes	Minor episodes: 10- 20 IU/kg IV every 12-24 hours Moderate episodes: 15-30 IU/kg IV every 12-24 hours Major episodes: 30- 50 IU/kg IV every 8-24 hours	100 IU/kg every 8 hours

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – human (Koate-DVI)	Control and prevention of bleeding episodes	Minor episodes: 10 IU/kg IV as a single dose; repeat only if there is evidence of further bleeding Moderate episodes: 15-25 IU/kg IV as a single dose followed by 10-15 IU/kg every 8-12 hours if needed Major episodes: 40- 50 IU/kg IV as a single dose followed by 20-25 IU/kg IV every 8-12 hours	25 IU/kg every 8 hours until the bleeding episode is resolved
Antihemophilic factor – human (Hemofil M)	Perioperative management	Minor surgery: 30- 40 IU/kg as a single infusion Major surgery: 40-50 IU/kg every 8-24 hours	Minor surgery: 80 IU/kg/dose Major surgery: 100 IU/kg every 8 hours
Antihemophilic factor – human (Koate-DVI)	Perioperative management	Major surgery: 50 IU/kg pre-operative dose followed by 50 IU/kg every 6-12 hours as needed Minor surgery: less intensive schedules may be adequate	Major surgery: 50 IU/kg every 6 hours
Antihemophilic factor – recombinant, PEGylated-aucl (Jivi)	Control and prevention of bleeding episodes	Minor episodes: 10-20 IU/kg every 24-48 hours Moderate episodes: 15-30 IU/kg every 24-48 hours Major episodes: 30-50 IU/kg every 8-24 hours	50 IU/kg every 8 hours
	Perioperative management	Minor surgery: 15-30 IU/kg every 24 hours Major surgery: 40-	Minor surgery: 30 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		50 IU/kg every 12-24 hours	Major surgery: 50 IU/kg/dose
	Routine prophylaxis	30-40 IU/kg twice weekly; may be adjusted to 45-60 IU/kg every 5 days with further individual adjustment to less or more frequent dosing	60 IU/kg/dose; frequency varies based on bleeding episodes

VI. Product Availability

Drug Name	Availability
Antihemophilic factor – recombinant (Advate)	Vial: 250, 500, 1,000, 1,500, 2,000, 3,000, 4,000 IU
Antihemophilic factor – recombinant (Adynovate)	Vial: 250, 500, 750, 1,000, 1,500, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Afstyla)	Vial: 250, 500, 1,000, 1,500, 2,000, 2,500, 3,000 IU
Antihemophilic factor – recombinant (Eloctate)	Vial: 250, 500, 750, 1,000, 1,500, 2,000, 3,000 4,000, 5,000, 6,000 IU
Antihemophilic factor – recombinant, glycopegylated-exei (Esperoct)	Vial: 500, 1,000, 1,500, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS, Kovaltry)	Vial: 250, 500, 1,000, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Novoeight)	Vial: 250, 500, 1,000, 1,500, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Nuwiq)	Vial: 250, 500, 1,000, 2,000, 2,500, 3,000, 4,000 IU
Antihemophilic factor – recombinant (Recombinate)	Vial: 220-400, 401-800, 801-1240, 1241-1800, 1801-2400 IU
Antihemophilic factor – recombinant (ReFacto, Xyntha)	Vial: 250, 500, 1,000, 2,000 IU
Antihemophilic factor – recombinant (Xyntha Solofuse)	Prefilled syringe: 250, 500, 1,000, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Obizur)	Vial: 500 IU
Antihemophilic factor – human (Hemofil M)	Vial: 250, 500, 1,000, 1,700 IU
Antihemophilic factor – human (Koate-DVI)	Vial: 250, 500, 1,000 IU

Drug Name	Availability
Antihemophilic factor – recombinant, PEGylated-aucl (Jivi)	Vial: 500, 1,000, 2,000, 3,000 IU

VII. References

1. Advate Prescribing Information. Westlake Village, CA: Baxalta US, Inc.; December 2018. Available at: www.advate.com. Accessed November 27, 2021.
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15. Recombinate Prescribing Information. Westlake Village, CA: Baxalta US Inc.; June 2018. Available at: www.recombinate.com. Accessed November 27, 2021.
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17. Xyntha Solofuse Prescribing Information. Philadelphia, PA: Wyeth Pharmaceuticals, Inc.; August 2020. Available at: www.xyntha.com. Accessed November 27, 2021.
18. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. *Haemophilia.* Jan 2013; 19(1): e1-47.
19. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed December 1, 2020.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7204	Injection, factor VIII, antihemophilic factor (recombinant), (Esperoct), glycopegylated-exei, per IU
J7207	Injection, factor VIII (antihemophilic factor, recombinant) PEGylated, 1 IU
J7208	Injection, factor VIII, (antihemophilic factor, recombinant), pegylated-aucl, (Jivi), 1 IU
J7209	Injection, factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 IU
J7210	Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU
J7211	Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU
J7182	Injection, factor VIII, (antihemophilic factor, recombinant), (NovoEight), per IU
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU
J7188	Injection, factor VIII (antihemophilic factor, recombinant) (Obizur), per IU
J7190	Factor VIII (antihemophilic factor, human) per IU
J7191	Factor VIII (antihemophilic factor, porcine) per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: -No significant changes. -References reviewed and updated.	11.27.17	02.18
1Q 2019 annual review: added HIM-Medical Benefit; added Jivi; removed Monoclate-P since it is no longer available on market; removed requirement for failure of Advate for Xyntha requests as it is not clinically necessary nor contractually driven; allowed use of Kovaltry for routine prophylaxis per FDA indication; moved criterion that member does not have VWD to section III Diagnoses/Indications Not Covered; references reviewed and updated.	10.29.18	02.19
No significant changes: Esperoct added to the policy; referenced reviewed and updated.	03.13.19	
1Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.	11.26.19	02.20
Added Commercial line of business.	03.13.20	
Added 1 month approval duration for use post-valoctocogene gene therapy administration in hemophilia A.	04.17.20	05.20
Added routine prophylaxis-specific requirement for severe hemophilia classification or at least one life-threatening or serious spontaneous bleed for classification of non-severe hemophilia; added requirement for prescriber attestation of not partaking in contact sports.	05.27.20	08.20
RT4: Added newly FDA-approved indication for Xyntha - routine prophylaxis of bleeding episodes.	08.31.20	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Removed requirement for prescriber attestation of not partaking in contact sports.	10.01.20	11.20
1Q 2021 annual review: added requirement for documentation of member's body weight for calculation of appropriate dosage; removed ReFacto from the policy as it is no longer available; removed references to valoctocogene roxaparvovec as it did not receive FDA approval and likely will not face FDA review again until at least late 2022; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	12.01.20	02.21
Added a requirement for high utilizers of factor VIII products for routine prophylaxis to use Hemlibra.	09.20.21	11.21
1Q 2022 annual review: removed the redirection to Hemlibra for high factor utilizers until data analysis re: potential cost savings is complete; updated HCPCS codes; references reviewed and updated.	11.27.21	02.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.