

## Clinical Policy: Bevacizumab (Avastin)

Reference Number: CP.PHAR.93

Effective Date: 12/11

Last Review Date: 04/17

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for bevacizumab (Avastin®).

### Policy/Criteria

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

#### I. Initial Approval Criteria

##### A. Colorectal Cancer (must meet all):

1. Age  $\geq$  18 years;
2. Meets a or b:
  - a. FDA approved use:
    - i. Colorectal cancer (a or b):
      - a) Primary or subsequent therapy for metastatic disease:
        - 1) In combination with 5-FU-based therapy\*;
        - b) Subsequent therapy for metastatic disease:
          - 1) In combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based therapy\* after disease progression on a first-line Avastin-containing regimen;
      - b. Off-label NCCN approved use:
        - i. Colorectal cancer (a or b):
          - a) Primary or subsequent therapy for unresectable, metastatic or medically inoperable disease (1, 2 or 3):
            - 1) In combination with capecitabine, FOLFOX, FOLFIRI, CapeOX, FOLFOXIRI, or 5-FU/LV\*;
            - 2) In combination with irinotecan;
            - 3) In combination with irinotecan and oxaliplatin;
          - b) Adjuvant therapy for resectable metastases:
            - 1) In combination with capecitabine, FOLFOX, FOLFIRI, CapeOX, FOLFOXIRI, or 5-FU/LV\*;
        - ii. Rectal cancer:
          - a) Primary therapy for resectable disease classified as either (T3/N0/M0 [stage IIA]) or (anyT/N1-2/M0 [stage III]\*\*):
            - 1) In combination with capecitabine, FOLFOX, FOLFIRI, FOLFOXIRI, CapeOX, or 5-FU/LV\*;
    3. Member's history is negative for the following:
      - a. Serious hemorrhage or recent hemoptysis;
      - b. Surgery within the last 28 days and unhealed surgical wounds.

*\*Examples of fluoropyrimidines: Capecitabine, floxuridine, fluorouracil (5-FU); examples of fluoropyrimidine-based regimens: 5-FU/LV (fluorouracil, leucovorin); FOLFOX (5-FU, leucovorin, oxaliplatin); FOLFIRI (5-FU, leucovorin, irinotecan); FOLFOXIRI (5-FU, leucovorin, oxaliplatin, irinotecan); CapeOX (capecitabine, oxaliplatin).*

*\*\*American Joint Committee on Cancer (TNM staging classification (7<sup>th</sup> ed., 2010) as reported in NCCN Colon and Rectal Cancer: T (primary tumor characteristics), N (regional lymph node status), M (metastasis status).*

**Approval duration: 6 months**

**B. Non-Squamous Non-Small Cell Lung Cancer (must meet all):**

1. Age  $\geq$  18 years;
2. Non-squamous non-small cell lung cancer;
3. Meets a or b:
  - a. FDA approved use:
    - i. Primary therapy for unresectable, locally advanced, recurrent or metastatic disease:
      - a) In combination with carboplatin and paclitaxel;
  - b. Off-label NCCN recommended use (i or ii):
    - i. Primary or subsequent therapy for unresectable, locally advanced, recurrent or metastatic disease (a, b, c or d):
      - a) In combination with carboplatin and paclitaxel;
      - b) In combination with carboplatin and pemetrexed;
      - c) In combination with pemetrexed;
      - d) In combination with cisplatin and pemetrexed;
    - ii. Continuation maintenance therapy (if prior Avastin use associated with achievement of tumor response or stable disease) (a or b):
      - a) As single agent;
      - b) In combination with pemetrexed;
4. Member's history is negative for the following:
  - a. Serious hemorrhage or recent hemoptysis;
  - b. Surgery within the last 28 days and unhealed surgical wounds.

**Approval duration: 6 months**

**C. Glioblastoma (must meet all):**

1. Age  $\geq$  18 years;
2. Glioblastoma;
3. Meets a or b:
  - a. FDA approved use:
    - i. Subsequent therapy for recurrent or progressive disease:
      - a) As single agent;
  - b. Off-label NCCN recommended use:
    - i. Subsequent therapy for recurrent or progressive disease:
      - a) In combination with irinotecan, carmustine, lomustine, temozolomide, or carboplatin;

4. Member's history is negative for the following:
  - a. Serious hemorrhage or recent hemoptysis;
  - b. Surgery within the last 28 days and unhealed surgical wounds.

