

RX.PA.026.MPC Ocular Disorders

The purpose of this policy is to define the prior authorization process for drugs used for the treatment of ocular disorders.

Avastin® (bevacizumab) is indicated for the treatment of:

- Age related macular degeneration – Choroidal retinal neovascularization
- Branch retinal vein occlusion with macular edema
- Central retinal vein occlusion with macular edema
- Choroidal retinal neovascularization, Secondary to pathologic myopia
- Diabetic Macular Edema (DME)

Lucentis® (ranibizumab) is indicated for the treatment of:

- Neovascular (Wet) Age-Related Macular Degeneration (AMD)
- Macular Edema following Retinal Vein Occlusion (RVO)
- Diabetic Macular Edema (DME)
- Diabetic Retinopathy (DR)
- Myopic choroidal neovascularization (mCNV)

Eylea® (afibercept) is indicated for the treatment of:

- Neovascular (Wet) Age-Related Macular Degeneration (AMD)
- Macular Edema following Retinal Vein Occlusion (RVO)
- Diabetic Macular Edema (DME)
- Diabetic retinopathy (DR) associated with diabetic macular edema

Macugen® (pegaptanib octasodium) is indicated for the treatment of:

- Exudative age-related macular degeneration

Visudyne® (verteporfin)

- Age related macular degeneration – Choroidal retinal neovascularization
- Histoplasmosis associated with classic subfoveal choroidal neovascularization
- Myopia associated with classic subfoveal choroidal neovascularization

The drugs, Lucentis® (ranibizumab), Eylea® (afibercept), Avastin® (bevacizumab), Macugen® (pegaptanib octasodium), and Visudyne® (verteporfin) are subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

I. CLINICAL CRITERIA (Use for ALL Drug Requests)

Must meet all of the criteria listed under the respective product:

*****If intravenous Avastin is requested for oncology related treatment please forward to Eviti for prior authorization.**

1. Avastin (bevacizumab)

- Must be prescribed by a retinal specialist (ophthalmologist acceptable)
- Must be age 18 years or older
- Must have a diagnosis of 1 of the following:
 - Neovascular (wet) age-related macular degeneration
 - Branch retinal vein occlusion with macular edema
 - Central retinal vein occlusion with macular edema
 - Diabetic macular edema
 - Myopic choroidal neovascularization
- Must not have an active ocular or periocular infection

2. Lucentis (ranibizumab)

- Must be prescribed by a retinal specialist (ophthalmologist acceptable)
- Must be age 18 years or older
- Must have a diagnosis of 1 of the following:
 - Neovascular (wet) age-related macular degeneration
 - Macular edema following retinal vein occlusion
 - Diabetic macular edema
 - Diabetic retinopathy
 - Myopic choroidal neovascularization
- Must not have an active ocular or periocular infection

3. Eylea (afibercept)

- Must be prescribed by a retinal specialist (ophthalmologist acceptable)
- Must be age 18 years or older
- Must have a diagnosis of 1 of the following:
 - Neovascular (wet) age-related macular degeneration
 - Macular edema following retinal vein occlusion
 - Diabetic macular edema
 - Diabetic retinopathy associated with diabetic macular edema
- Must not have an active ocular or periocular infection
- Must not have active intraocular inflammation

4. Macugen (pegaptanib octasodium)

- Must be prescribed by a retinal specialist (ophthalmologist acceptable)
- Must be age 18 years or older
- Must have a diagnosis of exudative age-related macular degeneration
- Must not have an active ocular or periocular infection

5. Visudyne (verteporfin)

- Must be prescribed by a retinal specialist (ophthalmologist acceptable)
- Must be age 18 years or older
- Must have a diagnosis of subfoveal choroidal neovascularization due to 1 of the following:
 - Age-related macular degeneration
 - Pathologic myopia
 - Presumed ocular histoplasmosis
- Must not have porphyria

Reauthorization Criteria:

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon chart documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial

APPLICABLE CODES:	
CODE	DESCRIPTION
J0178	Injection, aflibercept, 1 mg
J2503	Injection, pegaptanib sodium, 0.3 mg
J2778	Injection, ranibizumab, 0.1 mg
J3396	Injection, verteporfin, 0.1 mg
J9035	Injection, bevacizumab, 10 mg

REFERENCES

1. Lucentis [package insert]. South San Francisco, CA: Genentech, Inc.; April 2017.
2. Eylea [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; March 2015.

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3. Macugen [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; July 2016.
4. Visudyne [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; June 2016.
5. Avastin [package insert]. San Francisco, CA: Genentech, Inc.; January 2021.
6. American Academy of Ophthalmology Retina Panel. Preferred Pattern® Guidelines age-related macular degeneration. San Francisco, CA: American Academy of Ophthalmology; 2008. Accessed November 23, 2011. Available at: www.aao.org/ppp.