# Clinical Policy: Everolimus (Afinitor, Afinitor Disperz, Zortress)

Reference Number: CP.PHAR.63
Effective Date: 06.01.11
Last Review Date: 02.19
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

Everolimus (Afinitor®, Afinitor Disperz®, Zortress®) is an mTOR kinase inhibitor.

**For Health Insurance Marketplace (HIM),* *Afinitor Disperz is non-formulary and cannot be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

## FDA Approved Indication(s)

| Indication | Afinitor | Afinitor Disperz | Zortress |
|---|---|---|---|
| *Labeled uses (and recommended NCCN uses by product as indicated)* | | | |
| Breast cancer | X - adults | X - adults per NCCN | --- |
| PNET (pancreas) | X - adults | X - adults per NCCN | --- |
| NET (GI, lung, thymic-*off-label*) | X - adults | X - adults per NCCN | --- |
| RCC | X - adults | X - adults per NCCN | --- |
| TSC-AML (renal) | X - adults | X - adults per NCCN | --- |
| TSC-SEGA | X - 1 year and older | X - 1 year and older | --- |
| TSC-seizures | --- | X - 2 years and older | --- |
| Prophylaxis of organ rejection | --- | --- | X - adults |
| *Recommended NCCN uses (adults)* | | | |
| Meningioma | X | X | --- |
| HL | X | X | --- |
| STS-GIST | X | X | --- |
| STS-PEComa, angiomyolipoma, lymphangioleiomyomatosis | X | X | --- |
| Thymoma/thymic carcinoma | X | X | --- |
| DTC | X | X | --- |
| WM/LPL | X | X | --- |
| Endometrial carcinoma | X | X | --- |

*Abbreviations: DTC (differentiated thyroid carcinoma), GI (gastrointestinal), HL (Hodgkin lymphoma), PNET (pancreatic neuroendocrine tumor), NET (neuroendocrine tumors), RCC (renal cell carcinoma), STS-GIST (soft tissue sarcoma-gastrointestinal stromal tumor), STS-PEComa (soft tissue sarcoma-perivascular epithelioid cell tumor), TSC-AML (tuberous sclerosis complex- angiomyolipoma), TSC-SEGA (tuberous sclerosis complex-subepndymal giant cell astrocytoma), TSC-seizures (tuberous sclerosis complex-seizures). WM/LPL (Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma)*

Afinitor is indicated for the treatment of:

- Adult patients with advanced renal cell carcinoma (RCC) after failure of treatment with sunitinib or sorafenib.

- Adult patients with progressive neuroendocrine tumors of pancreatic origin (PNET) and adults with progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin that are unresectable, locally advanced or metastatic.
- Limitation(s) of use: Afinitor is not indicated for the treatment of patients with functional carcinoid tumors.
- Adult patients with renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery.
- Postmenopausal women with advanced hormone receptor (HR)-positive, human epidermal growth factor receptor-2 (HER2)-negative breast cancer (advanced HR+ BC) in combination with exemestane after failure of treatment with letrozole or anastrozole.

Afinitor and Afinitor Disperz are indicated for the treatment of pediatric and adult patients with tuberous sclerosis complex (TSC) who have subependymal giant cell astrocytoma (SEGA) that requires therapeutic intervention but cannot be curatively resected.

Afinitor Disperz is indicated for the adjunctive treatment of adult and pediatric patients aged 2 years and older with TSC-associated partial-onset seizures.

Zortress is indicated for the prophylaxis of organ rejection in adult patients:
- Kidney transplant: at low-moderate immunologic risk. Use in combination with basiliximab, cyclosporine (reduced doses) and corticosteroids.
- Liver transplant: administer no earlier than 30 days post-transplant. Use in combination with tacrolimus (reduced doses) and corticosteroids.

