Select Inhaled Respiratory Agents

Policy # 00526
Original Effective Date: 01/01/2017
Current Effective Date: 06/20/2018

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Inhaled Corticosteroid Products
Based on review of available data, the Company may consider the inhaled corticosteroid products Aerospan®‡ (flunisolide), Alvesco®‡ (ciclesonide), Asmanex®‡ Twisthaler®‡ (mometasone furoate), Asmanex®‡ HFA (mometasone furoate), Pulmicort Flexhaler®‡ (budesonide), and Armonair™‡ Respiclick®‡ (fluticasone propionate) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Aerospan (flunisolide), Alvesco (ciclesonide), Asmanex Twisthaler (mometasone furoate), Asmanex HFA (mometasone furoate), Pulmicort Flexhaler (budesonide), or Armonair Respiclick (fluticasone propionate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Arnuity™‡ Ellipta®‡ (fluticasone furoate), Flovent®‡ Diskus®‡ (fluticasone propionate), Flovent®‡ HFA (fluticasone propionate), or QVAR®‡ (beclomethasone dipropionate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Aerospan (flunisolide), Alvesco (ciclesonide), Asmanex Twisthaler (mometasone furoate), Asmanex HFA (mometasone furoate), Pulmicort Flexhaler (budesonide), or Armonair Respiclick (fluticasone propionate) WITHOUT clinical evidence or patient history that suggests the use of Arnuity Ellipta (fluticasone furoate), Flovent Diskus (fluticasone propionate), Flovent HFA (fluticasone propionate), or QVAR (beclomethasone propionate) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

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Inhaled Long Acting Beta Agonists (LABAs)
Based on review of available data, the Company may consider the inhaled long acting beta agonists Arcapta™‡ Neohaler™‡ (indacaterol) and Foradil®‡ Aerolizer®‡ (formoterol fumarate) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Arcapta Neohaler (indacaterol) or Foradil Aerolizer (formoterol fumarate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Striverdi®‡ Respimat®‡ (olodaterol) or Serevent®‡ Diskus (salmeterol xinafoate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Arcapta Neohaler (indacaterol) or Foradil Aerolizer (formoterol fumarate) WITHOUT clinical evidence or patient history that suggests the use of Striverdi Respimat (olodaterol) or Serevent Diskus (salmeterol xinafoate) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Nebulized Long Acting Chronic Obstructive Pulmonary Disease (COPD) Products
Based on review of available data, the Company may consider the nebulized long acting COPD products Brovana®‡ (arformoterol tartrate), Perforomist®‡ (formoterol fumarate), and Lonhala™‡ Magnair™‡ (glycopyrrolate) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Brovana (arformoterol tartrate), Perforomist (formoterol fumarate), or Lonhala Magnair (glycopyrrolate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of TWO of the following preferred bronchodilating agents for COPD: Advair®‡ Diskus (fluticasone propionate/salmeterol), Serevent Diskus (salmeterol xinafoate), Spiriva®‡ Respimat®‡ (tiotropium bromide), Spiriva HandiHaler®‡ (tiotropium bromide), Anoro®‡ Ellipta (umeclidinium/vilanterol), Stiolto®‡ Respimat (tiotropium bromide/olodaterol), Striverdi Respimat (olodaterol), Incruse®‡ Ellipta (umeclidinium), or Symbicort®‡ (budesonide/formoterol fumarate dihydrate) will be/was ineffective or will/did cause an adverse reaction to the patient.

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When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Brovana (arformoterol tartrate), Perforomist (formoterol fumarate), or Lonhala Magnair (glycopyrrolate) WITHOUT clinical evidence or patient history that suggests the use of TWO of the following preferred bronchodilating agents for COPD: Advair Diskus (fluticasone propionate/salmeterol), Serevent Diskus (salmeterol xinafoate), Spiriva Respimat (tiotropium bromide), Spiriva HandiHaler (tiotropium bromide), Anoro Ellipta (umeclidinium/vilanterol), Stiolto Respimat (tiotropium bromide/olodaterol), Striverdi Respimat (olodaterol), Incruse Ellipta (umeclidinium), or Symbicort (budesonide/formoterol fumarate dihydrate) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Inhaled Corticosteroid/Long Acting Beta Agonist Combination Products (ICS/LABAs)
Based on review of available data, the Company may consider the inhaled corticosteroid/long acting beta agonist combination product AirDuo™‡ Respiclick (fluticasone propionate/salmeterol) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for AirDuo Respiclick (fluticasone propionate/salmeterol) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Advair Diskus (fluticasone propionate/salmeterol), Advair HFA (fluticasone propionate/salmeterol), Breo®‡ Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/formoterol fumarate dihydrate), the branded generic Fluticasone Propionate/Salmeterol (branded generic of AirDuo Respiclick), or Dulera®‡ (mometasone furoate/formoterol furoate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of AirDuo Respiclick (fluticasone propionate/salmeterol) WITHOUT clinical evidence or patient history that suggests the use of Advair Diskus (fluticasone propionate/salmeterol), Advair HFA (fluticasone proprionate/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/formoterol fumarate dihydrate), the branded generic Fluticasone Propionate/Salmeterol (branded generic of AirDuo Respiclick), or Dulera (mometasone furoate/formoterol furoate) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

