Introduction

Excess weight is associated with many health risks such as diabetes, high blood pressure, high cholesterol, and heart disease along with an increased risk of death. Many individuals are able to lose weight by changing their diet and increasing their exercise. The challenge for most people is keeping off the weight they have lost. Initiation of drug therapy in overweight individuals should be made after consideration of the benefits and risks. There are a number of medications approved by the US Food and Drug Administration (FDA), when used in combination with diet and exercise, for the treatment of weight management. This policy describes when drugs for chronic weight management may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
<table>
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<tr>
<th>Drug</th>
<th>Medical Necessity</th>
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| **Contrave® (naltrexone/bupropion)** | **Contrave® (naltrexone/bupropion) may be considered medically necessary for chronic weight management when the following criteria are met:**  
  • Patient is 18 years of age or older  
  AND  
  • Patient has a body mass index (BMI) of ≥ 30 kg/m²  
  OR  
  • Patient has a BMI of ≥ 27 kg/m² and one or more of the following weight-related comorbid conditions:  
    o Type 2 diabetes mellitus  
    o Hypertension  
    o Sleep apnea  
    o Hyperlipidemia  
    o Symptomatic osteoarthritis of the lower extremities (knee or hip)  
    o Coronary artery disease  
  AND  
  • Medication is being used as an adjunct to a reduced-calorie diet and increased physical activity  
  AND  
  • The dose is limited to four Contrave® 8 mg/90 mg tablets per day (taken as two tablets in the morning and two tablets in the evening)  

**Note:** Drugs for weight management are excluded under many benefit plans. Therefore, use of Contrave® (naltrexone/bupropion) for weight management may not be covered. Please refer to the applicable benefit plan document to determine benefit availability (see Benefit Application for further information). |
| **Qsymia® (phentermine/topiramate extended-release)** | **Qsymia® (phentermine/topiramate extended-release) may be considered medically necessary for chronic weight management when the following criteria are met:**  
  • Patient is 18 years of age or older  
  AND  
  • Patient has a body mass index (BMI) of ≥ 30 kg/m²  
  OR  

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| Qsymia® (phentermine/topiramate extended-release) | • Patient has a BMI of $\geq 27$ kg/m$^2$ and one or more of the following weight-related comorbid conditions:  
  o Type 2 diabetes mellitus  
  o Hypertension  
  o Sleep apnea  
  o Hyperlipidemia  
  o Symptomatic osteoarthritis of the lower extremities (knee or hip)  
  o Coronary artery disease  
  AND  
  • Medication is being used as an adjunct to a reduced-calorie diet and increased physical activity  
  AND  
  • The dose is limited to one Qsymia® 15 mg/92 mg capsule per day |

Note: Drugs for weight management are excluded under many benefit plans. Therefore, use of Qsymia® (phentermine/topiramate extended-release) for weight management may not be covered. Please refer to the applicable benefit plan document to determine benefit availability (see Benefit Application for further information).