  Limitation(s) of use: Safety and efficacy of Zortress have not been established in the following:
  - Kidney transplant patients at high immunologic risk
  - Recipients of transplanted organs other than kidney or liver
  - Pediatric patients (less than 18 years)

**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 Afinitor, Afinitor Disperz, and Zortress are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Breast Cancer** (must meet all)**:**

1. Diagnosis of recurrent or metastatic breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is HR-positive and HER2-negative;
5. Prior history of endocrine therapy (Appendix B) unless contraindicated or clinically significant adverse effects are experienced;
6. Prescribed in combination with exemestane, fulvestrant or tamoxifen;
7. Request is for Afinitor or Afinitor Disperz;
8. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg per day (1 tablet per day);

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**
**Medicaid –** 6 months
**HIM** – 6 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**B. Neuroendocrine Tumor** (must meet all)**:**
1. Diagnosis of NET of one of the following origins (a – d):
   a. Pancreatic;
   b. GI tract;
   c. Lung;
   d. Thymus (off-label);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is unresectable, locally advanced or metastatic;
5. Request is for Afinitor or Afinitor Disperz;
6. Request meets one of the following (a or b):
   c. Dose does not exceed 10 mg per day (1 tablet per day);
   d. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**
**Medicaid –** 6 months
**HIM** – 6 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**C. Renal Cell Carcinoma** (must meet all):
1. Diagnosis of relapsed or stage IV (unresectable or metastatic) RCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. If clear cell histology, failure of a prior therapy (Appendix B) unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required.*
5. Request is for Afinitor or Afinitor Disperz;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg per day (1 tablet per day);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**
**Medicaid –** 6 months
**HIM** – 6 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**D. Renal Angiomyolipoma with Tuberous Sclerosis Complex** (must meet all)**:**
1. Diagnosis of renal angiomyolipoma associated with TSC, not requiring immediate surgery;
2. Prescribed by or in consultation with an oncologist;

3. Age ≥ 18 years;
4. Request is for Afinitor or Afinitor Disperz;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg per day (1 tablet per day);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**
**Medicaid –** 6 months
**HIM** – 6 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**E. Tuberous Sclerosis Complex with Subependymal Giant Cell Astrocytoma** (must meet all)**:**

1. Diagnosis of SEGA associated with TSC;
2. Prescribed by or in consultation with an oncologist;
3. Member is not a candidate for curative surgical resection;
4. Request is for Afinitor or Afinitor Disperz;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg per day (1 tablet per day);
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**
**Medicaid –** 6 months
**HIM** – 6 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**F. Tuberous Sclerosis Complex-Associated Partial-Onset Seizures** (must meet all):

1. Diagnosis of partial-onset seizures associated with TSC;
2. Prescribed by or in consultation with an oncologist;
3. Request is for Afinitor Disperz.

**Approval duration:**
**Medicaid –** 6 months
**HIM** – *refer to HIM.PA.103*
**Commercial –** Length of Benefit

**G. Prophylaxis of Organ Rejection** (must meet all):

1. Member has received or is scheduled for a kidney or liver transplant;
2. Prescribed by or in consultation with a nephrologist, hepatologist, or transplant specialist;
3. Age ≥ 18 years;
4. For kidney transplant, failure of tacrolimus unless contraindicated or clinically significant adverse effects are experienced;
5. Request is for Zortress;
6. Prescribed in combination with one of the following (a or b):
   a. For kidney transplant: Simulect®, cyclosporine, and corticosteroids;
   b. For liver transplant: tacrolimus and corticosteroids.

**Approval duration: 6 months**

**H. NCCN Compendium Indications (off-label)** (must meet all)**:**
1. Diagnosis of one of the following (a, b, c, d, or e):
   a. Meningioma, HL, WM//LPL, thymoma, or thymic carcinoma (refractory, recurrent or progressive disease);
   b. PEComa, angiomyolipoma (recurrent), or lymphangioleiomyomatosis;
   c. Endometrial carcinoma (in combination with letrozole);
   d. Gastrointestinal stromal tumors (GIST) (in combination with imatinib, Sutent®, or Stivarga® for disease progression after single agent therapy with imatinib, Sutent, and Stivarga)*;
      **Prior authorization may be required.*
   e. DTC (i.e., follicular, Hurthle cell or papillary carcinoma; failure of Lenvima® or Nexavar® unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization may be required.*
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request is for Afinitor or Afinitor Disperz;
5. 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*).

