Clinical Policy: Luspatercept-aamt (Reblozyl)

Reference Number: CP.PHAR.450
Effective Date: 03.01.20
Last Review Date: 02.26
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Luspatercept-aamt (Reblozyl®) is an erythroid maturation agent.

FDA Approved Indication(s)

Reblozyl is indicated for the treatment of anemia in adult patients with:

- Beta thalassemia who require regular red blood cell (RBC) transfusions
- Very low- to intermediate-risk myelodysplastic syndromes (MDS) who may require regular red blood cell (RBC) transfusions without previous erythropoiesis stimulating agent use (ESA-naïve)
- Very low- to intermediate-risk myelodysplastic syndromes with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) failing an erythropoiesis stimulating agent and requiring 2 or more RBC units over 8 weeks

Limitation(s) of use: Not indicated for use as a substitute for RBC transfusions in patients who require immediate correction of anemia.

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

I. Initial Approval Criteria

A. Transfusion Dependent Beta Thalassemia (must meet all)**:**

1. Diagnosis of transfusion-dependent thalassemia (TDT) with one of the following genotypes (a or b):
   a. Beta thalassemia;
   b. Hemoglobin E/beta thalassemia;
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 18 years;
4. Total volume of transfusions exceeds 6 RBC units (*see Appendix D*) within the last 6 months;
5. No transfusion-free period ≥ 35 days within the last 6 months;
6. Documentation of baseline transfusion burden within the last 6 months;
7. Dose does not exceed 1 mg/kg every 3 weeks.

Approval duration: 2 months (2 doses)

B. Myelodysplastic Syndromes (must meet all)**:**
1. Diagnosis of one of the following (a or b):
   a. MDS that is very low, low, or intermediate-1 risk as classified by IPSS-R;
   b. MDS-RS or MDS/MPN-RS-T that meets one of the following classifications (i, ii, or iii) (*see Appendix E*):
      i. Very low, low, or intermediate risk as classified by IPSS-R;
      ii. Low/intermediate-1 risk as classified by IPSS;
      iii. Very low, low, or intermediate risk as classified by WPSS;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age ≥ 18 years;
4. Member is dependent on RBC transfusions;
5. If member has MDS with ring sideroblasts < 15% (or ring sideroblasts < 5% with SF3B1 mutation), documentation of current serum erythropoietin ≤ 500 mU/mL and one of the following (a, b, or c):^
   ^For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Documentation of current serum erythropoietin > 200 mU/mL;
   b. One of the following (i or ii):
      i. Failure of Retacrit™, unless contraindicated or clinically significant adverse effects are experienced;*
      ii. If Retacrit is unavailable due to shortage, member must use Epogen®, unless contraindicated or clinically significant adverse effects are experienced;*
      **Prior authorization may be required for Retacrit and Epogen*
   c. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings (*see Appendix F*);
6. Member does not have del(5q) cytogenetic abnormality;
7. Reblozyl is not prescribed concurrently with Rytelo™;
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 1 mg/kg every 3 weeks;
   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: 2 months (2 doses)

C. Myelofibrosis-Associated Anemia (off-label) (must meet all):
1. Diagnosis of myelofibrosis-associated anemia;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Prescribed in one of the following ways (a or b):
   a. As monotherapy;
   b. In combination with Jakafi® if member has symptomatic splenomegaly and/or constitutional symptoms (e.g., fatigue, night sweats, fever, weight loss);
4. Dose is within FDA maximum limit for any FDA-approved indication or 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 – 6 months or to the member's renewal date, whichever is longer