| Saxenda® (liraglutide) | Saxenda® (liraglutide) may be considered medically necessary for chronic weight management when the following criteria are met:  
• Patient is 12 years of age or older  
AND  
• Patient has a body mass index (BMI) of $\geq 30$ kg/m$^2$  
OR  
• Patient has a BMI of $\geq 27$ kg/m$^2$ and one or more of the following weight-related comorbid conditions:  
  o Type 2 diabetes mellitus  
  o Hypertension  
  o Sleep apnea  
  o Hyperlipidemia  
  o Symptomatic osteoarthritis of the lower extremities (knee or hip)  
  o Coronary artery disease |
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| **Saxenda® (liraglutide)** | AND  
  • Medication is being used as an adjunct to a reduced-calorie diet and increased physical activity  
  AND  
  • The dose is limited 3 mg per day  
  **Note:** Drugs for weight management are excluded under many benefit plans. Therefore, use of Saxenda® (liraglutide) for weight management may not be covered. Please refer to the applicable benefit plan document to determine benefit availability (see Benefit Application for further information). |
| **Xenical® (orlistat)**   | **Xenical® (orlistat) may be considered medically necessary for chronic weight management when the following criteria are met:**  
  • Patient is 12 years of age or older  
  AND  
  • Patient has a body mass index (BMI) of ≥ 30 kg/m²  
  OR  
  • Patient has a BMI of ≥ 27 kg/m² and one or more of the following weight-related comorbid conditions:  
    - Type 2 diabetes mellitus  
    - Hypertension  
    - Sleep apnea  
    - Hyperlipidemia  
    - Symptomatic osteoarthritis of the lower extremities (knee or hip)  
    - Coronary artery disease  
  AND  
  • Medication is being used as an adjunct to a reduced-calorie diet and increased physical activity  
  AND  
  • The dose is limited to three Xenical® 120 mg capsules daily (taken as one capsule three times a day)  
  **Note:** Drugs for weight management are excluded under many benefit plans. Therefore, use of Xenical® (orlistat) for weight management may not be covered. Please refer to the applicable benefit plan document to determine benefit availability (see Benefit Application for further information). |
Drug | Medical Necessity
---|---
| determine benefit availability (see Benefit Application for further information).

| Drug | Investigational
---|---
| As listed | All other uses of the medications listed in this policy are considered investigational.

Length of Approval

| Approval | Criteria |
---|---|
| Initial authorization | Drugs listed in policy may be approved up to 6 months. |
| Re-authorization criteria | Future re-authorization of drugs listed in policy may be approved up to 12 months when clinical benefit/response at the time of re-authorization show:  
  • Weight loss of ≥ 3% in the first 12 weeks of treatment  
  AND  
  • Maintenance of weight loss and adherence to a reduced-calorie diet and increased physical activity |

Documentation Requirements

The patient’s medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the patient body mass index (BMI), relevant history including any weight-related comorbidities, dietary plan, physical activity plan, and medication dosage

Coding

N/A

Related Information
Consideration of Age

The ages stated in this policy for which Contrave® (naltrexone/bupropion), Qsymia® (phentermine/topiramate extended-release), Saxenda® (liraglutide), and Xenical® (orlistat) are considered medically necessary are based on the ages approved in the FDA labeling.

Benefit Application

Many benefit plans exclude drugs for weight management. Please refer to the applicable benefit plan to determine benefit availability and the terms, conditions, and limitations of coverage. For questions about benefit information, providers should contact customer service using the telephone number on the back of the member’s identification card.

Evidence Review

Summary of Evidence

Contrave® (naltrexone/bupropion)

The effects of Contrave on weight loss in conjunction with reduced caloric intake and increased physical activity was studied in double-blind, placebo-controlled trials (BMI range 27 to 45 kg/m²) with study durations of 16 to 56 weeks randomized to naltrexone and/or bupropion or placebo.

Four 56-week multicenter, double-blind, placebo-controlled obesity trials (Contrave Obesity Research, or COR-I, COR-II, COR-BMOD, and COR-Diabetes) were conducted to evaluate the effect of Contrave in conjunction with lifestyle modification in 4,536 patients randomized to Contrave or placebo. The COR-I, COR-II, and COR-BMOD trials enrolled patients with obesity (BMI 30 kg/m² or greater) or overweight (BMI 27 kg/m² or greater) and at least one comorbidity (hypertension or dyslipidemia). The COR-Diabetes trial enrolled patients with BMI greater than 27 kg/m² with type 2 diabetes with or without hypertension and/or dyslipidemia.

Treatment was initiated with a three-week dose-escalation period followed by approximately 1 year of continued therapy. Patients were instructed to take Contrave with food. COR-I and COR-II included a program consisting of a reduced-calorie diet resulting in an approximate 500
kcal/day decrease in caloric intake, behavioral counseling, and increased physical activity. COR-BMOD included an intensive behavioral modification program consisting of 28 group counseling sessions over 56 weeks as well as a prescribed diet and exercise regimen. COR-Diabetes evaluated patients with type 2 diabetes not achieving glycemic goal of a HbA1c less than 7% either with oral antidiabetic agents or with diet and exercise alone. Of the overall population from these four trials, 24% had hypertension, 54% had dyslipidemia at study entry, and 10% had type 2 diabetes.

