Clinical Policy: Lenalidomide (Revlimid)

Reference Number: CP.PHAR.71
Effective Date: 07.01.11
Last Review Date: 05.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Lenalidomide (Revlimid®) is an immunomodulatory agent with antiangiogenic and antineoplastic properties.

FDA Approved Indication

Revlimid is indicated for the treatment of patients with:

- Multiple myeloma (MM), in combination with dexamethasone
- MM as maintenance following autologous hematopoietic stem cell transplantation
- Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities
- Mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib (Velcade®)
- Previously treated follicular lymphoma (FL), in combination with a rituximab product
- Previously treated marginal zone lymphoma (MZL), in combination with a rituximab product

Limitation of use: Revlimid is not indicated and is not recommended for the treatment of patients with chronic lymphocytic leukemia (CLL) outside of controlled clinical trials.

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 Revlimid is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma (must meet all):

1. Diagnosis of MM;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Will be used for one of the following indications (a, b, c, or d):
   a. In combination with dexamethasone;
   b. As a single agent in steroid-intolerant patients with previously treated myeloma with relapse or progressive disease;
   c. As maintenance therapy as a single agent or in combination with bortezomib following autologous hematopoietic stem cell transplantation;

d. As maintenance therapy as a single agent or in combination with bortezomib for active (symptomatic) myeloma after response to primary myeloma therapy;

5. The requested agent is not prescribed concurrently with Thalomid® or Pomalyst®;
6. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM - 6 months
Commercial – 12 months or duration of request, whichever is less

B. Myelodysplastic Syndrome (must meet all):

1. Diagnosis of lower risk (i.e., IPSS-R [Very Low, Low, Intermediate], IPSS [Low/Intermediate-1], WPSS [Very Low, Low, Intermediate]) MDS;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Member has one of the following (a or b):
   a. Symptomatic or transfusion-dependent anemia due to MDS, and one of the following (i or ii):
      i. Presence of deletion 5q abnormality;
      ii. No deletion 5q abnormality, and either (a or b):
         a) Serum erythropoietin > 500 mU/mL;
         b) Serum erythropoietin ≤ 500 mU/mL, and failure of an erythropoiesis-stimulating agent (ESA; *Retacrit® is preferred*)*, unless contraindicated or clinically significant adverse effects are experienced;
            **Prior authorization may be required*
   b. MDS and myeloproliferative overlap neoplasms with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T);
5. The requested agent is not prescribed concurrently with Thalomid or Pomalyst;
6. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 10 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM - 6 months
Commercial – 12 months or duration of request, whichever is less

C. Mantle Cell Lymphoma (must meet all):

1. Diagnosis of MCL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;

4. Will be used for one of the following indications (a or b):
   a. Relapsed or progressive disease after two prior therapies, one of which included bortezomib (Velcade);
   b. In combination with rituximab*;
   **Prior authorization may be required for rituximab.*
5. The requested agent is not prescribed concurrently with Thalomid or Pomalyst;
6. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM - 6 months
Commercial – 12 months or duration of request, whichever is less

D. Marginal Zone Lymphoma (must meet all):
1. Diagnosis of MZL (including gastric or nongastric mucosa-associated lymphoid tissue (MALT) lymphoma, nodal MZL, and splenic MZL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Will be used for one of the following indications (a, b, or c):
   a. Second-line or subsequent therapy, and is prescribed in combination with rituximab* or Gazyva®*;
   b. Histologic transformation of MZL to non-germinal center diffuse large B-cell lymphoma after multiple lines of chemoimmunotherapy for indolent or transformed disease;
   c. In combination with Monjuvi®* in non-transplant candidates and have received one of the following (i or ii):
      i. Minimal or no chemoimmunotherapy prior to histologic transformation to diffuse large B-cell lymphoma and have no response or progressive disease after chemoimmunotherapy (e.g., anthracycline- or anthracenedione-based regimens);
      ii. Multiple prior therapies including ≥ 2 lines of chemoimmunotherapy for indolent or transformed disease;
      **Prior authorization may be required*
5. The requested agent is not prescribed concurrently with Thalomid or Pomalyst;
6. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 20 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months

Commercial – 12 months or duration of request, whichever is less

E. Follicular Lymphoma (must meet all):
1. Diagnosis of FL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Will be used for one of the following indications (a, b, c, or d):
   a. First-line therapy in combination with rituximab;*
   b. Second-line or subsequent therapy;
   c. Treatment of histologic transformation to non-germinal center diffuse large B-cell lymphoma after multiple lines of chemoimmunotherapy for indolent or transformed disease;
   d. In combination with Monjuvi®* for treatment of histologic transformation to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6 in non-transplant candidates and have received one of the following (i or ii):
      i. Minimal or no chemoimmunotherapy prior to histologic transformation to diffuse large B-cell lymphoma and have no response or progressive disease after chemoimmunotherapy (e.g., anthracycline- or anthracenedione-based regimens);
      ii. Multiple prior therapies including ≥ 2 lines of chemoimmunotherapy for indolent or transformed disease;

