Clinical Policy: Obinutuzumab (Gazyva)

Reference Number: CP.PHAR.305
Effective Date: 02.01.17
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

Obinutuzumab (Gazyva®) is a CD20-directed cytolytic antibody.

FDA Approved Indication(s)

Gazyva is indicated:

- In combination with chlorambucil, for the treatment of patients with previously untreated chronic lymphocytic leukemia (CLL)
- In combination with bendamustine followed by Gazyva monotherapy, for the treatment of patients with follicular lymphoma (FL) who relapsed after, or are refractory to, a rituximab-containing regimen
- In combination with chemotherapy followed by Gazyva monotherapy in patients achieving at least a partial remission, for the treatment of adult patients with previously untreated stage II bulky, III or IV FL
- For the treatment of adult patients with active lupus nephritis (LN) who are receiving standard therapy

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

I. Initial Approval Criteria

A. Lupus Nephritis (must meet all)**:**

1. Diagnosis of LN with kidney biopsy that confirms one of the following (a, b, or c):
   a. LN Class III (focal);
   b. LN Class IV (diffuse segmental or global);
   c. LN Class V (membranous);
2. Prescribed by or in consultation with a nephrologist or rheumatologist;
3. Age ≥ 18 years;
4. Member has a confirmed diagnosis of systemic lupus erythematosus (SLE);
5. Evidence of urine protein/creatinine ratio (UPCR) ≥ 1 mg/mg;
6. Prescribed in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic

immunosuppressants (e.g., azathioprine, cyclophosphamide, methotrexate, mycophenolate);
7. Gazyva is not prescribed concurrently with Lupkynis® or a biologic (e.g., Benlysta®, Saphnelo®, rituximab);
8. Dose does not exceed 1,000 mg at the initial infusion, on Week 2, 24, 26, and every 6 months thereafter.

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

B. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**
1. Diagnosis of CLL or small lymphocytic lymphoma (SLL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. One of the following (a, b, c, or d):
   a. Prescribed as a single agent;
   b. If prescribed for first-line therapy, prescribed in combination with one of the following (i, ii, or iii):
      i. Venclexta and/or Calquence® (i.e., Venclexta, Calquence, or Venclexta + Calquence);
      ii. Imbruvica®;
      iii. Chemotherapy (chlorambucil, bendamustine);
   c. If prescribed for second-line or subsequent therapy, prescribed in combination with Venclexta®;
   d. For histologic (Richter) transformation, prescribed in combination with one of the following (i, ii, or iii):
      i. Venclexta and Tecentriq®;
      ii. Venclexta and Jaypirca®;
      iii. As single-agent pre-treatment prior to Columvi™;
5. Request meets one of the following (a or b):*
   a. After initial loading doses, dose does not exceed 1,000 mg per 28-day cycle;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

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

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

C. Follicular Lymphoma (must meet all):
1. Diagnosis of FL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Gazyva is prescribed as a substitute* for rituximab in patients experiencing intolerance to rituximab (including severe hypersensitivity reactions requiring discontinuation) or rare complications such as mucocutaneous reactions including

paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis;
**Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.*

b. Gazyva is requested as one of the following (i, ii, or iii):
   i. First line therapy in combination with chemotherapy or Revlimid®;
   ii. Second-line or subsequent therapy, and Gazyva is prescribed in one of the following ways (1, 2, 3, or 4):
      1) As a single agent;
      2) In combination with chemotherapy;
      3) In combination with Revlimid;
      4) In combination with Brukinsa, and member has received ≥ 2 prior lines of systemic therapy;
   iii. Maintenance therapy as a single agent if disease is rituximab-refractory or following chemotherapy;

5. Request meets one of the following (a or b):*
   a. After initial loading doses, dose does not exceed 1,000 mg per 28-day cycle;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

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

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

D. Hairy Cell Leukemia (off-label) (must meet all)**:**
1. Diagnosis of hairy cell leukemia;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Gazyva is prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. As initial therapy in combination with Zelboraf® and member is unable to tolerate purine analogs (e.g., cladribine, pentostatin);
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).*

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

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

E. Additional NCCN Recommended Uses (off-label) (must meet all):
1. Diagnosis of one of the following B-cell neoplasms (a or b):
   a. Castleman disease;
   b. B-cell lymphomas (off-label):
      i. Marginal zone lymphoma (1, 2, or 3):
         1) Splenic marginal zone lymphoma;

2) Nodal marginal zone lymphoma;
3) Extranodal marginal zone lymphoma (a or b):
   a) Gastric MALT lymphoma;
   b) Nongastric MALT lymphoma;

ii. Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma (DLBCL);
iii. DLBCL;
iv. High-grade B-cell lymphoma;
v. Mantle cell lymphoma;
vi. Post-transplant lymphoproliferative disorders;
vii. HIV-related B-cell lymphoma;
viii. Burkitt lymphoma;
ix. Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma;