The co-primary endpoints were percent change from baseline body weight and the proportion of patients achieving at least a 5% reduction in body weight. In the 56-week COR-I trial, the mean change in body weight was -5.4% among patients assigned to Contrave 32 mg/360 mg compared with -1.3% among patients assigned to placebo (Intent-To-Treat [ITT] population). In this trial, the achievement of at least a 5% reduction in body weight from baseline occurred more frequently for patients treated with Contrave 32 mg/360 mg compared with placebo (42% vs 17%). The percentages of patients who achieved at least 5% or at least 10% body weight loss from baseline were greater among those assigned to Contrave, compared with placebo, in all four obesity trials.

Safety

Contrave has a boxed warning regarding suicidal thoughts and behaviors. Contrave contains the antidepressant bupropion and patients with major depressive disorder, both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. In placebo-controlled clinical trials with Contrave for the treatment of obesity in adult patients, no suicides or suicide attempts were reported in studies up to 56 weeks duration with Contrave (equivalent to bupropion doses of 360 mg/day). In these same studies, suicidal ideation was reported by 3 (0.20%) of 1,515 patients treated with placebo compared with 1 (0.03%) of 3,239 treated with Contrave.

In Contrave clinical trials, 24% of subjects receiving Contrave and 12% of subjects receiving placebo discontinued treatment because of an adverse event. The most frequent adverse reactions leading to discontinuation with Contrave were nausea (6.3%), headache (1.7%) and vomiting (1.1%). The top 5 adverse reactions among patients’ treatment with Contrave and more common than placebo are nausea (32.5% vs. 6.7%), constipation (19.2% vs. 7.2%), headache (17.6% vs. 10.4%), vomiting (10.7% vs. 2.9%), and dizziness (9.9% vs. 3.4%).
Qsymia® (phentermine/topiramate extended-release)

The effect of Qsymia on weight loss in conjunction with reduced caloric intake and increased physical activity was studied in 2 randomized, double-blind, placebo-controlled studies in obese patients (Study 1) and in obese and overweight patients with two or more significant co-morbidities (Study 2). Both studies had a 4-week titration period, followed by 52 weeks of treatment. There were 2 co-primary efficacy outcomes measured after 1 year of treatment (Week 56): 1) the percent weight loss from baseline; and 2) treatment response defined as achieving at least 5% weight loss from baseline.

In Study 1, obese patients (BMI greater than or equal to 35 kg/m²) were randomized to receive 1 year of treatment with placebo (N=514), Qsymia 3.75 mg/23 mg (N=241), or Qsymia 15 mg/92 mg (N=512) in a 2:1:2 ratio. Patients ranged in age from 18-71 years old (mean age 43) and 83% were female. Approximately 80% were Caucasian, 18% were African American, and 15% were Hispanic/Latino. At the beginning of the study the average weight and BMI of patients was 116 kg and 42 kg/m², respectively. Patients with type 2 diabetes were excluded from participating in Study 1. During the study, a well-balanced, reduced-calorie diet to result in an approximate 500 kcal/day decrease in caloric intake was recommended to all patients and patients were offered nutritional and lifestyle modification counseling.

In Study 2, overweight and obese patients were randomized to receive 1 year of treatment with placebo (N=994), Qsymia 7.5 mg/46 mg (N=498), or Qsymia 15 mg/92 mg (N=995) in a 2:1:2 ratio. Eligible patients had to have a BMI greater than or equal to 27 kg/m² and less than or equal to 45 kg/m² (no lower limit on BMI for patients with type 2 diabetes) and two or more of the following obesity-related co-morbid conditions:

- Elevated blood pressure (greater than or equal to 140/90 mmHg, or greater than or equal to 130/85 mmHg for diabetics) or requirement for greater than or equal to 2 antihypertensive medications;
- Triglycerides greater than 200-400 mg/dL or were receiving treatment with 2 or more lipid-lowering agents;
- Elevated fasting blood glucose (greater than 100 mg/dL) or diabetes; and/or
- Waist circumference greater than or equal to 102 cm for men or greater than or equal to 88 cm for women.
After 1 year of treatment with Qsymia, all dose levels resulted in statistically significant weight loss compared to placebo. A statistically significant greater proportion of the patients randomized to Qsymia than placebo achieved 5% and 10% weight loss.

