

## Clinical Policy: Weight Management Drugs for Youth

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Effective Date: 07.01.24

Last Review Date: 05.24

Line of Business: Medicaid – Oregon Health Plan

[Revision Log](#)

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

*Use of medications for the treatment of weight loss in adults (age  $\geq 21$  years of age) is a benefit exclusion under the Oregon Health Plan. The only exception are members with Young Adults with Special Health Care Needs (YSHCN) coverage and was born in or after the year 2004.*

### Description

The following agents are indicated for weight management and require prior authorization:

Liraglutide (Saxenda<sup>®</sup>), Bupropion/naltrexone (Contrave<sup>®</sup>), Phentermine/topiramate (Qsymia<sup>®</sup>), Semaglutide (Wegovy<sup>®</sup>), Setmelanotide (Imcivree<sup>™</sup>), Tirzepatide (Zepbound<sup>®</sup>).

### Goal(s):

- Allow case-by-case review for members covered under the EPSDT program Recommend semaglutide as weight reduction pharmacotherapy in patients which evidence has demonstrated efficacy, including CV benefits. (e.g. patients with a BMI  $\geq 30$  kg/m<sup>2</sup> or with a BMI of  $\geq 27$  kg/m<sup>2</sup> and comorbid conditions [e.g., diabetes mellitus, hypertension, dyslipidemia, or cardiovascular disease]).

### FDA Approved Indication(s)

Bupropion/naltrexone, Liraglutide, Phentermine/topiramate, Semaglutide, and Tirzepatide are indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of:

- 30 kg/m<sup>2</sup> or greater (obese), or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes mellitus, or dyslipidemia.

Liraglutide, Phentermine/topiramate, and Semaglutide are indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in pediatric patients aged 12 years and older with BMI in the 95th percentile or greater standardized for age and sex.

Semaglutide is indicated in combination with a reduced-calorie diet and increased physical activity to reduce the risk of major cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease (CVD) and either obesity or overweight.

Setmelanotide is indicated for chronic weight management in adult and pediatric patients 6 years of age and older with monogenic or syndrome obesity due to:

## CLINICAL POLICY

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- Proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing demonstrating variants in POMC, PCSK1, or LEPR genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS)
- Bardet-Biedl syndrome (BBS)

#### Length of Authorization:

- Initial: Up to 6 months

#### Requires PA:

- Non-preferred drugs used for weight management

#### Covered Alternatives:

- Current Trillium Preferred Drug List listed at:
  - <https://www.trilliumohp.com/providers/pharmacy.html>

#### 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 Trillium Community Health Plan that weight management drugs are **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Genetic Obesity Disorders (must meet all):

1. Diagnosis of obesity due to POMC deficiency, PCSK1 deficiency, LEPR deficiency, or BBS (*see Appendix B*);
2. Both of the following (a and b):
  - a. Age  $\geq 6$  years;
  - b. One of the following (i or ii):
    - i. Age  $< 21$  years;
    - ii. Member has Young Adults with Special Health Care Needs (YSHCN) coverage and was born in or after the year 2004;
3. One of the following (a or b):
  - a. Genetic testing confirms that variants in the following genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance (i, ii, or iii):
    - i. POMC;
    - ii. PCSK1;
    - iii. LEPR;
  - b. Diagnosis of BBS is confirmed clinically per Beales criteria (*see Appendix B*);
4. Member does not have a history of depression and/or suicidal ideation;
5. Request is for setmelanotide
6. Dose does not exceed any of the following (a and b):
  - a. First 2 weeks (i or ii):
    - i. Age  $\geq 6$  and  $< 18$  years: 1 mg per day;
    - ii. Age  $\geq 18$  years: 2 mg per day;

- b. Maintenance: 3 mg per day.

**Approval duration:** 6 months

**B. Weight Management (must meet all):**

1. Member meets one of the following (a, b or c):
  - a. BMI  $\geq 30$  kg/m<sup>2</sup>;
  - b. BMI  $> 27$  kg/m<sup>2</sup> with at least one indicator of increased cardiovascular risk (e.g., hypertension, dyslipidemia, diabetes, elevated waist circumference) or other obesity-related medical condition (e.g., sleep apnea);
  - c. If age is between 12 and 17 years: BMI at the 95<sup>th</sup> percentile or greater for age and sex (*see Appendix B*);
2. Both of the following (a and b):
  - a. Age  $\geq 12$  years;
  - b. One of the following (a or b):
    - i. Age  $< 21$  years;
    - ii. Member has Young Adults with Special Health Care Needs (YSHCN) coverage and was born in or after the year 2004;
3. One of the following (a or b):
  - a. Member has at least one indicator of increased cardiovascular risk (e.g., hypertension, dyslipidemia, diabetes, elevated waist circumference) or other obesity-related medical condition (e.g., sleep apnea);
  - b. Documentations supports member has previously tried a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet) for a time period of at least 3 months within the previous 6-month timeframe;
4. Documentation that member is actively engaged in a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet);
5. Requested weight management pharmacotherapy agent is FDA approved to be used to treat individuals that are the member's age (*see Appendix D*);
6. Dose does not exceed the FDA-approved maximum recommended dose;

