Clinical Policy: Goserelin Acetate (Zoladex)

Reference Number: CP.PHAR.171
Effective Date: 10.01.16
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

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

Description

Goserelin acetate (Zoladex®) is a gonadotropin-releasing hormone (GnRH) receptor agonist.

FDA Approved Indication(s)

Zoladex 3.6 and 10.8 are indicated for the treatment of prostatic carcinoma:

- In combination with flutamide for the management of locally confined Stage T2b-T4 (Stage B2-C) carcinoma. Treatment should start 8 weeks prior to initiating radiation therapy and continue during radiation therapy
- As palliative treatment of advanced carcinoma

Zoladex 3.6 is indicated:

- For the management of endometriosis, including pain relief and reduction of endometriotic lesions for the duration of therapy
- As an endometrial-thinning agent prior to endometrial ablation for dysfunctional uterine bleeding
- For the palliative treatment of advanced breast cancer in pre- and perimenopausal women

Limitation(s) of use: Experience with Zoladex for the management of endometriosis has been limited to women 18 years of age and older treated for 6 months.

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

I. Initial Approval Criteria

A. Prostate Cancer (must meet all):

1. Diagnosis of prostate cancer;
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.6 mg per month and/or 10.8 mg per 3 months;
   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: 12 months

B. Breast Cancer (must meet all):
1. Diagnosis of breast cancer;
2. Request is for Zoladex 3.6 mg;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.6 mg per month;
   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: 12 months

C. Endometriosis (must meet all):
1. Diagnosis of endometriosis;
2. Request is for Zoladex 3.6 mg;
3. Prescribed by or in consultation with a gynecologist;
4. Age ≥ 18 years;
5. Endometriosis as a cause of pain is one of the following (a or b):
   a. Surgically confirmed;
   b. Both of the following (i and ii):
      i. Clinically suspected;
      ii. Failure of a 3-month trial of one of the following within the last year, unless clinically adverse effects are experienced or all are contraindicated (1, 2, or 3):*

      **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

         1) A nonsteroidal anti-inflammatory drug *(see Appendix B for examples)*;
         2) An oral or injectable depot contraceptive *(see Appendix B for examples)*;
         3) A progestin *(see Appendix B for examples)*;
6. For members currently receiving treatment with goserelin, total duration of therapy has not exceeded 6 months;
7. Dose does not exceed 3.6 mg per month.

Approval duration: 6 months

D. Dysfunctional Uterine Bleeding (must meet all):
1. Diagnosis of dysfunctional uterine bleeding;
2. Request is for Zoladex 3.6 mg;
3. Prescribed by or in consultation with a gynecologist;
4. Age ≥ 18 years;
5. Prescribed as an endometrial-thinning agent prior to endometrial ablation;
6. For members currently receiving treatment with goserelin, member has not yet received two implants;
7. Dose does not exceed 3.6 mg per month.

Approval duration: 8 weeks (2 implants per ablation procedure)

E. Gender Dysphoria, Gender Transition (off-label) (must meet all)**:**

1. For HIM, request is for a member in a state other than the following, where gender dysphoria and gender transition treatment is not a covered benefit: AL, AZ, AR, FL, GA, IN, IA, KS, KY, LA, MS, MO, NE, NH, NC, OH, OK, SC, and TN;
2. Diagnosis of gender dysphoria or request is for gender transition;
3. Prescribed by or in consultation with both of the following (a and b):
   a. An endocrinologist;
   b. A provider with expertise in gender dysphoria and transgender medicine based on a certified training program or affiliation with local transgender health services (e.g., mental health professional such as psychologist, psychiatrist, see *Appendix D*);
4. Age and pubertal development - meets one of the following (a or b):
   a. Member is < 18 years of age and has reached or passed through Tanner Stage 2*;
      **Age ranges approximating Tanner Stage 2 pubertal development extend from 8 to 13 years of age in girls and 9 to 14 years of age in boys.*
   b. Member is ≥ 18 years of age and has failed to achieve physiologic hormone levels with gender-affirming hormonal therapy (e.g., estrogen, testosterone) unless contraindicated or clinically significant adverse effects are experienced;
5. Member demonstrates understanding of expected GnRH analogue treatment outcomes and has given consent for such treatment;
6. If member has a psychiatric comorbidity, member is followed by mental health provider;
7. Psychosocial support will be provided during treatment;
8. Provider attestation of understanding current State regulations regarding transgender-related health care and such care is coverable under the State regulations (see *Appendix D*);
9. Dose is within FDA maximum limit for any FDA-approved indication (see Section V) or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

