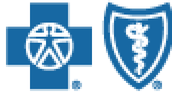

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy

Ophthalmic Prostaglandins

Table of Contents

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Policy Number: 346

BCBSA Reference Number: None

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

Drug	Formulary Information Standard Formulary Status
STEP 1	
bimatoprost	Covered
latanoprost	
travoprost	
STEP 2	
Lumigan® (bimatoprost)	Prior use of Step 1 Required
Travatan Z® (travoprost)	
Xalatan® (latanoprost)	
STEP 3	
Rocklatan™** (latanoprost / netarsudil)	Requires prior use of two step 2 medications.
Xelpros™** (latanoprost)	
Vyzulta™** (latanoprostene bunod)	
Zioptan™** (tafluprost)	

** Non-formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and criteria below are met

We cover the Ophthalmic Prostaglandin medications listed in the chart above for new starts* in the following stepped approach.1

*New start is defined as no previous paid claim for the requested medication within the past 130 days

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications may be covered when **one** of the following criteria are met:

- There must be evidence of a BCBSMA paid claim by the patient of a step 1 medication within the previous 130 days.
  OR
- There must be evidence of a BCBSMA paid claim by the patient of a step 2 medication within the previous 130 days.

Step 3: Non- Formulary step 3 medications may be covered when the following criteria is met:
• There must be evidence of BCBSMA paid claims by the patient of two different Step 2 drugs within the previous 130 days.
OR
• There must be evidence of a BCBSMA paid claim by the patient of a Step 3 drug within the previous 130 days. If the Medication is Not Covered/Non-formulary the drug needs to meet requirements for a Formulary Exception for continued coverage.

Note: If approved the Prior Authorization will be granted for up to one (1) year.

We do not cover drugs listed in the above chart unless the above step therapy criteria are met.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

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

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

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Policy History

Date	Action
4/2022	Clarified Non covered requirements
8/2019	Updated to add Vyzulta™ to step 2 & noncovered.

4/2019	Updated to add Rocklatan™ to step 2 & noncovered.
2/2019	Updated to add Xelpros™ to step 2.
6/2017	Updated address for Pharmacy Operations.
7/2015	Updated to add Bimatoprost to step 1.
1/2014	Updated ExpressPAth Language and removed Blue Value.
9/2013	Updated to include Travoprost at step 1 and to include Rescula™ at step 2.
7/2012	Updated 7/2012 to include coverage criteria for new FDA approved medication Zioptan™.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
2/2012	Reviewed MPG Psychiatry and Ophthalmology, no changes in coverage were made.
1/1/2012	New policy describing covered and non-covered indications. Effective 1/1/2012.

References

1. Lumigan® [package insert]. Irvine, CA: Allergan, Inc.; 2010.
2. Travatan Z® [package insert]. Fort Worth, TX: Alcon Laboratories, Inc.; 2010.
3. Xalatan® [package insert]. Woodstock, IL: Catalent Pharma Solutions; 2011.
4. Rescula™ [package insert]. Bethesda, Md: Sucampo lab; November 2012.
5. Travoprost [package insert]. Woodcliff Lake, NJ: Parr Pharm; March 2013.
6. Xelpros™ [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc; Sept 2018.
7. Zioptan® [package insert]. Lake Forest, IL: Oak Pharmaceuticals, Inc; Sept 2018.
8. Rocklatan® [package insert]. Irvine, CA: Aerie Pharmaceuticals, Inc.; Mar 2019.
9. Vyzulta™ [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; June 2018.

Endnotes

1. Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 9/13/2011.

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

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