Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Lucentis (ranibizumab) & Eylea (afibercept)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***March 2007 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: *February 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x] All
OTHER	[x] Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Lucentis (ranibizumab) and Eylea (Afibercept).

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

DEFINITIONS

N/A

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drugs, Lucentis (ranibizumab) and Eylea (Afibercept), are subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

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

1. **For ranibizumab (Lucentis):**
   - Must be prescribed by a retinal specialist
   - 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

2. **For aflibercept (Eylea):**
   - Must be prescribed by a retinal specialist
   - 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

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

If the established criteria are not met, the request is referred to a Medical Director for review.

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. 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.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual Review	*02/16, 02/17, 02/18*
Criteria Update	*04/17, 07/17*