**Approval duration:**
**Medicaid –** 6 months
**HIM** – 6 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**I. 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 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 Afinitor or Afinitor Disperz 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, request meets one of the following (a or b):
   a. New dose does not exceed 10 mg per day (1 tablet per day);
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration:**
**Medicaid –** 12 months
**HIM** – 12 months *(refer to HIM.PA.103 for Afinitor Disperz)*
**Commercial –** Length of Benefit

**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 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 and CP.PMN.53 for Medicaid or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

AML: angiomyolipoma
ER: estrogen receptor
DTC: differentiated thyroid cancer
FDA: Food and Drug Administration
GI: gastrointestinal
GIST: gastrointestinal stromal tumor
HER-2: human epidermal growth factor receptor-2
HL: Hodgkin lymphoma
HR: hormone receptor
NET: neuroendocrine tumor
PEComa: perivascular epithelioid cell tumor
PNET: pancreatic neuroendocrine tumor
RCC: renal cell carcinoma
SEGA: subepndymal giant cell astrocytoma
TSC: tuberous sclerosis complex
WM/LPL: Waldenstrom macroglobulinemia/lymphoplasmacytic 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 |
|---|---|---|
| *Breast Cancer: Examples of endocrine therapies per NCCN* | | |
| • Nonsteroidal aromatase inhibitors (anastrozole and letrozole);<br>• Steroidal aromatase inhibitors (exemestane)<br>• Serum estrogen receptor (ER) modulators (tamoxifen, toremifene)<br>• ER down-regulators (fulvestrant)<br>• Progestin (megestrol acetate)<br>• Androgens (fluoxymesterone)<br>• High-dose estrogen (ethinyl estradiol) | Varies | Varies |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| *RCC: Examples of first and second-line therapies for relapsed or stage IV disease per NCCN* | | |
| • Votrient® (pazopanib)<br>• Sutent® (sunitinib)<br>• Opdivo® (nivolumab) ± Yervoy® (iplimumab)<br>Avastin® (bevacizumab) ± (Intron A (interferon alfa-2b), Tarceva (erlotinib) or Afinitor/Afinitor Disperz (everolimus))<br>• Proleukin® (aldesleukin)<br>• Cabometyx® (cabozantinib)<br>• Torisel® (temsirolimus)<br>• Inlyta® (axitinib)<br>• Afinitor/Afinitor Disperz (everolimus) ± Lenvima (lenvatinib)<br>• Nexavar (sorafenib)<br>• Tarceva® (erlotinib) | Varies | Varies |
| *GIST* | | |
| imatinib (Gleevec®) | 400 mg PO QD or BID | 800 mg/day |
| Sutent (sunitinib) | 50 mg PO QD | 50 mg/day |
| Stivarga (regorafenib) | 160 mg PO QD | 160 mg/day |
| *DTC* | | |
| Lenvima (lenvatinib) | 24 mg PO QD | 24 mg/day |
| Nexavar (sorafenib) | 400 mg PO QD | 400 mg/day |

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

*Appendix C: Contraindications/Boxed Warnings*

- Afinitor and Afinitor Disperz are contraindicated in patients with clinically significant hypersensitivity to everolimus or to other rapamycin derivatives.
- Zortress is contraindicated in patients with known hypersensitivity to everolimus, sirolimus, or to components of the drug product.
- Boxed warning(s) for Zortress: malignancies and serious infections, kidney graft thrombosis, nephrotoxicitym and mortality in heart transplantation.

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Breast cancer, PNET (pancreas), NET (GI, lung), RCC, TSC-AML (renal) | Afinitor<br>10 mg PO QD | 20 mg/day |
| TSA-SEGA | Afinitor/Afinitor Disperz | |

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| | 4.5 mg/m$^2$ PO QD; adjust dose to attain trough concentrations of 5-15 ng/mL | Based on trough concentrations |
| TSC-associated partial-onset seizures | Afinitor Disperz<br>5 mg/m$^2$ PO QD; adjust dose to attain trough concentrations of 5-15 ng/mL | |
| Kidney transplant rejection prophylaxis | Zortress<br>0.75 mg PO BID; adjust dose to attain trough concentrations of 3 to 8 ng/mL | |
| Liver transplant rejection prophylaxis | Zortress<br>1 mg PO BID; adjust dose to attain trough concentrations of 3 to 8 ng/mL | |

## VI. Product Availability

| Drug Name | Availability |
|---|---|
| Everolimus (Afinitor) | Tablets: 2.5 mg, 5 mg, 7.5 mg and 10 mg |
| Everolimus (Afinitor Disperz) | Tablets for oral suspension: 2 mg, 3 mg, 5 mg |
| Everolimus (Zortress) | Tablets: 0.25 mg, 0.5 mg, 0.75 mg, 1 mg |

