MASSACHUSETTS

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Pharmacy Medical Policy

Vascular Endothelial Growth Factor (VEGF) Inhibitors Step Therapy

Table of Contents

Policy Number: 092

BCBSA Reference Number: N/A

Related Policies

- N/A

Prior Authorization Information

Policy	☐ Prior Authorization ☒ Step Therapy ☐ Quantity Limit ☐ Administrative	Reviewing Department	**Pharmacy Operations:** Tel: 1-800-366-7778 Fax: 1-800-583-6289
		Policy Effective Date	**10/1/2023**
Pharmacy (Rx) or Medical (MED) benefit coverage	☐ Rx ☒ MED	**To request for coverage:** Providers may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below. **Blue Cross Blue Shield of Massachusetts** **Pharmacy Operations Department** 25 Technology Place Hingham, MA 02043 Tel: 1-800-366-7778 Fax: 1-800-583-6289 **Individual Consideration for the atypical patient:** Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration	
Policy applies to Commercial Members: • Managed Care (HMO and POS), • PPO and Indemnity • MEDEX with Rx plan • Managed Major Medical with Custom BCBSMA Formulary • Comprehensive Managed Major Medical with Custom BCBSMA Formulary • Managed Blue for Seniors with Custom BCBSMA Formulary **Policy does NOT apply to**: • Medicare Advantage			

Summary

This is a comprehensive policy covering step therapy requirements for Vascular Endothelial Growth Factor (VEGF) Inhibitors for non-oncologic indications.

Policy

Length of Approval	24 months
Formulary Status	All requests must meet the Step Therapy requirement. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.

The step therapy requirements for VEGF Inhibitors:

Drug	Formulary Status (BCBSMA Commercial Plan)	Step Requirement
Step 1		
Alymsys ® (bevacizumab-maly)	Covered	Covered with no requirements
MVASI ™ (bevacizumab-awwb)	Covered	
Vegzelma ® (bevacizumab-adcd)	Covered	
Zirabev ™ (bevacizumab-bvzr)	Covered	
Avastin ® (bevacizumab)	Covered	
Step 2		
Bevacizumab ™*	ST	Requires prior use of ONE step 1 medication OR history of prior use of any step 2 medication within the previous 130 days. See below for prior use criteria.
Byooviz ™* (ranibizumab nuna)	ST	
Cimerli ™* (ranibizumab eqrn)	ST	
Eylea ®* (aflibercept)	ST	
Eylea ® HD* (aflibercept)	ST	
Lucentis ®* (ranibizumab)	ST	
Susvimo ™*(ranibizumab)	ST	
Vabysmo ™* (faricimab)	ST	
Beovu ®* (brolucizumab)	ST	Prior use of ONE Step 1 & ONE Step 2 Required

ST – Step Therapy; * Not available for retail Pharmacy billing

Prior Use Criteria

The plan uses prescription claim records to support criteria for prior use within previous 130 days or the trial and failure of formulary alternatives when available. Additional documentation will be required from the provider when historic prescription claim data is either not available or the medication fill history fails to establish criteria for prior use or trial and failure of formulary alternatives. Documentation will also be required to support any clinical reasons preventing the trial and failure of formulary alternatives. Please see the section on documentation requirements for more information.

Treatment of geographic atrophy – Syfovre ™

Prior Authorization Requirements

Length of Approval	12 months
Formulary Status	All requests must meet the applicable PA criteria and/or Step Therapy criteria. See section on individual consideration for more information if you require an exception to any of these criteria requirements.

Drug	Formulary Status (BCBSMA Commercial Plan)	Requirement
Syfovre ™ (pegcetacoplan)	PA	PA Required

Syfovre ™ (pegcetacoplan) may be covered for the acute treatment of geographic atrophy (GA) when **ALL** of the following criteria are met:

1. Age 18 years or older; **AND**
2. Confirmed diagnosis of geographic atrophy (GA); **AND**
3. Secondary to age-related macular degeneration (AMD).

Provider Documentation Requirements

Documentation from the provider to support a reason preventing trial of formulary alternative(s) must include the name and strength of alternatives tried and failed (if alternatives were tried, including dates if available) and specifics regarding the treatment failure. Documentation to support clinical basis preventing switch to formulary alternative should also provide specifics around clinical reason.

