MEDICAL MUTUAL®

Drug Policy

Policy: **Impacted Drugs:**	**Ophthalmic Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) Preferred Step Therapy Policy** • **Acular** • **Acular LS** • **Acuvail** • **Bromsite** • **Generic bromfenac 0.09% ophthalmic solution** • **Generic bromfenac 0.075% ophthalmic solution** • **Nevanac** • **Ilevro** • **Prolensa**	**Annual Review Date:** **08/22/2024** **Last Revised Date:** **08/22/2024**

OVERVIEW

Numerous brand and generic ophthalmic nonsteroidal anti-inflammatory drugs (NSAIDs) are currently available. The ophthalmic NSAIDs are indicated for the management of ocular pain and inflammation in the postoperative setting.

POLICY STATEMENT

A preferred step therapy program has been developed to encourage the use of a preferred product prior to the use of a non-preferred product. If the preferred step therapy rule is not met for a non-preferred product at the point of service, coverage will be determined by the preferred step therapy criteria below. All approvals are provided for 12 months in duration.

Automation: Patients with a history of a preferred product within the 130-day look-back period are excluded from step therapy.

Preferred products:

- Generic ketorolac 0.5% ophthalmic solution
- Generic ketorolac 0.4% ophthalmic solution
- Generic diclofenac 0.1% ophthalmic solution
- Generic flurbiprofen 0.03% ophthalmic solution

Non-preferred products:

- Acular

- Acular LS
- Acuvail
- Bromsite
- Generic bromfenac 0.09% ophthalmic solution
- Generic bromfenac 0.075% ophthalmic solution
- Nevanac
- Ilevro
- Prolensa

PREFERRED STEP THERAPY CRITERIA (FOR APPLICABLE REVIEWS)

1. If the patient has tried one preferred product, authorization for a non-preferred product may be given.

Approval Duration: 1 year (365 days)

Step Therapy Exception Criteria
Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred products. If so, please list specific diagnosis and/or specific patient characteristics [documentation required]; **OR**
B. The patient has a contraindication to all preferred products. If so, please list the specific contraindications to each preferred product [documentation required]; **OR**
C. The patient is continuing therapy with the requested non-preferred product after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:
    1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred product for 90 days within a 130-day look-back period; OR
    2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred product for 90 days AND that the patient has been receiving the requested non-preferred product via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred product); OR
    3. There are no generic alternatives to the requested non-preferred product [NOTE: ESI reviewer to list generic alternatives for requested non-preferred medication and confirm accuracy of physician response]

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other products, noted in the criteria as [documentation required]. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

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Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Acular® ophthalmic solution [prescribing information]. Irvine, CA: Allergan, Inc.; May 2012.
2. Acular LS® ophthalmic solution [prescribing information]. Irvine, CA: Allergan, Inc.; November 2011.
3. Acuvail® ophthalmic solution [prescribing information]. Irvine, CA: Allergan, Inc.; February 2019.
4. Ilevro® ophthalmic suspension [prescribing information]. Fort Worth, TX: Alcon Laboratories, Inc.; January 2019.
5. Nevanac® ophthalmic suspension [prescribing information]. Fort Worth, TX: Alcon Laboratories, Inc.; January 2018.
6. Prolensa™ ophthalmic solution [prescribing information]. Tampa, FL: Bausch & Lomb Incorporated; April 2020.
7. Bromfenac 0.09% ophthalmic solution [prescribing information]. Weston, FL: Apotex Corp.; June 2014.
8. Diclofenac 0.1% ophthalmic solution [prescribing information]. Tampa, FL: Bausch & Lomb Incorporated; Feb 2020.