D. 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 formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Transfusion Dependent Beta Thalassemia (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. Member meets one of the following (a or b):
   a. For members who have received > 9 weeks of treatment (> 3 doses): Member is responding positively to therapy as evidenced by at least a 33% reduction in transfusion burden from baseline;
   b. Request is for a dose increase and member has not yet received 9 weeks of treatment (3 doses) at the maximum dose of 1.25 mg/kg;
3. If request is for a dose increase, new dose does not exceed (a or b):
   a. 1 mg/kg every 3 weeks;
   b. 1.25 mg/kg every 3 weeks, and documentation supports inadequate response to 1 mg/kg dosing.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Myelodysplastic Syndromes (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Reblozyl for a covered indication and has received this medication for at least 30 days;
2. Member meets one of the following (a or b):
   a. Member is responding positively to therapy as evidenced by a decreased transfusion burden;
   b. Request is for a dose increase;
3. Reblozyl is not prescribed concurrently with Rytelo;
4. If request is for a dose increase, request meets one of the following (a, b, c, or d):*
   a. New dose does not exceed 1 mg/kg every 3 weeks;
   b. New dose does not exceed 1.33 mg/kg every 3 weeks, and documentation supports lack of transfusion independence after 2 consecutive doses at 1 mg/kg dosing;
   c. New dose does not exceed 1.75 mg/kg every 3 weeks, and documentation supports lack of transfusion independence after 2 consecutive doses at 1.33 mg/kg dosing;
   d. 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:
For a dose increase: 2 months [2 doses]
All other requests:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Myelofibrosis-Associated Anemia (off-label) (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Reblozyl for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication or 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 – 6 months or to the member's renewal date, whichever is longer

D. 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 formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 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.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

ESA: erythropoiesis-stimulating agent
FDA: Food and Drug Administration
G-CSF: granulocyte colony stimulating factor
Hb: hemoglobin
IPSS: International Prognostic Scoring System
IPSS-R: International Prognostic Scoring System - Revised
MDS: myelodysplastic syndromes
MDS-RS: myelodysplastic syndromes with ring sideroblasts
MDS/MPN-RS-T: myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis
TDT: transfusion dependent thalassemia
WPSS: WHO Classification-based Scoring System

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
Procrit®, Epogen®, Retacrit® (epoetin alfa)*	**MDS** 40,000 to 60,000 units SC 1 to 2 times per week every week	Target hemoglobin up to 12 g/dL
Aranesp® (darbepoetin alfa)*	**MDS** 150 to 300 mcg SC every other week	Target hemoglobin up to 12 g/dL

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

None reported

Appendix D: General Information

- Conversion of RBC units from mL: 1 RBC unit in this criteria refers to a quantity of packed RBCs approximately 200-350 mL.
  - For sites who use transfusion bags within this range, or ≥ 350 mL, the conversion in units should be done by dividing the volume transfused to the patient by 350 mL,
  - For sites who use transfusion bags < 200 mL, the conversion in units should be done by dividing the volume transfused to the patient by 200 mL.
- MDS/MPN-RS-T indication
  - During regulatory review of the MEDALIST data by the FDA, a post-hoc re-classification of patients using the WHO 2016 criteria was conducted to assess the efficacy and safety of Reblozyl in patients with MDS/MPN-RS-T. Among the 229 patients enrolled in MEDALIST, 23 patients were found to have a diagnosis of MDS/MPN-RS-T following this re-classification. In these patients with MDS/MPN-RS-T, a greater proportion of patients treated with Reblozyl (64.3%; n = 9/14) achieved the primary endpoint of transfusion independence for at least 8 weeks during weeks 1-24 compared to placebo (22.2%; n = 2/9).
- MDS COMMANDS trial subgroup analysis
  - The primary outcome of red blood cell transfusion independence for 12 weeks with a mean hemoglobin increase ≥ 1.5 g/dL was seen in 60% of the Reblozyl group and 35% of the epoetin alfa group. The primary outcome was seen more often in MDS patients with positive ring sideroblasts treated with Reblozyl compared to ESA (70% met in the Reblozyl group compared to 33% met in the ESA group in SF3B1 positive patients, and 45% met in the Reblozyl group compared to 36% met in the ESA group with SF3B1 negative patients). There was negligible difference seen (i.e., similar treatment benefit) between Reblozyl and ESA use in patients with negative ring sideroblasts — the difference was 47% vs 50%, respectively.
- NCCN guidelines for MDS
  - Current NCCN guidelines for MDS (version 1.2026) recommend luspatercept as first-line therapy for MDS with ring sideroblasts ≥ 15% (or ring sideroblasts ≥ 5% with an SF3B1 mutation). For MDS with ring sideroblasts < 15% (or ring sideroblasts < 5% with SF3B1 mutation), NCCN recommends epoetin alfa, darbepoetin alfa and luspatercept, all as category 2A recommendations; however, NCCN recommends luspatercept as preferred for patients with a serum erythropoietin > 200 mU/mL.