## VII. References

1. Afinitor Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2018. Available at: https://www.pharma.us.novartis.com/files/afinitor.pdf. Accessed October 23, 2018.
2. Zortress Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation;August 2018. Available at: https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/zortress.pdf. AccessedMarch 14, 2019.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed October 23, 2018.
4. National Comprehensive Cancer Network. Kidney Cancer Version 2.2019. Available at: http://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed October 23, 2018.
5. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors Version 3.2018. Available at: http://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed October 23, 2018.
6. National Comprehensive Cancer Network. Breast Cancer Version 2.2018. Available at: http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed October 23, 2018.
7. Kidney Disease Improving Global Outcomes. KDIGO clinical practice guideline for the care of kidney transplant recipients. American Journal of Transplantation 2009; 9 (Suppl 3): Si-S155. doi: 10.1111/j.1600-6143.2009.02834.x
8. Bia M, Adey DB, Bloon RD, Chan L, Kulkarni S, and Tomlanovich S. KDOQI US Commentary on the 2009 KDIGO clinical practice guideline for the care of kidney transplant recipients. Am J Kidneys Dis 2010;56:189-218.

9. Lucey MR, Terrault N, Ojo L, et al. Long-term management of the successful adult liver transplant: 2012 practice guideline by the American Association for the Study of Liver Diseases and the American Society of Transplantation. Liver Transplantation 2013;19:3-26.

**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 |
|---|---|
| J7527 | Everolimus, oral, 0.25mg |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Added efficacy data; corrected algorithm to match FDA indication for MBC, PNET, and SEGA. Removed Votrient from RCC failure question. | 06.14 | 07.14 |
| Edited FDA indications<br>Edited algorithm to include both Afinitor and Afinitor Disperz, and the pediatric population for SEGA. Also changed initial approval periods from 6 months to 3 months for initial auths.<br>Edited background & safety | 05.15 | 05.15 |
| Policy converted to new template;<br>Added maximum dose and contraindications per PI;<br>For breast cancer: added definition for advanced breast cancer; added that Afinitor may be used in after previous treatment with tamoxifen to comply with NCCN recommendation for use;<br>For RCC, added definition for advanced RCC<br>References updated | 04.16 | 05.16 |
| NCCN and FDA uses separated in criteria sets; dosing removed if NCCN uses added. NET: "Non-functional" designation removed for NET of GI and lung origin; the term "locally advanced" is incorporated into recurrent, unresectable or metastatic. RCC: The term "advanced" RCC is restated as recurrent, unresectable or metastatic. The term "unless contraindicated" is removed from "failed sunitinib or sorafenib treatment." Safety information removed. Approval durations lengthened to 6 and 12 months. | 04.17 | 05.17 |
| Added thyroid carcinoma as an NCCN compendium supported use. | 06.14.17 | 11.17 |
| 1Q18 annual review: Combined Medicaid and Commercial policies; removed dose form requirement by indication, no clinical difference expected (dosing is equivalent for SEGA indication); for RCC, included list of first line therapies per NCCN guidelines; for breast cancer, removed compendium supported use after tamoxifen as this was removed from the 1.2017 NCCN guideline update; added the | 11.09.17 | 02.18 |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| following off-label NCCN compendium supported uses: GIST, lymphoplasmacytic lymphoma, osteosarcoma, endometrial carcinoma; references reviewed and updated. | | |
| Criteria added for new FDA indication: TSC-associated partial-onset seizures; references reviewed and updated. | 05.22.18 | 08.18 |
| Zortress added to the policy; added HIM line of business; added that requested agent is for each FDA-approved agent for that indication; references reviewed and updated. | 09.04.18 | 11.18 |
| 1Q 2019 annual review; age added for oncology indications; breast cancer - prior therapy changed from aromatase inhibitor to endocrine therapy and combination therapy expanded to include fulvestrant or tamoxifen per NCCN; RCC prior therapy broadened to encompass NCCN listed therapies; TSC-seizures limited to Afinitor Disperz per label; section G off-label uses - meningioma added, osteosarcoma removed, prior therapy added for DTC per NCCN; references reviewed and updated. | 11.13.18 | 02.19 |
| RT4: added new dosage form of Zortress 1 mg. | 06.21.19 | |

**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.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.