

**Clinical Policy: Elbasvir/Grazoprevir (Zepatier)**

Reference Number: HIM.PA.SP62

Effective Date: 08.01.20

Last Review Date: 08.25

Line of Business: HIM\*

[Revision Log](#)

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

**Description**

Grazoprevir/elbasvir (Zepatier®) is a fixed-dose combination product containing elbasvir, a hepatitis C virus (HCV) NS5A inhibitor, and grazoprevir, an HCV NS3/4A protease inhibitor.

*\*These criteria do NOT apply to California Commercial Exchange Plans.*

**FDA Approved Indication(s)**

Zepatier is indicated for treatment of chronic HCV genotype 1 or 4 infection in adult and pediatric patients 12 years of age and older or weighing at least 30 kg. Zepatier is indicated for use with ribavirin (RBV) in certain patient populations.

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

**I. Initial Approval Criteria\***

*\*For members in Nevada, medical management techniques, including quantity management, beyond step therapy is not allowed.*

**A. Hepatitis C Infection (must meet all):**

1. Diagnosis of HCV infection as evidenced by detectable serum HCV RNA levels by quantitative assay in the last 6 months;
2. Prescribed\* by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or provider who has expertise in treating HCV based on a certified training program (*see Appendix F*);  
*\*This prescriber requirement does not apply to HIM Georgia*
3. Age  $\geq$  12 years or weight  $\geq$  30 kg;
4. Confirmed HCV genotype is 1 or 4;  
*\*Chart note documentation and copies of lab results are required*
5. For genotype 1a, laboratory testing for the presence or absence of virus with NS5A resistance-associated polymorphisms at amino acid positions 28, 30, 31, or 93;
6. Documentation of the treatment status of the patient (treatment-naïve or treatment-experienced);
7. If cirrhosis is present, confirmation of Child-Pugh A status;
8. Member must use **sofosbuvir-velpatasvir (Epclusa authorized generic)**, unless contraindicated or clinically significant adverse effects are experienced;^\*

<sup>^</sup> For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

\* Coadministration with omeprazole up to 20 mg is not considered acceptable medical justification for inability to use Epclusa

9. Life expectancy  $\geq$  12 months with HCV treatment;
10. Prescribed regimen is consistent with an FDA or AASLD-IDSa recommended regimen (see Section V Dosage and Administration for reference);
11. Dose does not exceed elbasvir/grazoprevir 50 mg/100 mg (1 tablet) per day.

**Approval duration: up to a total of 16 weeks\***

(\*Approved duration should be consistent with a regimen in Section V Dosage and Administration)

**B. Other diagnoses/indications (must meet all):**

1. Member must use **sofosbuvir-velpatasvir (Epclusa authorized generic)**, if applicable for the requested indication, unless contraindicated or clinically significant adverse effects are experienced;\*

\* Coadministration with omeprazole up to 20 mg is not considered acceptable medical justification for inability to use Epclusa

2. One of the following (a or b):
  - a. 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 (i or ii):
    - i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
    - ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
  - b. 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 2a above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

**II. Continued Therapy\***

\*For members in Nevada, medical management techniques, including quantity management, beyond step therapy is not allowed.

**A. Hepatitis C Infection (must meet all):**

1. Member meets one of the following (a, b, or c):
  - 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);
  - c. Documentation supports that member is currently receiving Zepatier for HCV infection and has recently completed at least at least 28 days of treatment with Zepatier;
2. Member is responding positively to therapy;

3. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section V Dosage and Administration for reference*);
4. Dose does not exceed elbasvir/grazoprevir 50 mg/100 mg (1 tablet) per day.