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When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Inhaled Long Acting Antimuscarinic Agents (LAMAs)
Based on review of available data, the Company may consider the inhaled long acting antimuscarinic agents Tudorza®‡ Pressair®‡ (aclidinium bromide) and Seebri™‡ Neohaler (glycopyrrolate) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Tudorza Pressair (aclidinium bromide) or Seebri Neohaler (glycopyrrolate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Spiriva Respimat (tiotropium bromide), Spiriva HandiHaler (tiotropium bromide), or Incruse Ellipta (umeclidinium) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Tudorza Pressair (aclidinium bromide) or Seebri Neohaler (glycopyrrolate) WITHOUT clinical evidence or patient history that suggests the use of Spiriva Respimat (tiotropium bromide), Spiriva HandiHaler (tiotropium bromide), or Incruse Ellipta (umeclidinium) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Inhaled Long Acting Antimuscarinic Agent/Long Acting Beta Agonist Combination Products (LAMA/LABAs)
Based on review of available data, the Company may consider the inhaled long acting antimuscarinic agent/long acting beta agonist combination products Bevespi Aerosphere™‡ (glycopyrrolate/formoterol fumarate) and Utibron™‡ Neohaler (indacaterol/glycopyrrolate) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Bevespi Aerosphere (glycopyrrolate/formoterol fumarate) or Utibron Neohaler (indacaterol/glycopyrrolate) when the following criterion is met:

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- There is clinical evidence or patient history that suggests the use of Anoro Ellipta (umeclidinium/vilanterol) or Stiolto Respimat (tiotropium bromide/olodaterol) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Bevespi Aerosphere (glycopyrrolate/formoterol fumarate), or Utibron Neohaler (indacaterol/glycopyrrolate) WITHOUT clinical evidence or patient history that suggests the use of Anoro Ellipta (umeclidinium/vilanterol) or Stiolto Respimat (tiotropium bromide/olodaterol) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Inhaled Short Acting Beta Agonists (SABAs)
Based on review of available data, the Company may consider the short acting beta agonists Proventil®‡ HFA (albuterol sulfate) and Xopenex®‡ HFA (levalbuterol tartrate) to be **eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Proventil HFA (albuterol sulfate) or Xopenex HFA (levalbuterol tartrate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of ProAir®‡ RespiClick (albuterol sulfate), ProAir HFA (albuterol sulfate) or Ventolin®‡ HFA (albuterol sulfate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Proventil HFA (albuterol sulfate) or Xopenex HFA (levalbuterol tartrate) WITHOUT clinical evidence or patient history that suggests the use of ProAir RespiClick (albuterol sulfate), ProAir HFA (albuterol sulfate), or Ventolin HFA (albuterol sulfate) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.****

Schematic

Class	Non-Preferred Products	Preferred Products
Inhaled Corticosteroids (ICS)	Aerospan Alvesco Asmanex Twisthaler Asmanex HFA	Arnuity Ellipta Flovent Diskus Flovent HFA QVAR

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	Pulmicort Flexhaler Armonair Respiclick	
Inhaled Long Acting Beta Agonists (LABAs)	Arcapta Neohaler Foradil Aerolizer	Striverdi Respimat Serevent Diskus
Nebulized Long Acting COPD Products	Brovana Perforomist Lonhala Magnair	Advair Diskus Serevent Diskus Spiriva Respimat Spiriva HandiHaler Anoro Ellipta Stiolto Respimat Striverdi Respimat Incruse Ellipta Symbicort
Inhaled Corticosteroids/Long Acting Beta Agonists (ICS/LABAs)	AirDuo Respiclick	Advair Diskus Advair HFA Breo Ellipta Symbicort Fluticasone/Salmeterol-(branded generic of AirDuo Respiclick) Dulera
Inhaled Long Acting Antimuscarinic Agents (LAMAs)	Tudorza Pressair Seebri Neohaler	Spiriva Respimat Spiriva HandiHaler Incruse Ellipta
Inhaled Long Acting Antimuscarinic Agents/Long Acting Beta Agonists (LAMA/LABA)	Utibron Neohaler Bevespi Aerosphere	Anoro Ellipta Stiolto Respimat
Inhaled Short Acting Beta Agonists (SABAs)	Proventil HFA Xopenex HFA	ProAir RespiClick ProAir HFA Ventolin HFA
Inhaled Long Acting Antimuscarinic Agents/Corticosteroids/Long Acting Beta Agonists (LAMA/ICS/LABA)	N/A	Trelegy™‡ Ellipta

Background/Overview

The various products mentioned in this policy are approved for use in COPD and/or asthma patients, depending on the particular product.