F. Ovarian Cancer (off-label) (must meet all)**:**

1. Diagnosis of ovarian cancer (including fallopian tube and primary peritoneal cancer, malignant sex cord-stromal tumors, carcinosarcoma (malignant mixed Müllerian tumors), low-grade serous carcinoma, endometrioid carcinoma, clear cell carcinoma of the ovary, mucinous neoplasms of the ovary);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as a single agent;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.6 mg per month and/or 10.8 mg per 3 months;
   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: 12 months

G. Salivary Gland Tumors (off-label) (must meet all)**:**
1. Diagnosis of salivary gland tumors;
2. Disease is androgen receptor positive and recurrent, unresectable, or metastatic;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Prescribed as a single agent or in combination with abiraterone and prednisone;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.6 mg per month and/or 10.8 mg per 3 months;
   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: 12 months

H. Uterine Sarcoma (off-label) (must meet all)**:**
1. Diagnosis of uterine sarcoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member has endometrial stromal sarcoma or adenosarcoma without sarcomatous overgrowth;
5. Member is premenopausal;
6. Prescribed in combination with anastrozole, letrozole or exemestane;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.6 mg per month and/or 10.8 mg per 3 months;
   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: 12 months

I. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Prostate Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zoladex for prostate cancer 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 3.6 mg per month and/or 10.8 mg per 3 months;
   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: 12 months

B. Breast Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zoladex for breast cancer and has received this medication for at least 30 days;
2. Request is for Zoladex 3.6 mg;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 3.6 mg per month;
   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: 12 months

C. Endometriosis (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. Request is for Zoladex 3.6 mg;
3. Member is responding positively to therapy as evidenced by improvement in any of the following parameters, including but not limited to: dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, size of endometrial lesions;
4. Total duration of goserelin therapy has not exceeded 6 months;
5. If request is for a dose increase, new dose does not exceed 3.6 mg per month.

Approval duration: up to a total treatment duration of 6 months

D. Dysfunctional Uterine Bleeding (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. Request is for Zoladex 3.6 mg;
3. Member is responding positively to therapy as evidenced by improvement in any of the following parameters, including but not limited to: dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, size of endometrial lesions;
4. Member has not yet received two implants;
5. If request is for a dose increase, new dose does not exceed 3.6 mg per month.

Approval duration: 4 weeks (2 implants total per ablation procedure)

E. Gender Dysphoria, Gender Transition (off-label) (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 is responding positively to therapy (e.g., member continues to meet their individual goals of therapy for gender dysphoria);
3. For HIM, request is for a member in a state other than the following, where gender dysphoria and gender transition treatment is not a covered benefit: AL, AZ, AR, FL, GA, IN, IA, KS, KY, LA, MS, MO, NE, NH, NC, OH, OK, SC, and TN;
4. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication (see Section V) or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

F. Ovarian Cancer, Salivary Gland Tumors, Uterine Sarcoma (off-label) (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zoladex for ovarian cancer, salivary gland tumors, or uterine sarcoma 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 3.6 mg per month and/or 10.8 mg per 3 months;
   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: 12 months

G. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GnRH: gonadotropin-releasing hormone
NCCN: National Comprehensive Cancer Network
WPATH: World Professional Association for Transgender Health

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
NSAIDs*: ibuprofen, naproxen, fenoprofen, ketoprofen, mefenamic acid, meclofenamate, indomethacin, tolmetin, diclofenac, etodolac, diflunisal, meloxicam, piroxicam	Endometriosis Varies – refer to specific prescribing information	Varies – refer to specific prescribing information
Combined oral estrogen-progesterone contraceptives*: ethinyl estradiol + (desogestrel, ethynodiol diacetate, drospirenone, etonogestrel, levonorgestrel, norelgestromin, norethindrone, norgestimate, or norgestrel); estradiol valerate + dienogest; mestranol + norethindrone	Endometriosis 1 tablet PO QD (may vary per specific prescribing information)	1 tablet per day (may vary per specific prescribing information)

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Progestin-only oral contraceptives*: norethindrone	Endometriosis 0.35 mg PO QD	0.35 mg PO QD
Depot progestin contraceptive*: medroxyprogesterone acetate	Endometriosis IM: 150 mg per 3 months (every 13 weeks) SC: 104 mg per 3 months (every 12-14 weeks)	See regimen

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.
**Examples provided may not be all-inclusive*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity; pregnancy unless used for treatment of advanced breast cancer
- Boxed warning(s): None reported