   **Prior authorization may be required for rituximab.*
5. The requested agent is not prescribed concurrently with Thalomid or Pomalyst;
6. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 20 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

F. Other NCCN Compendium Supported Diagnoses/Indications (off-label) (must meet all):
1. Prescribed for one of the following NCCN category 1 or 2a recommended indications:
   a. Myelofibrosis-associated anemia, and one of the following (i or ii):
      i. Serum erythropoietin ≥ 500 mU/mL;
      ii. Serum erythropoietin < 500 mU/mL, and failure of an ESA (*Retacrit is preferred*)*, unless contraindicated or clinically significant adverse effects are experienced;
   b. Systemic light chain amyloidosis in combination with dexamethasone;

c. Primary central nervous system (CNS) lymphoma as a single agent or in combination with rituximab* for relapsed or refractory disease, or if member is unsuitable or intolerant to high-dose methotrexate;
d. Classic Hodgkin lymphoma as third-line or subsequent therapy for relapsed or refractory disease;
e. Langerhans cell histiocytosis as a single agent therapy;
f. Any of the following non-Hodgkin lymphoma subtypes:
   i. T-cell leukemia/lymphoma as second-line or subsequent therapy;
   ii. AIDS-related B-cell lymphoma as second-line or subsequent therapy;
   iii. Kaposi sarcoma (KS), and both of the following (1 and 2):
      1) If AIDS-related, Revlimid is prescribed in combination with antiretroviral therapy;
      2) Failure of liposomal doxorubicin and paclitaxel, unless clinically significant adverse effects are experienced or both are contraindicated;
   iv. Castleman's disease (CD) as subsequent therapy following treatment of relapsed, refractory, or progressive disease;
   v. Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) as second-line and subsequent therapy;
   vi. Diffuse large B-cell lymphoma as second-line or subsequent therapy (including in combination with Monjuvi in non-transplant candidates);
   vii. Hepatosplenic gamma-delta T-cell lymphoma for refractory disease after two primary treatment regimens;
   viii. High-grade B-cell lymphoma as second-line or subsequent therapy;
   ix. Peripheral T-cell lymphoma as initial palliative intent therapy, second-line or subsequent therapy;
   x. Post-transplant lymphoproliferative disorders of B-cell lymphomas as second-line or subsequent therapy;

**Prior authorization may be required for rituximab and ESAs*

2. Prescribed by or in consultation with one of the following specialists (a or b):
   a. AIDS-related KS: an oncologist or immunologist;
   b. All other diagnoses: an oncologist or hematologist;
3. Age ≥ 18 years;
4. The requested agent is not prescribed concurrently with Thalomid or Pomalyst;
5. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 25 mg per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM - 6 months
Commercial – 12 months or duration of request, whichever is less

G. 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. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit or documentation supports that member is currently receiving Revlimid for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. The requested agent is not prescribed concurrently with Thalomid or Pomalyst;
4. For Revlimid requests, member must use generic lenalidomide, if available (e.g., contraindications to excipients);
5. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 10 mg per day for MDS, 20 mg/day for MZL and FL, and 25 mg per day for all other indications;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AIDS: acquired immune deficiency syndrome
CD: Castleman's disease
CLL: chronic lymphocytic leukemia
ESA: erythropoiesis-stimulating agent
FDA: Food and Drug Administration
FL: follicular lymphoma
KS: Kaposi sarcoma
MALT: mucosa-associated lymphoid tissue
MCL: mantle cell lymphoma
MDS: myelodysplastic syndrome
MM: multiple myeloma
MZL: marginal zone lymphomas