Appendix E: MDS Risk Classification

- International Prognostic Scoring System - Revised (IPSS-R) classification:

Risk Category	Risk Score
Very low	≤ 1.5
Low	< 1.5 – 3
Intermediate	< 3 – 4.5
High	< 4.5 – 6
Very high	> 6

- International Prognostic Scoring System (IPSS) classification:

Risk Category	Risk Score
Low	0
Intermediate-1	0.5 – 1

Risk Category	Risk Score
Intermediate-2	1.5 – 2
High	2.5 – 3.5

- WHO Classification-based Prognostic Scoring System (WPSS) classification:

Risk Category	Risk Score
Very low	0
Low	1
Intermediate	2
High	3 – 4
Very high	5 – 6

Appendix F: States with Regulations against Redirections in Cancer

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA
LA	Yes≠	For stage 4 advanced, metastatic cancer or associated conditions. ≠Exception if clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy
MS	Yes	**Applies to HIM requests only** For advanced metastatic cancer and associated conditions
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
OH	Yes	**Applies to Commercial and HIM requests only** For stage 4 metastatic cancer and associated conditions
OK	Yes	**Applies to HIM requests only** For advanced metastatic cancer and associated conditions
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes^	For stage 4 advanced metastatic cancer, metastatic blood cancer, and associated conditions ^Exception if step therapy is for AB-rated generic equivalent, interchangeable biological product, or biosimilar product to the equivalent brand drug
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
TDT	1 mg/kg SC once every 3 weeks If a patient does not achieve a reduction in RBC transfusion burden after at least 2 consecutive doses (6	1.25 mg/kg

Indication	Dosing Regimen	Maximum Dose
	weeks) at the 1 mg/kg starting dose, increase to max dose of 1.25 mg/kg. If a patient does not achieve a reduction in RBC transfusion burden after 3 consecutive doses (9 weeks) at 1.25 mg/kg, discontinue treatment.	
MDS	Initial: 1 mg/kg SC once every 3 weeks Dose increases for insufficient response after initiation of treatment: If a patient is not RBC transfusion-free after at least 2 consecutive doses (6 weeks) at the 1 mg/kg starting dose, increase the dose to 1.33 mg/kg SC every 3 weeks. If a patient is not RBC transfusion-free after at least 2 consecutive doses (6 weeks) at the 1.33 mg /kg dose level, increase the dose to a maximum of 1.75 mg/kg SC every 3 weeks. Discontinue if a patient does not experience a decrease in transfusion burden after 9 weeks of treatment (administration of 3 doses) at 1.75 mg/kg	1.75 mg/kg

VI. Product Availability

Single dose vials for injection: 25 mg, 75 mg

VII. References

1. Reblozyl Prescribing Information. Cambridge, MA: Acceleron Pharma, Inc. May 2024. Available at: www.reblozyl.com. Accessed October 21, 2025.
2. Della Porta MG, Garcia-Manero G, Santini V, et al. Luspatercept versus epoetin alfa in erythropoiesis-stimulating agent-naive, transfusion-dependent, lower-risk myelodysplastic syndromes (COMMANDS): primary analysis of a phase 3, open-label, randomised, controlled trial. *Lancet Haematol*. 2024;11(9):e646-e658.
3. Cappellini MD, Vipralasit V, Taher A, et al. The BELIEVE Trial: Results of a phase 3, randomized, double-blind, placebo-controlled study of luspatercept in adult beta-thalassemia patients who require regular red blood cell (RBC) transfusions [Oral]. Oral presented at: 60th American Society of Hematology Annual Meeting and Exposition (ASH); December 1-4, 2018; San Diego, CA.
4. Taher AT, Farmakis D, Porter JB, et al. Guidelines for the management of transfusion-dependent β-thalassaemia (TDT) 5th ed. Thalassaemia International Federation (2025). Available at: https://thalassaemia.org.cy/publications/tif-publications/guidelines-for-the-management-of-transfusion-dependent-%ce%b2-thalassaemia-5th-edition-2025/. Accessed November 25, 2025.