**Approval duration: 6 months**

**D. Renal Cell Carcinoma** (must meet all):

1. Age  $\geq$  18 years;
2. Renal cell carcinoma;
3. Meets a or b:
  - a. FDA approved use:
    - i. Metastatic disease:
      - a) In combination with interferon alfa-2a/2b;
  - b. Off-label NCCN recommended use:
    - i. Relapsed or stage IV (advanced or metastatic) disease (a, b or c):
      - a) Clear cell histology - primary therapy:
        - 1) In combination with interferon alfa-2b;
      - b) Clear cell histology - subsequent therapy:
        - 1) As single agent;
      - c) Non-clear cell histology:
        - 1) As single agent;
4. Member's history is negative for the following:
  - a. Serious hemorrhage or recent hemoptysis;
  - b. Surgery within the last 28 days and unhealed surgical wounds.

**Approval duration: 6 months**

**E. Carcinoma of the Cervix** (must meet all):

1. Age  $\geq$  18 years;
2. Cervical carcinoma;
3. Meets a or b:
  - a. FDA approved use:
    - i. Persistent, recurrent or metastatic disease (a or b):
      - a) In combination with paclitaxel and cisplatin;
      - b) In combination with paclitaxel and topotecan;
  - b. Off-label NCCN recommended use:
    - i. Persistent, recurrent or metastatic disease (a or b):
      - a) Primary therapy (1 or 2):
        - 1) In combination with carboplatin;
        - 2) In combination with topotecan;
      - b) Subsequent therapy:
        - 1) As single agent;
4. Member's history is negative for the following:
  - a. Serious hemorrhage or recent hemoptysis;
  - b. Surgery within the last 28 days and unhealed surgical wounds.

**Approval duration: 6 months**

**F. Epithelial Ovarian/Fallopian Tube/Primary Peritoneal Cancer** (must meet all):

1. Age  $\geq$  18 years;
2. Meets a or b:
  - a. FDA approved use (i or ii):
    - i. Epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer:
      - a) Persistent/recurrent platinum-resistant disease:
        - 1) In combination with paclitaxel;
        - 2) In combination with pegylated liposomal doxorubicin;
        - 3) In combination with topotecan;
      - b) Persistent/recurrent platinum-sensitive disease:
        - 1) In combination with carboplatin and paclitaxel;
        - 2) In combination with carboplatin and gemcitabine;
        - 3) As single agent;
    - ii. Off-label NCCN recommended use (i, ii, iii, iv or v):
      - i. Epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer:
        - a) Persistent/recurrent disease:
          - 1) As single-agent;
        - b) Unresectable disease – primary therapy:
          - 1) In combination with carboplatin and paclitaxel;
        - c) Stage II-IV disease post completion surgery\* - adjuvant therapy:
          - 1) In combination with carboplatin and paclitaxel;
      - iii. Granulosa cell tumor\*\* (relapsed stage II-IV disease) – subsequent therapy:
        - a) As single-agent;
      - iii. Serous/endometrioid epithelial carcinoma (stage II-IV low-grade [grade 1]) - adjuvant therapy:
        - a) In combination with carboplatin and paclitaxel;
      - iv. Mucinous carcinoma of the ovary (stage II-IV) - adjuvant therapy:
        - a) In combination with carboplatin and paclitaxel;
  3. Member's history is negative for the following:
    - a. Serious hemorrhage or recent hemoptysis;
    - b. Surgery within the last 28 days and unhealed surgical wounds.