NCCN: National Comprehensive Cancer Network

REMS: Risk Evaluation and Mitigation Strategy
SLL: small lymphocytic lymphoma

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
melphalan/ prednisone (MP)	**Multiple Myeloma** (Conventional primary therapy) melphalan 8 mg/m^2/day PO days 1-4; prednisone 60 mg/m2/day PO days 1-4. Repeat cycle every 28 days	As recommended in dosing regimen
vincristine*/ doxorubicin*/ dexamethasone (VAD)	**Multiple Myeloma** (Conventional primary therapy) vincristine 0.4 mg/day IV continuous infusion days 1- 4; doxorubicin 9 mg/m2/day IV continuous infusion days 1-4; dexamethasone 40 mg PO days 1-4, 9-12, 17-20. Repeat cycle every 28-35 days	As recommended in dosing regimen
dexamethasone (pulse dose as single agent)	**Multiple Myeloma** (Conventional primary therapy) dexamethasone 40 mg PO days 1-4, 9-12, 17-20	As recommended in dosing regimen
Thalomid® (thalidomide)/ dexamethasone	**Multiple Myeloma** (Conventional primary therapy) thalidomide 200 mg/day PO daily; dexamethasone 40 mg/day days 1-4, 9-12,17-20 for odd cycles and days 1-4 for even cycles. Repeat cycle every 28 days	As recommended in dosing regimen
Pomalyst® (pomalidomide)	**Multiple Myeloma** 4 mg PO QD on days 1-21 of repeated 28-day cycles until disease progression. Pomalyst may be given in combination with dexamethasone.	4 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Pomalyst may be given in combination with Kyprolis/dexamethasone Avoid Pomalyst in patients with a serum creatinine greater than 3.0 mg/dL	
Bortezomib (Velcade)	**Mantle Cell Lymphoma** 1.3 mg/m^2/dose SC or IV BIW for 2 weeks (Days 1, 4, 8, and 11) followed by a 10-day rest period (Days 12-21) for six 3-week cycles. For extended therapy of more than 8 cycles, Velcade may be administered on the standard schedule or on a maintenance schedule of once weekly for 4 weeks (Days 1, 8, 15, and 22) followed by a 13-day rest period (Days 23 to 35). At least 72 hours should elapse between consecutive doses of Velcade	1.3 mg/m^2/dose
liposomal doxorubicin (Doxil®, Lipodox® 50)	**AIDS-related KS** 20 mg/m^2 IV every 2-3 weeks with a cumulative lifetime dose of 400-450 mg/m^2 due to cardiotoxicity	See regimen
paclitaxel	**AIDS-related KS** 135 mg/m^2 IV every 3 weeks **or** 100 mg/m^2 every 2 weeks	See regimen
ESAs		
Aranesp® (darbepoetin alfa)	**Anemia associated with MDS**† 150-300 mcg SC every other week	500 mcg every other week
epoetin alfa (Epogen®, Procrit®, Retacrit®)	**Anemia associated with MDS**† 40,000-60,000 units SC one to two times weekly **Anemia associated with myelofibrosis**† n a clinical trial, patients initially received erythropoietin 10,000 units SC 3 days per week. Erythropoietin was increased to 20,000 units 3 days per week if a response was not obtained after 2 months and erythropoietin was discontinued in patients who did not experience a response at 3 months	Varies depending on indication and frequency of administration

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.

†Off-label

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): pregnancy; hypersensitivity
- Boxed warning(s): embryo-fetal toxicity, hematologic toxicity, venous and arterial thromboembolism

Appendix D: General Information

- Anemia is defined as hemoglobin level less than 10 g/dl.
- Transfusion dependence was defined in two different studies as either greater than 2 units or greater than 4 units of RBCs within 8 weeks prior to enrollment into the studies.
- According to NCCN guideline, current drug therapies for MCL include: a) induction therapy (including CHOP [Cytoxan, Adriamycin, vincristine, and prednisone], hyperCVAD [Cytoxan, vincristine, Adriamycin, and dexamethasone], RDHA [Rituxan, dexamethasone, cytarabine], NORDIC regimen, bendamustine + Rituxan, VR-CAP [bortezomib, rituximab, cyclophosphamide, doxorubicin, prednisone]), and b) second-line therapy (including Calquence®, Venclexta®, Imbruvica® ± Rituxan, bortezomib ± Rituxan, bendamustine ± Rituxan and Revlimid ± Rituxan).
- The FDA notified the public of an increased risk of second primary malignancies in patients with newly-diagnosed MM who received Revlimid. Clinical trials conducted after Revlimid was approved showed that newly-diagnosed patients treated with Revlimid had an increased risk of developing acute myelogenous leukemia, myelodysplastic syndromes, and Hodgkin lymphoma.
- Revlimid is only available under a restricted distribution program called the Revlimid REMS program due to the black box warning for fetal risk, hematologic toxicity, and deep vein thrombosis/pulmonary embolism. Patient and physician enrollment in the manufacturer's REMS program is required.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MDS	10 mg PO QD	10 mg/day
MM (maintenance therapy)	10 mg PO QD continuously (Days 1-28 of repeated 28-day cycles) until disease progression or unacceptable toxicity. After 3 cycles of maintenance therapy, the dose can be increased to 15 mg once daily if tolerated.	15 mg/day
MM (primary therapy for newly diagnosed patients)	25 mg PO QD days 1-21 of repeated 28 day cycles with dexamethasone 40 mg PO QD on days 1, 8, 15, 22 of each 28 day cycle.	25 mg/day
MM (previously treated patients)	25 mg PO QD days 1-21 of repeated 28 days cycles with dexamethasone 40 mg QD days 1-4, 9-12 and 17- 20 of	25 mg/day