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. One of the following (a, b, c, d, or e):
   a. Gazyva is prescribed as a substitute* for rituximab in patients experiencing intolerance to rituximab (including severe hypersensitivity reactions requiring discontinuation) or rare complications such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis;
      **Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.*
   b. For marginal zone lymphoma: Gazyva is requested for one of the following uses (i, ii, or iii):
      i. Maintenance therapy if disease is rituximab-refractory, recurrent, and has been treated with Gazyva and bendamustine;
      ii. Second-line or subsequent therapy in combination with chemotherapy or Revlimid (*see Appendix B for examples of prior therapy*);
      iii. Nodal marginal zone lymphoma only: First line therapy in combination with chemotherapy;
   c. Gazyva is prescribed for second-line or subsequent therapy prior to Columvi for one of the following subtypes (i-vi):
      i. Histologic transformation of indolent lymphomas to DLBCL;
      ii. DLBCL;
      iii. High-grade B-cell lymphoma;
      iv. Mantle cell lymphoma;
      v. Post-transplant lymphoproliferative disorders;
      vi. HIV-related B-cell lymphoma;
   d. For mantle cell lymphoma, and prescribed in combination with Venclexta and Brukinsa®: Both of the following (i and ii):
      i. Disease is positive for TP53 mutation;
      ii. A clinical trial is not available (*a clinical trial is strongly recommended*);
   e. For mantle cell lymphoma: Gazyva is prescribed as a substitute for rituximab at provider's discretion;

5. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

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

F. 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. Lupus Nephritis (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 as evidenced by one of the following (a, b, or c):
   a. Reduced level of proteinuria measured by UPCR $\leq$ 0.5 mg/mg from baseline with low dose steroids (e.g., prednisone);
   b. No reduction from baseline in estimated glomerular filtration rate (eGFR) of greater than 20% with low dose steroids (e.g., prednisone);
   c. eGFR $\geq$ 60 mL/min/1.73 m^2 with low dose steroids (e.g., prednisone);
3. Prescribed in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, cyclophosphamide, methotrexate, mycophenolate);

4. Gazyva is not prescribed concurrently with Lupkynis or a biologic (e.g., Benlysta, Saphnelo, rituximab);
5. If request is for a dose increase, new dose does not exceed 1,000 mg every 6 months.

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

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Gazyva 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. After initial loading doses, new dose does not exceed 1,000 mg per 28-day cycle;
   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:
HIM/Medicaid/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

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 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

CLL: chronic lymphocytic leukemia
DLBCL: diffuse large B-cell lymphoma
eGFR: estimated glomerular filtration rate
FDA: Food and Drug Administration
FL: follicular lymphoma
LN: lupus nephritis
MALT: mucosa-associated lymphoid tissue
NCCN: National Comprehensive Cancer Network
NHL: non-Hodgkin lymphoma
SLE: systemic lupus erythematosus
SLL: small lymphocytic lymphoma
UPCR: urine protein/creatinine ratio

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
FL and Marginal Zone Lymphomas *Examples of first-line, second-line and subsequent therapies:* • bendamustine + rituximab • RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) • RCVP (rituximab, cyclophosphamide, vincristine, prednisone) • Single-agent examples: rituximab; Leukeran® (chlorambucil) ± rituximab; cyclophosphamide ± rituximab; Revlimid® (lenalidomide) ± rituximab; Aliqopa® (copanlisib)	Varies	Varies

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

- Contraindication(s): patients with known hypersensitivity reactions (e.g., anaphylaxis) to obinutuzumab or any of the excipients, including serum sickness with prior obinutuzumab use
- Boxed warning(s): hepatitis B virus reactivation and progressive multifocal leukoencephalopathy

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLL	100 mg IV on day 1, 900 mg IV on day 2 of cycle 1, then 1,000 mg IV on days 8 and 15 of cycle 1; begin the next cycle of therapy on day 29. For cycles 2 to 6, give obinutuzumab 1,000 mg IV on day 1 repeated every 28 days.	See regimen

Indication	Dosing Regimen	Maximum Dose
FL	1,000 mg IV on day 1, 8 and 15 of Cycle 1; 1,000 mg on day 1 of Cycles 2-6 or Cycles 2-8; and then 1,000 mg every 2 months for up to 2 years. For patients with relapsed or refractory FL, administer Gazyva in combination with bendamustine in six 28-day cycles. Patients who achieve stable disease, complete response, or partial response to the initial 6 cycles should continue on Gazyva 1,000 mg as monotherapy for up to two years. For patients with previously untreated FL, administer Gazyva with one of the following chemotherapy regimens: • Six 28-day cycles in combination with bendamustine • Six 21-day cycles in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone), followed by 2 additional 21-day cycles of Gazyva alone • Eight 21-day cycles in combination with CVP (cyclophosphamide, vincristine, prednisone) Patients with previously untreated FL who achieve a complete response or partial response to the initial 6 or 8 cycles should continue on Gazyva 1,000 mg as monotherapy for up to two years.	See regimen
LN	1,000 mg IV at the initial infusion, on Week 2, 24, 26, and every 6 months thereafter	See regimen

