MEDICAL MUTUAL®

Drug Policy

Policy:	**Ophthalmic Prostaglandins** **Preferred Step Therapy**	**Annual Review Date:** **11/21/2024**
Impacted Drugs:	**Bimatoprost 0.03% ophthalmic solution (generic)** **Rhopressa (netarsudil 0.02% ophthalmic solution)** **Rocklatan™ (netarsudil 0.02%/latanoprost 0.005% ophthalmic solution – Aerie)** **tafluprost 0.0015% ophthalmic solution (generic)** **travoprost 0.004% ophthalmic solution (generic)** **Xelpros (latanoprost 0.005% ophthalmic emulsion)** **Vyzulta (latanoprostene bunod 0.024% ophthalmic solution)**	**Last Revised Date:** **11/21/2024**

OVERVIEW

Ophthalmic prostanoids include prostaglandin analogues (travoprost [generic to discontinued Travatan], Travatan Z, Zioptan, and latanoprost), prostamides (Lumigan, bimatoprost 0.03% [generic to discontinued Lumigan 0.03%]), and docosanoids (latanoprostene bunod [Vyzulta]). Rocklatan is a combination product containing netarsudil and latanoprost. All previously listed prostanoids are indicated for the reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OH). Bimatoprost is also available as a 0.03% solution (Latisse™) indicated to treat hypotrichosis of the eyelashes by increasing their growth including length, thickness, and darkness, a cosmetic indication.

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 agent at the point of service, coverage will be determined by the preferred step therapy criteria below. All approvals are provided for 1 year in duration.

Automation: Patients > 18 years of age will be targeted in this step therapy program. A patient with a history of one Step 1 Product within the 130-day look-back period is excluded from Step Therapy.

Preferred Medications (Step 1)

- generic latanoprost 0.005% ophthalmic solution

Non-Preferred Medications (Step 2)

- generic bimatoprost 0.03% ophthalmic solution
- generic tafluprost 0.0015% ophthalmic solution
- generic travoprost 0.004% ophthalmic solution
- Iyuzeh (latanoprost 0.005% ophthalmic solution; preservative-free)
- Rhopressa (netarsudil 0.02% ophthalmic solution)
- Rocklatan™ (netarsudil 0.02%/latanoprost 0.005% ophthalmic solution – Aerie)

- Vyzulta (latanoprostene bunod 0.024% ophthalmic solution)
- Xelpros (latanoprost 0.005% ophthalmic emulsion)

PREFERRED STEP THERAPY CRITERIA

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

Initial Approval/ Extended Approval.
A) *Initial Approval:* 2 years
B) *Extended Approval:* 2 years

Preferred Step Therapy Exception Criteria
In certain situations, the patient is not required to trial preferred agents. 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 agents. If so, please list specific diagnosis and/or specific patient characteristics*; **OR**
B. The patient has a contraindication to all preferred agents. If so, please list the specific contraindications to each preferred agent*; **OR**
C. The patient is continuing therapy with the requested non-preferred agent 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 or 2):
    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 agent for 90 days within a 130-day look-back period AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product); 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 agent for 90 days AND that the patient has been receiving the requested non-preferred agent 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 agent) AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product).

***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. Xalatan® 0.005% ophthalmic solution [prescribing information]. New York, NY: Pfizer Inc; June 2014.
2. Lumigan® 0.03% ophthalmic solution [prescribing information]. Irvine, CA: Allergan, Inc.; September 2014.
3. Travatan® Z 0.004% ophthalmic solution [prescribing information]. Fort Worth, TX: Alcon Laboratories, Inc.; August 2011.
4. Zioptan™ 0.0015% ophthalmic solution [prescribing information]. Lake Forest, IL: Akorn, Inc.; August 2014.
5. Bimatoprost 0.03% ophthalmic solution [prescribing information]. Baltimore, MD: Lupin Pharmaceuticals, Inc.; March 2015.
6. Vyzulta 0.024% ophthalmic solution [prescribing information]. Rochester, NY: Bausch & Lomb Incorporated; November 2017.
7. Xelpros 0.005% ophthalmic emulsion [prescribing information]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; September 2018.
8. Rocklatan 0.02%/0.005% ophthalmic solution [prescribing information]. Irvine, CA: Aerie Pharmaceuticals, Inc: March 2019.
9. Rhopressa (netarsudil) [prescribing information]. Irvine, CA: Aerie Pharmaceuticals; March 2019.