Indication	Dosing Regimen	Maximum Dose
	each 28 day cycle for the first 4 cycles then 40 mg QD for days 1-4 every 28 days.	
Relapsed MM (previously treated patients)	25 mg PO QD days 1-21 of repeated 28 day cycles with dexamethasone 40 mg PO QD on days 1, 8, 15, 22 and Kyprolis. Maximum 18 cycles for Kyprolis. Cycle 1: 20 mg/m^2 IV over 10 minutes on days 1-2. If tolerated, increase to target dose of 27 mg/m^2 IV over 10 minutes on days 8, 9, 15, 16 Cycles 2-12: 27 mg/m^2 IV over 10 minutes on days 1, 2, 8, 9, 15, 16 Cycles 3-18 27 mg/m^2 IV over 10 minutes on days 1, 2, 15, 16 Kyprolis dosed at a maximum body surface area of 2.2 m^2	25 mg/day
MCL	25 mg PO QD on Days 1- 21 of repeated 28-day cycles	25 mg/day
MZL and FL	20 mg PO QD on Days 1- 21 of repeated 28-day cycles	20 mg/day

VI. Product Availability

Capsules: 2.5 mg, 5 mg, 10 mg, 15 mg, 20 mg, 25 mg

VII. References

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: added HIM line of business; policies combined for Commercial and Medicaid lines of business; MDS: removed criteria requirements for low-risk disease and deletion 5q cytogenetic abnormality; MCL: removed disease staging; removed off-label use for primary cutaneous B-cell lymphoma; references reviewed and updated.	01.22.18	05.18
2Q 2019 annual review: added hematologist prescriber option; updated NCCN compendium supported uses to include primary CNS lymphoma and hepatosplenic gamma-delta T-cell lymphoma; MM: added use as a single agent in steroid-intolerant patients with previously treated myeloma with relapse or progressive disease; MCL: added option for second-line therapy in combination with Rituxan; reference reviewed and updated.	02.05.19	05.19
RT4: FL, MZL FDA approved indications added, previously presented as NCCN recommended uses; references reviewed and updated.	07.02.19	
2Q 2020 annual review: per NCCN Compendium for MM maintenance therapy added option for use in combination with bortezomib; for MDS added MDS and myeloproliferative overlap neoplasms; added primary CNS lymphoma and AIDS-Related Kaposi Sarcoma to Section IF; references reviewed and updated.	02.13.20	05.20
AIDS-related KS: updated criteria to require concurrent use with antiretroviral therapy and failure of first line agents per NCCN guidelines; added immunologist as a prescriber option per specialist feedback.	06.29.20	11.20
2Q 2021 annual review: per NCCN Compendium modified the following - for MCL removed optional use as second-line therapy as a single agent; consolidated off-label use for primary CNS lymphoma and expanded use to members unsuitable or intolerant to high-dose methotrexate; for classic Hodgkin lymphoma clarified use is for third-line or subsequent therapy and removed optional use as palliative therapy. Oral oncology generic redirection language added; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	01.21.21	05.21
MDS and myelofibrosis-associated anemia: added specific NCCN recommended uses; MZL: added requirement for concurrent use with rituximab or Gazyva for non-transformative disease per FDA and NCCN; all indications: added requirement for no concurrent use with Thalomid or Pomalyst since all are thalidomide analogs.	06.24.21	08.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	09.27.21	02.22
2Q 2022 annual review: per NCCN added additional use in combination with Monjuvi for MZL and FL, for myelofibrosis-associated anemia corrected requirements for ≥ 500 vs < 500 (previously was > 500 vs ≤ 500), added off-label use for Langerhans cell histiocytosis as a single agent therapy, modified KS requirements to allow use in non-AIDs related KS, revised CLL/SLL to remove options for first-line therapy; removed mycosis fungoides/Sezary syndrome off-label use; removed primary cutaneous CD30+ T-cell lymphoproliferative disorders off-label use; modified peripheral T-cell lymphoma to allow use as initial palliative intent therapy; references reviewed and updated.	02.16.22	05.22

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.