*\*Follow-up surgery performed if fertility-conserving strategies are no longer desired.*

*\*\*A type of malignant sex cord-stromal tumor.*

**Approval duration: 6 months**

**G. Other diagnoses/indications:** Refer to CP.PHAR.57 - Global Biopharm Policy.

1. Oncology: The following NCCN recommended uses meeting NCCN categories 1, 2a or 2b are approved per the CP.PHAR.57 Global Biopharm Policy:
  - a. Age  $\geq$  18 years;
    - i. Breast cancer;
    - ii. Endometrial carcinoma;
    - iii. Malignant pleural mesothelioma;

- iv. Primary central nervous system cancers (a or b):
  - a) Adult intracranial and spinal ependymoma (excluding subependymoma);
  - b) Anaplastic glioma;
- v. Soft tissue sarcoma (a or b):
  - a) Angiosarcoma;
  - b) Solitary fibrous tumor/hemangiopericytoma;
- 2. Ophthalmology (intravitreal administration):
  - a. Retinopathy of prematurity;
  - b. Age  $\geq$  18 years:
    - i. Neovascular glaucoma;
    - ii. Neovascular (wet) age-related macular degeneration;
    - iii. Diabetic retinopathy;
    - iv. Macular edema secondary to (a or b):
      - a) Branch or central retinal vein occlusion;
      - b) Diabetes;
    - v. Choroidal/retinal neovascularization secondary to (a or b):
      - a) Pathologic myopia;
      - b) Angioid streaks;
- 3. Member's current history is negative for the following:
  - a. Serious hemorrhage or recent hemoptysis;
  - b. Surgery within the last 28 days and unhealed surgical wounds.

**Approval duration: 6 months**

## II. Continued Approval

### A. All Indications (must meet all):

- 1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
- 2. Documentation of positive response to therapy (e.g.: no disease progression, not experiencing unacceptable toxicity);
- 3. If use is ophthalmic, evidence of detained neovascularization or improvement in visual acuity.

**Approval duration: 12 months**

### 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 CP.PHAR.57 – Global Biopharm Policy.

## Background

### *Description/Mechanism of Action:*

Bevacizumab binds vascular endothelial growth factor (VEGF) and prevents the interaction of VEGF to its receptors (Flt-1 and KDR) on the surface of endothelial cells. The interaction of VEGF with its receptors leads to endothelial cell proliferation and new blood vessel formation in

*in vitro* models of angiogenesis. Administration of bevacizumab to xenotransplant models of colon cancer in nude (athymic) mice caused reduction of microvascular growth and inhibition of metastatic disease progression.

*Formulations:*

Avastin: Intravenous solution: 100 mg/4 mL (4 mL); 400 mg/16 mL (16 mL)

*FDA Approved Indications:*

Avastin is a VEGF-specific angiogenesis inhibitor/solution for intravenous infusion indicated for the treatment of:

- Metastatic colorectal cancer, with intravenous 5-fluorouracil-based chemotherapy for first- or second-line treatment.\*
- Metastatic colorectal cancer, with fluoropyrimidine- irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line Avastin containing regimen.
- Non-squamous non-small cell lung cancer, with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease.
- Glioblastoma, as a single agent for adult patients with progressive disease following prior therapy. Effectiveness based on improvement in objective response rate. No data available demonstrating improvement in disease-related symptoms or survival with Avastin.
- Metastatic renal cell carcinoma with interferon alfa.
- Cervical cancer, in combination with paclitaxel and cisplatin or paclitaxel and topotecan in persistent, recurrent, or metastatic disease.
- Platinum-resistant recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan.
- Platinum-sensitive recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, in combination with carboplatin and paclitaxel or in combination with carboplatin and gemcitabine, followed by Avastin as a single agent.

\*Limitation of use: Avastin is not indicated for adjuvant treatment of colon cancer.

### Appendices

#### Appendix A: Abbreviation Key

5-FU/LV: fluorouracil, leucovorin

5-FU: fluorouracil

CapeOX: capecitabine, oxaliplatin

FOLFIRI: fluorouracil, leucovorin, irinotecan

FOLFOX: fluorouracil, leucovorin, oxaliplatin

FOLFOXIRI: fluorouracil, leucovorin, oxaliplatin, irinotecan

VEGF: vascular endothelial growth factor

### 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-

**Bevacizumab**

date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<b>HCPCS Codes</b>	<b>Description</b>
J9035	Injection, bevacizumab, 10 mg
C9257	Injection, bevacizumab, 0.25 mg

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

The following is a list of diagnosis codes that support coverage for the applicable covered procedure code(s).