**Approval duration: up to a total of 16 weeks\***

(\*Approved duration should be consistent with a regimen in Section V Dosage and Administration)

**B. 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: HIM.PA.33 for health insurance marketplace; 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: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

**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 policy – HIM.PA.154 for health insurance marketplace, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

AASLD: American Association for the Study of Liver Diseases

DAA: direct-acting antiviral

FDA: Food and Drug Administration

HBV: hepatitis B virus

HCV: hepatitis C virus

HIV: human immunodeficiency virus

IDSA: Infectious Diseases Society of America

NS3/4A, NS5A/B: nonstructural protein

PegIFN: pegylated interferon

RBV: ribavirin

RNA: ribonucleic acid

SVR12: sustained virologic response at 12 weeks

*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/<br>Maximum                                               |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| sofosbuvir/<br>velpatasvir<br>(Epclusa®) | Without cirrhosis or with<br>compensated cirrhosis, treatment<br>naïve or treatment-experienced*<br>patient:<br><b>Genotypes 1 or 4</b><br><br>One tablet PO QD for 12 weeks | sofosbuvir 400<br>mg/<br>velpatasvir 100<br>mg (1 tablet) per<br>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.*

*\*From clinical trials, treatment-experienced refers to previous treatment with NS3/4A protease inhibitor (telaprevir, boceprevir, or simeprevir) and/or peginterferon/RBV unless otherwise stated*

#### Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Patients with moderate or severe hepatic impairment (Child-Pugh B or C) due to the expected significantly increased grazoprevir plasma concentration and the increased risk of alanine aminotransferase (ALT) elevations or those with any history of hepatic decompensation due to the risk of hepatic decompensation.
  - With inhibitors of organic anion transporting polypeptides 1B1/3 (OATP1B1/3) inhibitors that are known or expected to significantly increase grazoprevir plasma concentrations, strong CYP3A inducers, and efavirenz.
  - If Zepatier is administered with RBV, the contraindications to RBV also apply.
- Boxed warning(s): risk of hepatitis B virus (HBV) reactivation in patients coinfecting with HCV and HBV

#### Appendix D: Direct-Acting Antivirals for Treatment of HCV Infection

| Brand Name | Drug Class     |                                             |                                               |                                |                 |
|------------|----------------|---------------------------------------------|-----------------------------------------------|--------------------------------|-----------------|
|            | NS5A Inhibitor | Nucleotide Analog NS5B Polymerase Inhibitor | Non-Nucleoside NS5B Palm Polymerase Inhibitor | NS3/4A Protease Inhibitor (PI) | CYP3A Inhibitor |
| Epclusa*   | Velpatasvir    | Sofosbuvir                                  |                                               |                                |                 |
| Harvoni*   | Ledipasvir     | Sofosbuvir                                  |                                               |                                |                 |
| Mavyret*   | Pibrentasvir   |                                             |                                               | Glecaprevir                    |                 |
| Sovaldi    |                | Sofosbuvir                                  |                                               |                                |                 |
| Vosevi*    | Velpatasvir    | Sofosbuvir                                  |                                               | Voxilaprevir                   |                 |
| Zepatier*  | Elbasvir       |                                             |                                               | Grazoprevir                    |                 |

\*Combination drugs

#### Appendix E: General Information

- Acceptable medical justification for inability to use Epclusa (preferred product):
  - In patients indicated for co-administration of Epclusa with ribavirin: contraindications to ribavirin.

- In patients indicated for co-administration with amiodarone: serious symptomatic bradycardia in patients taking amiodarone, with cardiac monitoring recommended.
- Unacceptable medical justification for inability to use Epclusa (preferred product):
  - Coadministration with omeprazole up to 20 mg is not considered acceptable medical justification for inability to use Epclusa.
    - Per the Epclusa Prescribing Information: “If it is considered medically necessary to coadminister, Epclusa should be administered with food and taken 4 hours before omeprazole 20 mg.”
- HBV reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. HBV reactivation has been reported when treating HCV for patients co-infected with HBV, leading to fulminant hepatitis, hepatic failure, and death, in some cases. Patients should be monitored for HBV reactivation and hepatitis flare during HCV treatment and post-treatment follow-up, with treatment of HBV infection as clinically indicated.
- For patients infected with HCV Genotype 1a: Testing for the presence of virus with NS5A resistance-associated polymorphisms is recommended. Clinical trial results show decreased efficacy of Zepatier in HCV genotype 1a with presence of NS5A polymorphisms. If baseline NS5A polymorphisms are present for genotype 1a, refer to Section V on the longer recommended duration of therapy.
- Child-Pugh Score:

|                | 1 Point                                  | 2 Points                                  | 3 Points                                             |
|----------------|------------------------------------------|-------------------------------------------|------------------------------------------------------|
| Bilirubin      | Less than 2 mg/dL<br>Less than 34 umol/L | 2-3 mg/dL<br>34-50 umol/L                 | Over 3 mg/dL<br>Over 50 umol/L                       |
| Albumin        | Over 3.5 g/dL<br>Over 35 g/L             | 2.8-3.5 g/dL<br>28-35 g/L                 | Less than 2.8 g/dL<br>Less than 28 g/L               |
| INR            | Less than 1.7                            | 1.7 - 2.2                                 | Over 2.2                                             |
| Ascites        | None                                     | Mild / medically controlled               | Moderate-severe / poorly controlled                  |
| Encephalopathy | None                                     | Mild / medically controlled<br>Grade I-II | Moderate-severe / poorly controlled.<br>Grade III-IV |

*Child-Pugh class is determined by the total number of points: A = 5-6 points; B = 7-9 points; C = 10-15 points.*

#### *Appendix F: Healthcare Provider HCV Training*

Acceptable HCV training programs and/or online courses include, but are not limited to the following:

- Hepatitis C online course (<https://www.hepatitisc.uw.edu/>): University of Washington is funded by the Division of Viral Hepatitis to develop a comprehensive, online self-study course for medical providers on diagnosis, monitoring, and management of hepatitis C virus infection. Free CME and CNE credit available.
- Fundamentals of Liver Disease (<https://liverlearning.aasld.org/fundamentals-of-liver-disease>): The AASLD, in collaboration with ECHO, the American College of Physicians (ACP), CDC, and the Department of Veterans Affairs, has developed Fundamentals of Liver Disease, a free, online CME course to improve providers’ knowledge and clinical skills in hepatology.

- Clinical Care Options: <http://www.clinicaloptions.com/hepatitis.aspx>

*Appendix G: Incomplete Adherence and AASLD-IDSA Recommended Management of Treatment Interruptions*

- There are minimal data regarding the outcome of patients who have incomplete adherence to direct-acting antiviral (DAA) therapy or the threshold level of adherence below which the incidence of sustained virologic response at 12 weeks (SVR12) is significantly reduced. In general, a treatment interruption of < 7 days is unlikely to impact SVR12.
- There are few data on which to base recommendations regarding how to manage patients who have discontinued DAAs for several days to weeks. The below recommendations are applicable to treatment-naïve patients with HCV, without cirrhosis or with compensated cirrhosis, *and receiving either Mavyret or Epclusa*. Patients with prior DAA treatment, or receiving other DAA treatment regimens, or other populations (e.g., patients who are posttransplant or have decompensated cirrhosis) should be managed in consultation with an expert.
  - Interruptions during the first 28 days of DAA therapy:
    - If missed ≤ 7 days, restart DAA therapy immediately and complete therapy for originally planned duration (8 or 12 weeks).
    - If missed ≥ 8 days, restart DAA therapy immediately and obtain HCV RNA test as soon as possible. If HCV RNA is negative, complete originally planned DAA treatment course (8 or 12 weeks). Recommendation to extend DAA treatment for an additional 4 weeks for patients with genotype 3 and/or cirrhosis. If HCV RNA is positive or not obtained, extend DAA treatment for an additional 4 weeks.
  - Interruptions after receiving ≥ 28 days of DAA therapy:
    - If missed ≤ 7 days, restart DAA therapy immediately and complete therapy for originally planned duration (8 or 12 weeks).
    - If missed 8-20 consecutive days, restart DAA therapy immediately and obtain HCV RNA test as soon as possible. If HCV RNA is negative, complete originally planned DAA treatment course (8 or 12 weeks). Recommendation to extend DAA treatment for an additional 4 weeks for patients with genotype 3 and/or cirrhosis. If HCV RNA is positive or not obtained, stop treatment and retreat according to the recommendations in the AASLD-IDSA Retreatment Section.
    - If missed ≥ 21 consecutive days, stop DAA treatment and assess for SVR12. If SVR12 not achieved, retreat according to the recommendations in the AASLD-IDSA Retreatment Section.