**Approval duration:** 6 months

**C. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the PDL the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the PDL the non-formulary policy for the relevant line of business: OR.CP.PMN.1001 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

## II. Continued Therapy

### A. Genetic Obesity Disorders (must meet all):

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);
2. One of the following (a or b):
  - a. Age <21 years;
  - b. Member has Young Adults with Special Health Care Needs (YSHCN) coverage and was born in or after the year 2004;
3. Member is responding positively to therapy as evidenced by one of the following (a, b, or c):
  - a. Initial re-authorization for POMC, PCSK1, or LEPR deficiency: After 12-16 weeks of treatment, reduction of at least 5% of baseline body weight or 5% of baseline BMI;
  - b. Initial re-authorization for BBS: After 1 year of treatment, reduction of at least 5% of baseline body weight or 5% of baseline BMI;
  - c. Subsequent re-authorizations for all indications: Maintenance of  $\geq 5\%$  reduction in weight or BMI compared with baseline;
4. Request is for setmelanotide
5. If request is for a dose increase, new dose does not exceed 3 mg per day.

**Approval duration:** up to 6 months

### B. Weight Management (must meet all):

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);
2. One of the following (a or b):
  - a. Age <21 years;
  - b. Member has Young Adults with Special Health Care Needs (YSHCN) coverage and was born in or after the year 2004;
3. Member has lost at least 1% of BMI from baseline or maintained at least a 1% BMI weight loss;
4. Member is actively engaged in a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet);
5. Member has been adherent to therapy based on provider attestation;
6. If request is for a dose increase, new dose does not exceed the FDA-approved maximum recommended dose.

**Approval duration:** up to 6 months

**C. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the PDL the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the PDL the non-formulary policy for the relevant line of business: OR.CP.PMN.1001 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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.PMN.53 for Medicaid or evidence of coverage documents.
- B. Use of medications for the treatment of weight loss in adults (age  $\geq 21$  years of age) is a benefit exclusion under the Oregon Health Plan.

**IV. Appendices/General Information:**

*Appendix A: Abbreviation/Acronym Key*

- |                                                  |                                                      |
|--------------------------------------------------|------------------------------------------------------|
| BBS: Bardet-Biedl syndrome                       | LEPR: leptin receptor                                |
| BMI: body mass index                             | PAD: peripheral arterial disease                     |
| CVD: cardiovascular disease                      | PCSK1: proprotein convertase subtilisin/kexin type 1 |
| FDA: Food and Drug Administration                | POMC: pro-opiomelanocortin                           |
| GIP: glucose-dependent insulintropic polypeptide | VUS: variant of uncertain significance               |
| GLP-1: glucagon-like peptide-1                   |                                                      |

*Appendix B: General Information:*

- Body mass index calculator: <https://globalrph.com/medcalcs/body-mass-index-bmi/>
- BMI Cutoffs for Obesity by Sex and Age for Pediatric Patients Aged 12 Years and Older (CDC Criteria):

| Age (in years) | 95 <sup>th</sup> Percentile BMI Value |        |
|----------------|---------------------------------------|--------|
|                | Male                                  | Female |
| 12             | 24.2                                  | 25.3   |
| 12.5           | 24.7                                  | 25.8   |
| 13             | 25.2                                  | 26.3   |
| 13.5           | 25.6                                  | 26.8   |
| 14             | 26.0                                  | 27.3   |
| 14.5           | 26.5                                  | 27.7   |
| 15             | 26.8                                  | 28.1   |
| 15.5           | 27.2                                  | 28.5   |
| 16             | 27.6                                  | 28.9   |
| 16.5           | 27.9                                  | 29.3   |

|      | 95 <sup>th</sup> Percentile BMI Value |      |
|------|---------------------------------------|------|
| 17   | 28.3                                  | 29.6 |
| 17.5 | 28.6                                  | 30.0 |

- Examples of coronary artery/heart disease include: coronary artery bypass graft, angina, history of myocardial infarction or stroke.
- A clinical diagnosis of BBS is confirmed using Beales criteria. There must be presence of at least 4 primary features, OR 3 primary and 2 secondary features:
  - Primary features: rod-cone dystrophy, polydactyly, obesity, learning disabilities, hypogonadism in males, renal anomalies
  - Secondary features: speech disorder/delay, strabismus/cataracts/astigmatism, brachydactyly/syndactyly, developmental delay, polyuria/polydipsia (nephrogenic diabetes insipidus), ataxia/poor coordination/imbalance, mild spasticity (especially lower limbs), diabetes mellitus, dental crowding/hypodontia/small roots/high arched palate, left ventricular hypertrophy/congenital heart disease, hepatic fibrosis