<b>ICD-10-CM Code</b>	<b>Description</b>
A18.53	Tuberculosis chorioretinitis
C17.0 – C17.9	Malignant neoplasm of small intestine
C18.0 – C18.9	Malignant neoplasm of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C34.00 – C34.02	Malignant neoplasm of main bronchus
C34.10 – C34.12	Malignant neoplasm of upper lobe, bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30 – C34.32	Malignant neoplasm of lower lobe, bronchus or lung
C34.80 – C34.82	Malignant neoplasm of overlapping sites of bronchus and lung
C34.90 – C34.92	Malignant neoplasm of unspecified part of bronchus or lung
C48.0 – C48.8	Malignant neoplasm of retroperitoneum and peritoneum
C49.0 – C49.9	Malignant neoplasm of other connective and soft tissue
C50.01 – C50.929	Malignant neoplasm of breast
C53.0 – C53.9	Malignant neoplasm of cervix uteri
C54.0 – C55	Malignant neoplasm of corpus uteri
C56.1 – C56.9	Malignant neoplasm of ovary
C57.0 – C57.9	Malignant neoplasm of other and unspecified female genital organs
C64.1 – C64.9	Malignant neoplasm of kidney, except renal pelvis
C65.1 – C65.9	Malignant neoplasm of renal pelvis
C70.0 – C70.9	Malignant neoplasm of meninges
C71.0 – C71.9	Malignant neoplasm of brain
C72.0 – C72.9	Malignant of spinal cord, cranial neoplasm nerves and other parts of central nervous system
E08.311, E08.3211 – E08.3219, E08.3311 – E08.3319, E08.3411 – E08.3419, E08.3511 – E08.3519	Diabetes mellitus due to underlying condition with diabetic retinopathy with macular edema
E09.311,	Drug or chemical induced diabetes mellitus with diabetic retinopathy with macular edema

ICD-10-CM Code	Description
E09.3211 – E09.3219, E09.3311 – E09.3319, E09.3411 – E09.3419, E09.3511 – E09.3519	
E10.311, E10.3211 – E10.3219, E10.3311 – E10.3319, E10.3411 – E10.3419, E10.3511 – E10.3519	Type 1 diabetes mellitus with diabetic retinopathy with macular edema
E11.311, E11.3211 – E11.3219, E11.3311 – E11.3319, E11.3411 – E11.3419, E11.3511 – E11.3519	Type 2 diabetes mellitus with diabetic retinopathy with macular edema
E13.311, E13.3211 – E13.3219, E13.3311 – E13.3319, E13.3411 – E13.3419, E13.3511 – E13.3519	Other specified diabetes mellitus with diabetic retinopathy with macular edema
H16.401 – H16.449	Corneal neovascularization
H30.001 – H30.049	Focal chorioretinal inflammation
H30.101 – H30.139	Disseminated chorioretinal inflammation
H30.891 – H30.899	Other chorioretinal inflammations
H30.90 – H30.93	Unspecified chorioretinal inflammations
H32	Chorioretinal disorders in diseases classified elsewhere
H34.8110 – H 34.8192	Central retinal vein occlusion
H34.8310 – H34.8392	Tributary (branch) retinal vein occlusion
H35.051 – H35.059	Retinal neovascularization, unspecified
H35.141 – H35.169	Retinopathy of prematurity, stages 3 through 5
H35.3210 – H35.3293	Exudative age-related macular degeneration
H35.33	Angioid streaks of macula
H35.81	Retinal edema
H40.50X0-H40.53X4	Glaucoma secondary to other eye disorders [associated with vascular disorders of eye]
H44.20-H44.23	Degenerative myopia
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
Z85.068	Personal history of other malignant neoplasm of small intestine
Z85.118	Personal history of other malignant neoplasm of bronchus and lung
Z85.3	Personal history of malignant neoplasm of breast
Z85.41	Personal history of malignant neoplasm of cervix uteri
Z85.42	Personal history of malignant neoplasm of other parts of uterus



ICD-10-CM Code	Description
Z85.43	Personal history of malignant neoplasm of ovary
Z85.44	Personal history of malignant neoplasm of other female genital organs
Z85.528	Personal history of other malignant neoplasm of kidney
Z85.53	Personal history of malignant neoplasm of renal pelvis
Z85.841	Personal history of malignant neoplasm of brain
Z85.848	Personal history of malignant neoplasm of other parts of nervous tissue

