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® (aflibercept) 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® (aflibercept), Avastin® (bevacizumab), Macugen® (pegaptanib octasodium), and Visudyne® (verteporfin) are subject to the prior authorization process.

PROCEDURE

A. <u>Initial Authorization Criteria:</u>

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 (aflibercept)**
   - 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

B. Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc) listed in the FDA approved labeling.

C. Avastin, Lucentis, Eylea, Macugen and Visudyne will be considered investigational or experimental for any other use and coverage may be provided if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia (AHFS-DI, DrugDex, Lexi-Drug, etc…) or at least two published peer-reviewed randomized controlled trials for the treatment of the diagnosis(es) for which it is prescribed. Abstracts (including meeting abstracts) are excluded from review consideration. These requests will be reviewed on a case by case basis to determine medical necessity.

D. <u>Reauthorization Criteria:</u>

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.

<u>Limitations:</u>

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

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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.
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 Fransico, CA: American Academy of Ophthalmology; 2008. Accessed November 23, 2011. Available at: www.aao.org/ppp.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Update to off-label restrictions	*04/2022*
Annual review	*02/2022*
Addition of dosing requirements and off-label restrictions	*12/2021*
Removal of step therapy requirements	*08/2021*
P&T Review	*11/2020*