*Appendix C: Contraindications/Boxed Warnings*

| Drug Name                       | Contraindication(s)                                                                                                                                                                                                                                                                                                                                                    | Boxed warning(s)                                                                                                                                                                                                                                                                                              |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Liraglutide (Saxenda)           | Personal or family history of medullary thyroid carcinoma (MTC) or with multiple endocrine neoplasia syndrome type 2 (MEN 2), pregnancy, patients with a prior hypersensitivity reaction to liraglutide or to any of the excipients in Saxenda.                                                                                                                        | Risk of thyroid C-cell tumors                                                                                                                                                                                                                                                                                 |
| Naltrexone/bupropion (Contrave) | Uncontrolled hypertension, seizure disorder, concomitant use or use within 14 days of a monoamine oxidase inhibitor, chronic opioid use, use of other bupropion-containing products, bulimia or anorexia nervosa, abrupt discontinuation of alcohol, benzodiazepines, barbiturates, or antiepileptic drugs, and hypersensitivity to any of the ingredients in Contrave | Increased risk of suicidal thinking and behavior in children, adolescents, and young adults taking antidepressants for major depressive disorder and other psychiatric disorders. Monitor for worsening and emergence of suicidal thoughts and behaviors. Contrave has not been studied in pediatric patients |
| Phentermine/topiramate (Qsymia) | Pregnancy; glaucoma; hyperthyroidism; use during or within 14 days of taking monoamine oxidase inhibitors; known hypersensitivity to phentermine, topiramate, or other components of Qsymia or idiosyncrasy to the sympathomimetic amines                                                                                                                              | None reported                                                                                                                                                                                                                                                                                                 |
| Semaglutide (Wegovy)            | Personal or family history of medullary thyroid carcinoma (MTC) or with multiple endocrine neoplasia syndrome type 2 (MEN 2), known hypersensitivity                                                                                                                                                                                                                   | Risk of thyroid C-cell tumors                                                                                                                                                                                                                                                                                 |

| Drug Name                | Contraindication(s)                                                                                                                                                                                                             | Boxed warning(s)              |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
|                          | reaction to semaglutide or to any of the excipients in Wegovy                                                                                                                                                                   |                               |
| Setmelanotide (Imcivree) | None reported                                                                                                                                                                                                                   | None reported                 |
| Tirzepatide (Zepbound)   | Personal or family history of medullary thyroid carcinoma (MTC) or in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2), known serious hypersensitivity to tirzepatide or to any of the excipients in Zepbound | Risk of thyroid C-cell tumors |

*Appendix D: Drugs FDA Approved for Weight Management*

| Drug Name                       | Adults | Pediatrics               |
|---------------------------------|--------|--------------------------|
| Liraglutide (Saxenda)           | Yes    | Yes – 12 years and older |
| Naltrexone/bupropion (Contrave) | Yes    | No                       |
| Phentermine/topiramate (Qsymia) | Yes    | Yes – 12 years and older |
| Semaglutide (Wegovy)            | Yes    | Yes – 12 years and older |
| Setmelanotide (Imcivree)        | Yes    | Yes – 6 years and older  |
| Tirzepatide (Zepbound)          | Yes    | No                       |

*Appendix E: Dosage and Administration*

| Drug Name                       | Dosing Regimen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Dose Limit/ Maximum Dose |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Bupropion/naltrexone (Contrave) | <p><b>Weight management</b></p> <ul style="list-style-type: none"> <li>Week 1: One tablet PO QAM</li> <li>Week 2: One tablet PO BID</li> <li>Week 3: Two tablets PO QAM and 1 tablet PO QPM</li> <li>Week 4 and onward: 2 tablets PO BID</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 32/360 mg/day            |
| Liraglutide (Saxenda)           | <p><b>Weight management</b></p> <ul style="list-style-type: none"> <li>Week 1: 0.6 mg SC QD</li> <li>Week 2: 1.2 mg SC QD</li> <li>Week 3: 1.8 mg SC QD</li> <li>Week 4: 2.4 mg SC QD</li> <li>Week 5 and onward: 3 mg SC QD</li> </ul> <p><b>Adult patients:</b> If patients do not tolerate an increased dose during dose escalation, consider delaying dose escalation for approximately one additional week. Discontinue Saxenda if the patient cannot tolerate the 3 mg dose.</p> <p><b>Pediatric patients:</b> Dose escalation for pediatric patients may take up to 8 weeks. Pediatric patients who do not tolerate 3 mg daily may have their dose reduced to 2.4 mg daily. Discontinue Saxenda if the patient cannot tolerate the 2.4 mg dose.</p> | 3 mg/day                 |

