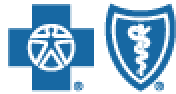

MASSACHUSETTS

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Pharmacy Medical Policy

Ophthalmic Prostaglandins

Table of Contents

- Related Policies
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Policy Number: 346

BCBSA Reference Number: N/A

Related Policies

- N/A

Prior Authorization Information

<table>
<tr><td rowspan="2">Policy</td><td rowspan="2">☐ Prior Authorization
☒ Step Therapy
☐ Quantity Limit
☐ Administrative</td><td>Reviewing Department</td><td>Pharmacy Operations:
Tel: 1-800-366-7778
Fax: 1-800-583-6289</td></tr>
<tr><td>Policy Effective Date</td><td>11/1/2023</td></tr>
<tr><td>Pharmacy (Rx) or Medical (MED) benefit coverage</td><td>☒ Rx
☐ MED</td><td colspan="2" rowspan="2">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</td></tr>
<tr><td colspan="2">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 <u>NOT</u> apply to:
• Medicare Advantage</td></tr>
</table>

Summary

This is a comprehensive policy covering step therapy requirements for ophthalmic prostaglandins.

The step therapy requirements for ophthalmic prostaglandins:

Drug	Formulary Status (BCBSMA Commercial Plan)	Step Requirement
Step 1		

bimatoprost	Covered	Covered with no requirements
latanoprost	Covered	
Tafluprost	Covered	
travoprost	Covered	
Step 2		
Lumigan ® (bimatoprost)	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.
Travatan Z ® (travoprost)	ST	
Xalatan ® (latanoprost)	ST	
Step 3		
Rocklatan ™ (latanoprost/netarsudil)	NFNC, ST	Requires prior use of TWO step 2 medication OR history of prior use of a step 3 medication within the previous 130 days. See below for prior use criteria.
Xelpros ™ (latanoprost)	NFNC, ST	
Vyzulta ™ (latanoprostene bunod)	NFNC, ST	
Zioptan ™ (tafluprost)	NFNC, ST	

ST – Step Therapy; NFNC – Non-formulary Non-Covered

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.

Policy

Length of Approval	24 months
Formulary Status	All requests must meet the Step Therapy requirement and for non-covered medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

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
11/2023	Reformatted Policy.
9/2023	Reformatted Policy. Updated IC section to align with 118E MGL § 51A.
7/2023	Reformatted Policy.
1/2023	Updated to add Tafluprost to step 3 as Non-Covered.
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.

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. 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.