VI. Product Availability

Single-dose vial: 1,000 mg/40 mL (25 mg/mL)

VII. References

1. Gazyva Prescribing Information. South San Francisco, CA: Genentech, Inc.; December 2025. Available at: https://www.gazyva.com/. Accessed July 7, 2026.

Lupus nephritis

2. Furie RA, Rovin BH, Garg JP, et al. Efficacy and safety of obinutuzumab in active lupus nephritis. N Engl J Med. 2025;392(15):1471-1483.
3. Sammaritano LR, Askanase A, Bermas BL, et al. 2024 American College of Rheumatology (ACR) guideline for the screening, treatment, and management of lupus nephritis. Arthritis Rheumatol. 2025;77(9):1115-1135.
4. Fanouriakis A, Kostopoulou M, Anders HJ, et al. EULAR recommendations for the management of systemic lupus erythematosus with kidney involvement: 2025 update. Ann Rheum Dis. Published online October 16, 2025.

5. Kidney Disease: Improving Global Outcomes (KDIGO) Lupus Nephritis Work Group. KDIGO 2024 clinical practice guideline for the management of lupus nephritis. Kidney Int. 2024;105(1S):S1-S69.KDI.

Oncology

6. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 26, 2026.
7. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 1.2027. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. Accessed August 26, 2026.
8. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed August 26, 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
J9301	Injection, obinutuzumab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: added criteria for FL for first- and second-line therapy, maintenance therapy, and as a rituximab substitute as supported by NCCN; replaced "in combination with bendamustine" for second-line treatment in marginal zone lymphoma with "in combination with chemotherapy" as NCCN supports several regimens; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.04.22	11.22
4Q 2023 annual review: for CLL/SLL added combination therapy option with Venclexta per NCCN; for FL added "in combination with chemotherapy" for second-line or subsequent therapy; for FL and MZL simplified combination regimens and agents to "chemotherapy" to align with NCH criteria; added criteria for NCCN-supported indication of hairy cell leukemia; revised terminology from "AIDS-Related B-Cell Lymphomas" to "HIV-Related B-Cell Lymphomas" per NCCN; references reviewed and updated.	08.09.23	11.23
4Q 2024 annual review: added Commercial line of business for use in medical coverage determinations; for CLL/SLL removed requirement for del(17p)/TP53-negative status per NCCN Compendium; for B-cell lymphomas, added option for Gazyva monotherapy prior to Columvi administration for specific lymphomas and for FL removed requirement for combination	07.19.24	11.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
chemotherapy in second line and subsequent therapy per NCCN; for hairy cell leukemia, clarified that member must be unable to tolerate purine analogs per NCCN and removed active infection as an option for criteria consolidation; references reviewed and updated.		
4Q 2025 annual review: for CLL/SLL indication and combination therapy with Venclexta, removed requirement for previous combination use as first-line therapy per NCCN; for section header "Follicular and Other B-Cell Lymphomas," revised to "B-Cell Lymphomas and Tumors with B-Cell Predominance" to capture indication for Castleman disease; for indication of histologic transformation of marginal zone lymphoma to DLBCL, revised indication language from marginal zone lymphoma to indolent lymphomas per NCCN; for certain B-cell neoplasms where Gazyva is prescribed prior to Columvi administration, removed monotherapy requirement, revised third-line to for second-line therapy, and added mantle cell lymphoma indication per NCCN; for FL and marginal zone lymphomas, add combination therapy with Revlimid option per NCCN; for mantle cell lymphoma, added option for in combination with Venclexta and Brukinsa per NCCN; added monotherapy option for hairy cell leukemia per NCCN; revised all initial approval durations for Medicaid and HIM lines of business to 12 months; references reviewed and updated.	07.07.25	11.25
RT4: added new indication of LN.	11.14.25	
4Q 2026 annual review: separated FL criteria from "B-Cell Lymphomas and Tumors with B-Cell Predominance" and renamed existing criteria "Additional NCCN Recommended Uses (off-label);" for CLL/SLL, added treatment option combinations for first-line therapy and histologic (Richter) transformation per NCCN; for FL, added NCCN-supported regimens for second-line and subsequent therapy; added indication of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma per NCCN; for mantle cell lymphoma, added option for use as a substitute for rituximab at provider's discretion per NCCN; added ICHRA line of business; references reviewed and updated.	07.07.26	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.

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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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