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Rationale/Source

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests the preferred products listed in this policy will be ineffective or cause an adverse reaction to the patient. Based on a review of the available data and in the absence of any of the caveats mentioned, there is no advantage of using the non-preferred agents mentioned in this policy over the preferred agents mentioned in this policy.

References

1. Advair Diskus [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated April 2016.
2. Advair HFA [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated December 2014.
3. Aerospan [package insert]. Meda Pharmaceuticals. Somerset, New Jersey. Updated June 2015.
4. Alvesco [package insert]. Sunovion Pharmaceuticals, Inc. Marlborough, Massachusetts. January 2013.
5. Anoro Ellipta [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated February 2016.
6. Arcapta Neohaler [package insert]. Novartis. East Hanover, New Jersey. Updated September 2012.
7. Arnuity Ellipta [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated November 2014.
8. Asmanex HFA [package insert]. Merck and Company. Whitehouse Station, New Jersey. Updated July 2016.
9. Asmanex Twisthaler [package insert]. Merck and Company. Whitehouse Station, New Jersey. September 2014.
10. Breo Ellipta [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated July 2016.
11. Brovana [package insert]. Sunovion Pharmaceuticals. Marlborough, Massachusetts. Updated February 2014.
12. Dulera [package insert]. Merck. Whitehouse Station, New Jersey. Updated July 2016.
13. Flovent Diskus [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated May 2014.
14. Flovent HFA [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated July 2016.
15. Foradil Aerolizer [package insert]. Merck. Whitehouse Station, New Jersey. Updated September 2012.
16. Incruse Ellipta {package insert}. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated February 2016.
17. Perforomist [package insert]. Mylan Specialty. Morgantown, West Virginia. Updated March 2013.
18. ProAir HFA [package insert]. Teva. Frazer, Pennsylvania. Updated June 2016.
19. ProAir Respiclick [package insert]. Frazer, Pennsylvania. Updated April 2016.
20. Proventil HFA [package insert]. Merck. Whitehouse Station, New Jersey. Updated December 2014.
21. Pulmicort Flexhaler [package insert[. AstraZeneca. Wilmington, Delaware. Updated July 2010.
22. Qvar [package insert]. Teva Respiratory, LLC. Horsham, Pennsylvania. Updated July 2014.
23. Seebri Neohaler. [package insert]. Novartis. East Hanover, New Jersey. Updated January 2016.
24. Serevent Diskus [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Update unknown.
25. Spiriva Respimat [package insert]. Boehringer Ingelheim. Ridgefield, Connecticut. Updated June 2016.
26. Spiriva Handihaler [package insert]. Boehringer Ingelheim. Ridgefield, Connecticut. Updated January 2016.
27. Stiolto Respimat [package insert]. AstraZeneca. Wilmington, Delaware. Updated June 2016.
28. Striverdi Respimat [package insert]. Boehringer Ingelheim. Ridgefield, Connecticut. Updated June 2016.
29. Symbicort [package insert]. AstraZeneca. Wilmington, Delaware. Updated February 2016.
30. Tudorza Pressair [package insert]. AstraZeneca. Wilmington, Delaware. Updated March 2016.
31. Utibron Neohaler [package insert]. Novartis. East Hanover, New Jersey. Updated January 2016.
32. Ventolin HFA [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated December 2014.
33. Xopenex HFA [package insert]. Sunovion. Marlborough, Massachusetts. Updated March 2015.
34. Bevespi Aerosphere [package insert]. AstraZeneca. Wilmington, Delaware. Updated April 2016.
35. AirDuo Respiclick [package insert]. Teva. Frazer, Pennsylvania. Updated January 2017.
36. Armonair Respiclick [package insert]. Teva. Frazer, Pennsylvania. Updated January 2017.
37. Trelegy Ellipta [package insert]. GlaxoSmithKline. Research Triangle Park, North Carolina. Updated September 2017.
38. Lonhala Magnair [package insert]. Sunovion. Germany. January 2018.

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Policy History

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09/08/2016	Medical Policy Committee review
09/21/2016	Medical Policy Implementation Committee approval. New policy.
08/03/2017	Medical Policy Committee review
08/23/2017	Medical Policy Implementation Committee approval. Moved Stiolto Respimat to a preferred agent. New drug (AirDuo) placed in the non-preferred position. Branded generic of AirDuo (fluticasone/salmeterol) place in preferred position. Adjust existing criteria based on these changes.
01/04/2018	Medical Policy Committee review
01/17/2018	Medical Policy Implementation Committee approval. Placed new drug, Armonair Respiclick, in the non-preferred column for ICS products. Added a new section for new drug class (LAMA/ICS/LABA) and placed Trelegy Ellipta in the preferred column.
06/07/2018	Medical Policy Committee review
06/20/2018	Medical Policy Implementation Committee approval. Switched Dulera to a preferred product. Added Lonhala Magnair to the policy. Changed nebulized long acting beta agonists to nebulized long acting COPD products. Added Advair Diskus and Symbicort as preferred options prior to Brovana, Perforomist, and Lonhala Magnair.

Next Scheduled Review Date: 06/2019

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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