**V. Dosage and Administration**

| Indication: HCV                                                                                                                      | Dosing Regimen                   | Maximum Dose                                                        | Reference                |
|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------|--------------------------|
| <b>Genotype 1a:</b><br>Treatment-naïve or<br>pegIFN/RBV-experienced with<br>or without compensated<br>cirrhosis and without baseline | One tablet PO QD<br>for 12 weeks | One tablet<br>(grazoprevir<br>100 mg/<br>elbasvir 50 mg)<br>per day | FDA-approved<br>labeling |

| Indication: HCV                                                                                                                                                                                          | Dosing Regimen                                                                                                                                      | Maximum Dose                                            | Reference                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------|
| NS5A polymorphisms at amino acid positions 28, 30, 31, or 93                                                                                                                                             |                                                                                                                                                     |                                                         |                                                                   |
| <b>Genotype 1a:</b><br>Treatment-naïve or PegIFN/RBV experienced with or without compensated cirrhosis and with baseline NS5A polymorphisms at amino acid positions 28, 30, 31, or 93                    | One tablet PO QD plus weight-based RBV for 16 weeks                                                                                                 | One tablet (grazoprevir 100 mg/ elbasvir 50 mg) per day | FDA-approved labeling                                             |
| <b>Genotype 1b:</b><br>Treatment-naïve or PegIFN/RBV experienced with or without compensated cirrhosis                                                                                                   | One tablet PO QD for 12 weeks<br><br>An 8-week regimen can be considered in those with genotype 1b infection and mild fibrosis (F0-F2) <sup>‡</sup> | One tablet (grazoprevir 100 mg/ elbasvir 50 mg) per day | 1) FDA-approved labeling<br>2) AASLD-IDSA (updated December 2023) |
| <b>Genotype 1a or 1b:</b><br>pegIFN/RBV/NS3/4A PI* - experienced with or without compensated cirrhosis, (for genotype 1a: without baseline NS5A polymorphisms at amino acid positions 28, 30, 31, or 93) | One tablet PO QD plus weight-based RBV for 12 weeks                                                                                                 | One tablet (grazoprevir 100 mg/ elbasvir 50 mg) per day | FDA-approved labeling                                             |
| <b>Genotype 4:</b><br>Treatment-naïve with or without compensated cirrhosis                                                                                                                              | One tablet PO QD for 12 weeks                                                                                                                       | One tablet (grazoprevir 100 mg/ elbasvir 50 mg) per day | FDA-approved labeling                                             |
| <b>Genotype 4:</b><br>PegIFN/RBV-experienced with or without compensated cirrhosis                                                                                                                       | One tablet PO QD plus weight-based RBV for 16 weeks                                                                                                 | One tablet (grazoprevir 100 mg/ elbasvir 50 mg) per day | FDA-approved labeling                                             |

*AASLD/IDSA treatment guidelines for hepatitis C infection are updated at irregular intervals; refer to the most updated AASLD/IDSA guideline for most accurate treatment regimen.*