**Safety**

Adverse reactions occurring at a rate of greater than or equal to 5% and at a rate at least 1.5 times placebo include paraesthesia, dizziness, dysgeusia, insomnia, constipation, and dry mouth.

Qsymia is contraindicated in pregnant patients. The use of Qsymia can cause fetal harm and weight loss offers no clear clinical benefit to a pregnant patient. Available data from a pregnancy registry and epidemiologic studies indicate an increased risk in oral clefts (cleft lip with or without cleft palate) with first trimester exposure to topiramate, a component of Qsymia. When phentermine and topiramate were co-administered to rats at doses of 3.75 and 25 mg/kg, respectively [approximately 2 times the maximum recommended human dose (MRHD) based on area under the curve (AUC)], or at the same dose to rabbits (approximately 0.1 times and 1 time, respectively, the clinical exposures at the MRHD based on AUC), there were no drug-related malformations. However, structural malformations, including craniofacial defects and reduced fetal weights occurred in offspring of multiple species of pregnant animals administered topiramate at clinically relevant doses.

**Saxenda® (liraglutide)**

The safety and efficacy of Saxenda for chronic weight management in conjunction with reduced caloric intake and increased physical activity were studied in three 56-week, randomized, double-blind, placebo-controlled trials. In all studies, Saxenda was titrated to 3 mg daily during a 4-week period. All patients received instruction for a reduced calorie diet (approximately 500 kcal/day deficit) and exercise counseling (recommended increase in physical activity of minimum 150 mins/week) that began with the first dose of study medication or placebo and continued throughout the trial.

Study 1 enrolled 3731 patients with obesity (BMI greater than or equal to 30 kg/m²) or with overweight (BMI 27-29.9 kg/m²) and at least one weight-related comorbid condition such as treated or untreated dyslipidemia or hypertension; patients with type 2 diabetes mellitus were excluded. Patients were randomized in a 2:1 ratio to either Saxenda or placebo. Patients were stratified based on the presence or absence of abnormal blood glucose measurements at
randomization. All patients were treated for up to 56 weeks. Those patients with abnormal glucose measurements at randomization (2254 of the 3731 patients) were treated for a total of 160 weeks. At baseline, mean age was 45 years (range 18-78), 79% were women, 85% were Caucasian, 10% were African American, and 11% were Hispanic/Latino. Mean baseline body weight was 106.3 kg and mean BMI was 38.3 kg/m².

Study 2 was a 56-week trial that enrolled 635 patients with type 2 diabetes and with either overweight or obesity (as defined above). Patients were to have an HbA of 7-10% and be treated with metformin, a sulfonylurea, or a glitazone as single agent or in any combination, or with diet and exercise alone. Patients were randomized in a 2:1 ratio to receive either Saxenda or placebo. The mean age was 55 years (range 18-82), 50% were women, 83% were Caucasian, 12% were African American, and 10% were Hispanic/Latino. Mean baseline body weight was 105.9 kg and mean BMI was 37.1 kg/m².

Study 3 was a 56-week trial that enrolled 422 patients with obesity (BMI greater than or equal to 30 kg/m²) or with overweight (BMI 27-29.9 kg/m²) and at least one weight-related comorbid condition such as treated or untreated dyslipidemia or hypertension; patients with type 2 diabetes mellitus were excluded. All patients were first treated with a diet (total energy intake 1200-1400 kcal/day) in a run-in period lasting up to 12 weeks. Patients who lost at least 5% of their screening body weight after 4 to 12 weeks during the run-in were then randomized, with equal allocation, to receive either Saxenda or placebo for 56 weeks. The mean age was 46 years (range 18-73), 81% were women, 84% were Caucasian, 13% were African American, and 7% were Hispanic/Latino. Mean baseline body weight was 99.6 kg and mean BMI was 35.6 kg/m².