5. Fenaux P, Platzbecker U, Mufti GJ, et al. Luspatercept in patients with lower-risk myelodysplastic syndromes. *N Engl J Med*. 2020;382:140-151.
6. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 26, 2025.
7. National Comprehensive Cancer Network. Myelodysplastic Syndromes Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf. Accessed November 26, 2025.
8. Patnaik MM, Tefferi A. Refractory anemia with ring sideroblasts (RARS) and RARS with thrombocytosis (RARS-T) – "2019 Update on Diagnosis, Risk-stratification, and Management." *Am J Hematol.* 2019;94(4): 475–488.
9. Reblozyl Data on File. Use of Reblozyl (luspatercept-aamt) in patients with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis. Bristol Meyers Squibb. 2020 May.

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).

ICD-10-CM Code	Description
D56.1*	Beta thalassemia

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

HCPCS Codes	Description
J0896	Injection, luspatercept-aamt, 0.25 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	11.15.21	02.22
Template changes applied to other diagnoses/indications.	09.27.22	
1Q 2023 annual review: for TDT continued therapy, clarified criterion that positive response to therapy as evidenced by at least a 33% reduction in transfusion burden from baseline is required after 9 weeks of treatment (3 doses) at the maximum dose unless the request is for a dose increase prior to 9 weeks of treatment; per NCCN Compendium, removed requirement for combination w/G-CSF for MDS indication; references reviewed and updated.	11.02.22	02.23
RT4: added new indication for MDS treatment in ESA naïve patients; removed MDS transfusion requirement for ≥ 2 RBC units per 8 weeks; revised ESA redirection to apply only to MDS with ring	10.24.23	11.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
sideroblasts < 15% (or ring sideroblasts < 5% with SFB3B1 mutation) per NCCN.		
1Q 2024 annual review: no significant changes; references reviewed and updated.	11.04.23	02.24
For MDS, revised criterion MDS with ring sideroblasts < 15% (or ring sideroblasts < 5% with SFB3B1 mutation) from "failure of ESA agent unless contraindicated or documentation of current erythropoietin > 500 mU/mL" to "one of the following: response to or ineligible for ESA therapy OR both of the following: documentation of current serum erythropoietin ≤ 500 mU/mL AND failure of Retacrit or if Retacrit is unavailable due to shortage, member must use Epogen" to direct to our preferred ESA agents; for MDS initial approval criteria, added "MDS that is very low, low, or intermediate-1 risk as classified by IPSS-R" as an option under diagnosis; for MDS initial and continued therapy criteria, added "Reblozyl is not prescribed concurrently with Rytelo."	08.08.24	
1Q 2025 annual review: for MDS, removed requirement for ineligibility, inadequate response, or failure of an ESA for serum erythropoietin ≤ 500 mU/mL per NCCN; added criteria for myelofibrosis-associated anemia per NCCN Compendium; references reviewed and updated.	11.24.24	02.25
1Q 2026 annual review: for MDS with ring sideroblasts < 15% scenario, added requirement for failure of Retacrit/Epogen unless serum erythropoietin > 200 mU/mL per NCCN and added oncology step bypass; added step therapy bypass for IL HIM per IL HB 5395; revised Medicaid/HIM initial approval duration for myelofibrosis-associated anemia and continued approval durations for TDT and MDS to 12 months; revised Commercial approval durations for myelofibrosis-associated anemia initial approval and all continued therapy indications to "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.	10.21.25	02.26

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.