*\* NS3/4A protease inhibitor = telaprevir, boceprevir, or simeprevir*

*‡ Off-label, AASLD-IDSA guideline-supported dosing regimen*

## VI. Product Availability

Tablet: grazoprevir 100 mg with elbasvir 50 mg

## VII. References

1. Zepatier Prescribing Information. Whitehouse Station, NJ: Merck and Company, Inc.; May 2022. Available at: [https://www.merck.com/product/usa/pi\\_circulars/z/zepatier/zepatier\\_pi.pdf](https://www.merck.com/product/usa/pi_circulars/z/zepatier/zepatier_pi.pdf). Accessed April 14, 2025.
2. American Association for the Study of Liver Diseases/ Infectious Disease Society of America (AASLD-IDSA). HCV guidance: recommendations for testing, managing, and treating hepatitis C. Last updated December 19, 2023. Available at: <https://www.hcvguidelines.org/>. Accessed May 30, 2025.
3. CDC. CDC. Clinical Overview of Hepatitis C. Last updated January 31, 2025. Available at: <https://www.cdc.gov/hepatitis-c/hcp/clinical-overview/>. Accessed May 30, 2025.

| Reviews, Revisions, and Approvals                                                                                                                                                                                                                                                                                                                                                                                                                                  | Date     | P&T Approval Date |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------|
| 3Q 2021 annual review: no significant changes; added clarification that the brand version of Epclusa is the preferred alternative; Vosevi removed as possible redirection as it shares no common indications with Zepatier and therefore cannot be an alternative; included reference to Appendix E with addition of contraindications that would warrant bypassing preferred agent; updated Appendix B therapeutic alternatives; references reviewed and updated. | 05.10.21 | 08.21             |
| RT4: added pediatric use extension to 12 years of age and older or weight at least 30 kg.                                                                                                                                                                                                                                                                                                                                                                          | 01.13.22 |                   |
| 3Q 2022 annual review: no significant changes; added omeprazole coadministration as unacceptable rationale for not using preferred Epclusa in Appendix E and within criteria; references reviewed and updated.                                                                                                                                                                                                                                                     | 07.20.22 | 08.22             |
| Template changes applied to other diagnoses/indications and continued therapy section.                                                                                                                                                                                                                                                                                                                                                                             | 10.12.22 |                   |
| Per SDC, revised redirection for Florida only to require use of Epclusa authorized generic; all other requests continue to require use of brand Epclusa.                                                                                                                                                                                                                                                                                                           | 01.12.23 |                   |
| 3Q 2023 annual review: eliminated adherence program participation criterion since member is already being managed by an HCV-trained specialist and due to competitor analysis; added asterisk to Epclusa redirection in initial criteria to clarify that the coadministration with omeprazole statement applies here; added redirections to other diagnoses initial criteria section; references reviewed and updated.                                             | 04.17.23 | 08.23             |
| Per April SDC, applied Epclusa authorized generic redirection to all requests.                                                                                                                                                                                                                                                                                                                                                                                     | 09.21.23 | 12.23             |

| Reviews, Revisions, and Approvals                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date     | P&T Approval Date |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------|
| Added disclaimer that medical management techniques, including quantity management, beyond step therapy are not allowed for members in NV per SB 439.                                                                                                                                                                                                                                                                                                                                                     | 05.31.24 |                   |
| 3Q 2024 annual review: removed qualifier of “chronic” from HCV criteria as AASLD-IDSA recommends treatment of both acute and chronic HCV; added prescriber exception for HIM Georgia per plan request; added “if applicable for the requested indication” to Eplclusa authorized generic redirection in the Other diagnoses/indications section; added Appendix G for guidance on incomplete adherence and AASLD-IDSA recommended management of treatment interruptions; references reviewed and updated. | 05.30.24 | 08.24             |
| 3Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; for continued therapy criteria, added “Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen”; references reviewed and updated.<br>For continued therapy criteria, revised option for treatment duration minimum from 60 days to 28 days and removed requirement for specific confirmed genotype.                                                                                                    | 07.15.25 | 08.25             |

### **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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