Reviews, Revisions, and Approvals	Date	Approval Date
Reviewed with no clinical changes	12/12	12/12
Updated background, safety profile and contraindications	02/14	03/14
Added cervical cancer indication Updated criteria per NCC guidelines for monotherapy or combination therapy and first line or maintenance therapy	11/14	11/14
Converted criteria into bullet points and changed to new policy template Edited FDA-approved indications in section I to correspond to PI – all indications are limited to adults; added ovarian cancer; Limited compendial indications to cancer type – all compendial indications are in section II Added HCPCS and ICD-10 codes Policy arranged in disease specific criteria sets Added ocular indications as previously approved from CP.PHAR.38	10/15	11/15
CP.PHAR.93.Avastin policy converted to new template; incorporates Avastin content from CP.PHAR.39 AMD Retinal Disorder Treatments. Added age and max dose; monotherapy defined as “other anti-VEGF drugs;” removed requests for documentation. References: removed 2008 Genentech letter regarding infections correlating with Avastin intravitreal use as it is no longer available.	03/16	09/16
Updated coding. Updated disclaimer language.	09/16	09/16
New FDA labeled indication added: Platinum-sensitive epithelial ovarian, fallopian tube, or primary peritoneal cancer. Doses removed. Under renal cell carcinoma, FDA approved use, added 2a/2b subtypes to interferon alpha. Safety criteria limited to black box warnings precluding initiation of therapy. Off-label ocular use is edited to follow supported uses in Micromedex and Clinical Pharmacology (i.e., AMD secondary to choroidal neovascularization, macular edema secondary to branch/central retinal vein occlusion or diabetes, choroidal retinal neovascularization secondary to pathologic myopia or angioid streaks, diabetic retinopathy, retinopathy of prematurity). Choroidal neovascularization associated with no known cause or with inflammation or ocular histoplasmosis syndrome is removed but may be requested under the Global Biopharm policy. Approval duration	03/17	04/17

Reviews, Revisions, and Approvals	Date	Approval Date
lengthened to 6 and 12 months. Added ICD-10 appropriate code ranges for eye conditions that now have a new 6 <sup>th</sup> or 7 <sup>th</sup> digit indicating the specific eye.		

**References**

1. Avastin prescribing information. South San Francisco, CA: Genentech, Inc.; December 2016. Available at [https://www.gene.com/download/pdf/avastin\\_prescribing.pdf](https://www.gene.com/download/pdf/avastin_prescribing.pdf). Accessed March 23, 2017.
2. Colon cancer (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
3. Rectal cancer (Version 3.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
4. Non-small cell lung cancer (Version 5.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
5. Central nervous system cancers (Version 1.2016). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
6. Kidney cancer (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
7. Rini BI, Halabi S, Rosenberg JE, et al. Bevacizumab plus interferon alfa compared with interferon alfa monotherapy in patients with metastatic renal cell carcinoma: CALGB 90206. *J Clin Oncol*. 2008; 26:5422-5428.
8. Cervical cancer (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
9. Ovarian cancer, including fallopian tube cancer and primary peritoneal cancer (Version 1.2016). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed March 23, 2017.
10. Bevacizumab. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed March 23, 2017.
11. Bevacizumab. In: Micromedex. Ann Arbor, MI: Truven Health Analytics; 2017. Available from: [www.micromedexsolutions.com](http://www.micromedexsolutions.com). Accessed March 23, 2017.
12. Bevacizumab. In: Clinical Pharmacology. Tampa, FL: Gold Standard; 2017. Available at [www.clinicalpharmacology.com](http://www.clinicalpharmacology.com). Accessed March 27, 2017.
13. Age-related macular degeneration preferred practice pattern guidelines. American Academy of Ophthalmology; 2015. Available at [www.aao.org/ppp](http://www.aao.org/ppp). Accessed March 23, 2017.
14. Retinal vein occlusions preferred practice pattern guidelines. American Academy of Ophthalmology; 2015. Available at [www.aao.org/ppp](http://www.aao.org/ppp). Accessed March 23, 2017.
15. Diabetic retinopathy preferred practice pattern guidelines. American Academy of Ophthalmology; 2016. Available at [www.aao.org/ppp](http://www.aao.org/ppp). Accessed March 23, 2017.

**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

### Bevacizumab

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.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

©2017 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.