Individual Consideration (For Atypical Patients)

Our medical policies are written for most people with a given condition. Each policy is based on peer reviewed clinical evidence. We also take into consideration the needs of atypical patient populations and diagnoses.

If the coverage criteria outlined is unlikely to be clinically effective for the prescribed purpose, the health care provider may request an exception to cover the requested medication based on an individual's unique clinical circumstances. This is also referred to as "individual consideration" or an "exception request."

Some reasons why you may need us to make an exception include: therapeutic contraindications; history of adverse effects; expected to be ineffective or likely to cause harm (physical, mental, or adverse reaction).

To facilitate a thorough and prompt review of an exception request, we encourage the provider to include additional supporting clinical documentation with their request. This may include:

- Clinical notes or supporting clinical statements;
- The name and strength of formulary alternatives tried and failed (if alternatives were tried) and specifics regarding the treatment failure, if applicable;
- Clinical literature from reputable peer reviewed journals;
- References from nationally recognized and approved drug compendia such as American Hospital Formulary Service® Drug Information (AHFS-DI), Lexi-Drug, Clinical Pharmacology, Micromedex or Drugdex®; and
- References from consensus documents and/or nationally sanctioned guidelines.

Providers may call, fax or mail relevant clinical information, including clinical references for individual patient consideration, to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Phone: 1-800-366-7778
Fax: 1-800-583-6289

We may also use prescription claims records to establish prior use of formulary alternatives or to show if step therapy criteria has been met. We will require the provider to share additional information when prescription claims data is either not available or the medication fill history fails to establish use of preferred formulary medications or that step therapy criteria has been met.

Policy History

Date	Action
10/2023	Updated to move Eylea ® to Step 2 and to add Eylea HD ® and Syfovre ™ and Bevacizumab ™ to the policy.
9/2023	Reformatted policy and updated IC to align with 118E MGL § 51A
8/2023	Update to move Eylea ® and Beovu ® to step 3.
7/2023	Reformatted Policy
5/2023	Updated to a two-step policy prior to the August change announced in policy 999.
4/2023	Updated to add Vegzelma ® to step 1 of policy
11/2022	Updated to add Alymsys to step 1 and Cimerli to step 2.
8/2022	Updated to add Byooviz and to move Lucentis ® to step 3
3/2022	Updated new Medications Vabysmo ™ & Susvimo ™
11/2020	VEGF Inhibitors Step Therapy issued. Effective 11/2020. Policy #343 Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions and policy #401 Intravitreal Angiogenesis Inhibitors for Retinal Vascular Conditions were retired effective 11/2020. For coverage information, see policy #092 VEGF Inhibitors Step Therapy.

Forms

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

https://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf

OR

Print and fax, Massachusetts Standard Form for Medication Prior Authorization Requests #434

References

1. Avastin ® [package insert South San Francisco, CA: Genentech, Inc.: 6/2019.
2. Beovu ® [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation: 1/2020.
3. Eylea ® [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.: 8/2019.
4. Lucentis ® [package insert]. South San Francisco, CA: Genentech, Inc.: 11/2019.
5. Macugen ® [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals N. America LLC: 7/2016.
6. Susvimo ™ [package insert]. South San Francisco, CA: Genentech, Inc.: 3/2021.
7. Vabysmo ™ [package insert]. South San Francisco, CA: Genentech, Inc.: 3/2021.
8. Byooviz ™ [package insert]. Cambridge, MA: Biogen, Inc.: 4/2022.
9. Alymsys ® [package insert]. Bridgewater, NJ: Amneal Pharmaceuticals LLC: 4/2022.
10. Mvasi ™ [package insert]. Thousand Oaks, CA: Amgen, Inc.: 11/2021.
11. Zirabev ™ [package insert]. NY, NY: Pfizer, Inc.: 2/2023.
12. Vegzelma ® [package insert]. Jersey City, NJ: Celltrion USA, Inc: 4/2022.
13. Syfovre ™ [package insert]. Waltham, MA: Apellis Pharmaceuticals, Inc.: 2/2023.
14. Eylea ® HD [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.: 8/2023.