For Study 1 and Study 2, the primary efficacy parameters were mean percent change in body weight and the percentages of patients achieving greater than or equal to 5% and 10% weight loss from baseline to week 56. For Study 3, the primary efficacy parameters were mean percent change in body weight from randomization to week 56, the percentage of patients not gaining more than 0.5% body weight from randomization (i.e., after run-in) to week 56, and the percentage of patients achieving greater than or equal to 5% weight loss from randomization to week 56. Because losing at least 5% of fasting body weight through lifestyle intervention during the 4- to 12-week run-in was a condition for their continued participation in the randomized treatment period, the results may not reflect those expected in the general population.

After 56 weeks, treatment with Saxenda resulted in a statistically significant reduction in weight compared with placebo. Statistically significantly greater proportions of patients treated with Saxenda achieved 5% and 10% weight loss than those treated with placebo. In Study 3, statistically significantly more patients randomized to Saxenda than placebo had not gained more than 0.5% of body weight from randomization to week 56.
Safety

Saxenda includes a boxed warning since it causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice. Malignant thyroid C-cell carcinomas were detected in rats and mice. It is unknown whether Saxenda will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors has not been determined.

Cases of MTC in patients treated with liraglutide have been reported in the post-marketing period; the data in these reports are insufficient to establish or exclude a causal relationship between MTC and liraglutide use in humans. Saxenda is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2.

In clinical trials, 9.8% of patients treated with Saxenda and 4.3% of patients treated with placebo prematurely discontinued treatment as a result of adverse reactions. The most common adverse reactions leading to discontinuation were nausea (2.9% versus 0.2% for Saxenda and placebo, respectively), vomiting (1.7% versus less than 0.1%), and diarrhea (1.4% versus 0%). The top 5 adverse reactions among patients’ treatment with Saxenda and more common than placebo are nausea (39.3% vs. 13.8%), diarrhea (20.9% vs. 9.9%), constipation (19.4% vs. 8.5%), vomiting (15.7% vs. 3.9%), and headache (13.6% vs. 12.6%).

Xenical® (orlistat)

The effects of Xenical on weight loss, weight maintenance, and weight regain and on a number of comorbidities (e.g., type 2 diabetes, lipids, blood pressure) were assessed in the 4-year XENDOS study and in seven long-term (1- to 2-years duration) multicenter, double-blind, placebo-controlled clinical trials. During the first year of therapy, the studies of 2-year duration assessed weight loss and weight maintenance. During the second year of therapy, some studies assessed continued weight loss and weight maintenance and others assessed the effect of Xenical on weight regain. These studies included over 2800 patients treated with Xenical and 1400 patients treated with placebo (age range 17-78 years, 80.2% women, 91.0% Caucasians, 5.7% Blacks, 2.3% Hispanics, 0.9% Other). The majority of these patients had obesity-related risk factors and comorbidities. In the XENDOS study, which included 3304 patients (age range 30-58 years, 55% women, 99% Caucasians, 1% other), the time to onset of type 2 diabetes was assessed in addition to weight management. In all these studies, treatment with Xenical and placebo designates treatment with Xenical plus diet and placebo plus diet, respectively.
During the weight loss and weight maintenance period, a well-balanced, reduced-calorie diet that was intended to result in an approximate 20% decrease in caloric intake and provide 30% of calories from fat was recommended to all patients. In addition, all patients were offered nutritional counseling.