| Drug Name                       | Dosing Regimen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Dose Limit/<br>Maximum Dose |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Phentermine/topiramate (Qsymia) | <p><b>Weight management</b><br/>3.75 mg/23 mg PO QD for 14 days; then increase to 7.5 mg/46 mg PO QD for up to 12 weeks total; do not exceed 7.5 mg/46 mg dose for patients with moderate or severe renal impairment or patients with moderate hepatic impairment.</p> <ul style="list-style-type: none"> <li>After 12 weeks of treatment with Qsymia 7.5 mg/46 mg, evaluate weight loss for adults or BMI reduction for pediatric patients aged 12 years and older. If an adult patient has not lost at least 3% of baseline body weight or a pediatric patient has not experienced a reduction of at least 3% of baseline BMI, increase to 11.25 mg/69 mg PO QD for 14 days, followed by 15 mg/92 mg PO QD. If patient has not lost at least 5% of baseline body weight on Qsymia 15 mg/92 mg, discontinue Qsymia, as it is unlikely that the patient will achieve and sustain clinically meaningful weight loss with continued treatment.</li> <li>Monitor the rate of weight loss in pediatric patients. If weight loss exceeds 2 lbs (0.9 kg)/week, consider dosage reduction.</li> </ul> | 15 mg/92 mg/day             |
| Semaglutide (Wegovy)            | <p><b>Weight management</b></p> <ul style="list-style-type: none"> <li>Week 1-4: 0.25 mg SC QW</li> <li>Week 5-8: 0.5 mg SC QW</li> <li>Week 9-12: 1 mg SC QW</li> <li>Week 13-16: 1.7 mg SC QW</li> <li>Week 17 and onward: 2.4 mg SC QW</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2.4 mg/week                 |
| Setmelanotide (Imcivree)        | <p><b>Obesity due to POMC, PCSK1, or LEPR deficiency or due to BBS</b></p> <ul style="list-style-type: none"> <li>≥ 12 years and older: 2 mg SC once daily for 2 weeks; if tolerated, titrate up to 3 mg SC once daily</li> <li>Age 6 to 12 years: 1 mg SC once daily for 2 weeks; if tolerated, titrate up to 3 mg SC once daily</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3 mg/day                    |
| Tirzepatide (Zepbound)          | <p><b>Weight management</b><br/>The recommended starting dosage is 2.5 mg SC once weekly. The 2.5 mg dosage is for treatment initiation and is not intended for chronic weight management.</p> <ul style="list-style-type: none"> <li>After 4 weeks, increase the dosage to 5 mg SC once weekly.</li> <li>The dosage may be increased in 2.5 mg increments, after at least 4 weeks on the</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 15 mg/week                  |



| Drug Name | Dosing Regimen                                                                                                                                                                                                                                                         | Dose Limit/<br>Maximum Dose |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|           | current dose. The recommended maintenance dosages are 5 mg, 10 mg, or 15 mg SC once weekly. Consider treatment response and tolerability when selecting the maintenance dosage. If patients do not tolerate a maintenance dosage, consider a lower maintenance dosage. |                             |

**Appendix F: Product Availability:**

| Medication                      | Formulation and Strength                                                            |
|---------------------------------|-------------------------------------------------------------------------------------|
| Bupropion/naltrexone (Contrave) | Extended-release tablet: 8 mg naltrexone/90 mg bupropion                            |
| Liraglutide (Saxenda)           | Pre-filled, multi-dose pen: 0.6 mg, 1.2 mg, 1.8 mg, 2.4 mg, or 3 mg (6 mg/mL, 3 mL) |
| Phentermine/topiramate (Qsymia) | Capsules: 3.75 mg/23 mg, 7.5 mg/46 mg, 11.25 mg/69 mg, 15 mg/92 mg                  |
| Semaglutide (Wegovy)            | Pre-filled, single-dose pens: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg                 |
| Setmelanotide (Imcivree)        | Vial: 10 mg/mL (1 mL multi-dose)                                                    |
| Tirzepatide (Zepbound)          | Pre-filled, single-dose pens: 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg           |
|                                 | Pre-filled, single-dose vials: 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg          |

**V. References**

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| Reviews, Revisions, and Approvals                                                                                       | Date     | Plan Approval Date |
|-------------------------------------------------------------------------------------------------------------------------|----------|--------------------|
| Policy created; adapted from FFS policy Weight Management Drugs for Youth approved at the April 2024 State P&T meeting. | 04.24.24 | 05.9.24            |
| Added standard YSHCN language to initial and continued therapy coverage criteria for new 2025 OHP program coverage.     | 10.16.24 | 11.19.24           |

**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.

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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.

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