Appendix D: General Information

- World Professional Association for Transgender Health (WPATH) offers their Global Education Institute (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care. Additionally, the following link provides a search tool to locate WPATH member providers: https://app.wpath.org/provider/search
- Transgender Care Therapy Certification Training is also offered by the International Transgender Certification Association (ITCA). Professionals with expertise in transgender care can be located using the following search tool: https://transgendercertification.com/locate-a-professional/
- The WPATH Standards of Care Version 8 recommend that adolescents are managed by a multidisciplinary care team that involves both medical and mental health professionals. The list of key disciplines includes but is not limited to: adolescent medicine/primary care, endocrinology, psychology, psychiatry, speech/language pathology, fertility, social work, support staff, and the surgical team. The need to include a healthcare professional with some expertise in mental health does not dictate the inclusion of a psychologist, psychiatrist or social work in every assessment. Instead, a general medical practitioner, nurse or other qualified health care professional could also fulfill this requirement if they have sufficient expertise to diagnose gender incongruence, recognize mental health concerns, distinguish between these concerns and gender dysphoria, incongruence, and diversity, assist a transgender person in care planning and preparing for gender affirmative medical and surgical treatments, and refer to a mental health professional if needed.
- The Movement Advancement Project can be referenced to confirm transgender-related health care is coverable under the State regulations. This can be accessed at: https://www.lgbtmap.org/equality-maps/healthcare/youth_medical_care_bans

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Goserelin acetate (Zoladex 3.6, 10.8)	Prostate cancer - stage B2-C	3.6 mg SC 8 weeks before radiotherapy, followed by 10.8 mg SC in 28 days (alternative: 4 injections of 3.6 mg at 28-day intervals, 2 preceding and 2 during radiotherapy)	See regimen
Goserelin acetate (Zoladex 3.6)	Prostate cancer - palliative therapy	3.6 mg SC every 28 days	3.6 mg per 28 days
	Endometriosis	3.6 mg SC every 28 days	3.6 mg per 28 days (6 months total treatment)
	Dysfunctional uterine bleeding	3.6 mg SC every 28 days	3.6 mg per 28 days (2 doses total per ablation procedure)
	Breast cancer - palliative therapy	3.6 mg SC every 28 days	3.6 mg per 28 days

VI. Product Availability

Implant: 3.6 mg, 10.8 mg

VII. References

1. Zoladex (3.6 mg) Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; March 2026. Available at https://www.zoladexhcp.com. Accessed July 09, 2026.
2. Zoladex (10.8 mg) Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; March 2026. Available at https://www.zoladexhcp.com. Accessed July 09, 2026.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Goserelin acetate. Available at nccn.org. Accessed July 13, 2026.
4. National Comprehensive Cancer Network. Prostate cancer (Version 5.2026). Available at https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed July 13, 2026.
5. National Comprehensive Cancer Network. Breast cancer (Version 5.2026). Available at https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed July 13, 2026.
6. National Comprehensive Cancer Network. Uterine Neoplasms (Version 3.2026). Available at https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed July 13, 2026.
7. National Comprehensive Cancer Network. Head and Neck Cancers (Version 2.2026). Available at https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf . Accessed July 13, 2026.
8. National Comprehensive Cancer Network. Ovarian cancer (Version 4.2026). Available at https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed July 22, 2025.

9. Committee on Practice Bulletins - Gynecology. Management of endometriosis. July 2010 (reaffirmed 2016); 116(1): 223-236.
10. Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender nonconforming people. WPATH: World Professional Association for Transgender Health. 7th version; 2012.
11. WPATH: World Professional Association for Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Available at: https://www.wpath.org/soc8. Accessed July 13, 2026.

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
J9202	Goserelin acetate implant, per 3.6 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added criteria set for off-label use in gender dysphoria, gender transition; references reviewed and updated.	12.14.21	02.22
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	07.26.22	11.22
4Q 2023 annual review: no significant changes; for gender dysphoria continuation of therapy added example of positive response to therapy; references reviewed and updated.	06.30.23	11.23
4Q 2024 annual review: added Commercial line of business; references reviewed and updated.	10.02.24	11.24
For gender dysphoria and gender transition, added requirement for provider attestation of understanding current State regulations regarding transgender-related health care and such care is coverable under the State regulations, added to Appendix D link and notation that the Movement Advancement Project can be referenced to confirm transgender-related health care is coverable under the State regulations.	02.12.25	
4Q 2025 annual review: added NCCN compendium supported off-label uses in ovarian cancer, salivary gland tumors, and uterine sarcoma; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	07.10.25	11.25
For gender dysphoria and gender transition, as a result of the Marketplace Integrity and Affordability rule, added requirement for HIM, request is for a member in a state other than the following, where gender dysphoria and gender transition treatment is not a	02.24.26	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
covered benefit: AL, AZ, AR, FL, GA, IN, IA, KS, KY, LA, MS, MO, NE, NH, NC, OH, OK, SC, and TN.		
4Q 2026 annual review: added ICHRA line of business; for ovarian cancer, salivary gland tumors, and uterine sarcoma added requirement for age ≥ 18 years; per NCCN compendium for ovarian cancer added requirement prescribed as a single agent; per NCCN compendium for salivary gland tumors added requirement prescribed as a single agent or in combination with abiraterone and prednisone; references reviewed and updated.	07.09.26	11.26

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.

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