Pooled data from five clinical trials indicated that the overall mean weight loss from randomization to the end of 1 year of treatment in the intent-to-treat population was 13.4 lbs in the patients treated with Xenical and 5.8 lbs in the placebo-treated patients. After 1 year of treatment, the mean percent weight loss difference between Xenical-treated patients and placebo-treated patients was 3%. One thousand seventy-two (69%) patients treated with Xenical and 701 (63%) patients treated with placebo completed 1 year of treatment. Of the patients who completed 1 year of treatment, 57% of the patients treated with Xenical (120 mg three times a day) and 31% of the placebo-treated patients lost at least 5% of their baseline body weight.

Three studies were designed to evaluate the effects of Xenical compared to placebo in reducing weight regain after a previous weight loss achieved following either diet alone (one study, 14302) or prior treatment with Xenical (two studies, 14119C and 14185). The diet utilized during the 1-year weight regain portion of the studies was a weight-maintenance diet, rather than a weight-loss diet, and patients received less nutritional counseling than patients in weight-loss studies. For studies 14119C and 14185, patients' previous weight loss was due to 1 year of treatment with Xenical in conjunction with a mildly hypocaloric diet. Study 14302 was conducted to evaluate the effects of 1 year of treatment with Xenical on weight regain in patients who had lost 8% or more of their body weight in the previous 6 months on diet alone.

In study 14119C, patients treated with placebo regained 52% of the weight they had previously lost while the patients treated with Xenical regained 26% of the weight they had previously lost (p<0.001). In study 14185, patients treated with placebo regained 63% of the weight they had previously lost while the patients treated with Xenical regained 35% of the weight they had lost (p<0.001). In study 14302, patients treated with placebo regained 53% of the weight they had previously lost while the patients treated with Xenical regained 32% of the weight that they had lost (p<0.001).

In the 4-year double-blind, placebo-controlled XENDOS study, the effects of Xenical in delaying the onset of type 2 diabetes and on body weight were compared to placebo in 3304 obese patients who had either normal or impaired glucose tolerance at baseline. Thirty-four percent of the 1655 patients who were randomized to the placebo group and 52% of the 1649 patients who were randomized to the Xenical group completed the 4-year study.

At the end of the study, the mean percent weight loss in the placebo group was -2.75% compared with - 5.17% in the Xenical group (p<0.001). Forty-five percent of the placebo
patients and 73% of the Xenical patients lost ≥5% of their baseline body weight, and 21% of the placebo patients and 41% of the Xenical patients lost ≥10% of their baseline body weight following the first year of treatment. Following 4 years of treatment, 28% of the placebo patients and 45% of the Xenical patients lost ≥5% of their baseline body weight and 10% of the placebo patients and 21% of the Xenical patients lost ≥10% of their baseline body weight. After 4 years of treatment, the mean % difference in weight loss between Xenical treated patients and placebo was 2.5%.

Safety

Gastrointestinal (GI) symptoms were the most commonly observed treatment-emergent adverse events associated with the use of Xenical in the seven double-blind, placebo-controlled clinical trials and are primarily a manifestation of the mechanism of action. (Commonly observed is defined as an incidence of ≥5% and an incidence in the Xenical 120 mg group that is at least twice that of placebo.) The top 5 adverse events among patients’ treatment with Xenical during year 1 and more common than placebo are oily spotting (26.6% vs. 1.3%), flatus with discharge (23.9% vs. 1.4%), fecal urgency (22.1% vs. 6.7%), fatty/oily stool (20.0% vs. 2.9%), and oil evacuation (11.9% vs. 0.8%). In general, the first occurrence of these events was within 3 months of starting therapy. Overall, approximately 50% of all episodes of GI adverse events associated with Xenical treatment lasted for less than 1 week, and a majority lasted for no more than 4 weeks. However, GI adverse events may occur in some individuals over a period of 6 months or longer.

References

**Date** | **Comments**
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01/01/21 | New policy, approved December 8, 2020, effective for dates of service on or after January 1, 2020. Add to Prescription Drug section. Coverage criteria added for Contrave (naltrexone/bupropion), Qsymia (phentermine/topiramate extended-release), Saxenda (liraglutide), and Xenical (orlistat) for the treatment of chronic weight management.

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2021 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.

Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Amharic):
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