Clinical Policy: Ophthalmic Agents: Glaucoma Agents

Reference Number: OH.PHAR.PPA.77
Effective Date: 01/01/2020 Revision Log
Last Review Date:
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

GLAUCOMA AGENTS – BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
BETAXOLOL CARTEOLOL LEVOBUNOLOL (generic of Betagan®) METIPRANOLOL (generic of Optipranolol®) TIMOLOL gel solution (generic of Timoptic-XE®) TIMOLOL solution (generic of Timoptic®)	BETOPTIC®S (betaxolol) ISTALOL™ (timolol)

GLAUCOMA AGENTS – PROSTAGLANDIN INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
LATANOPROST (generic of Xalatan®)	TRAVATAN®Z (travoprost)	BIMATOPROST 0.03% LUMIGAN™ 0.01% (bimatoprost) TRAVAPROST VYZULTA™ (latanoprostene bunod) XELPROS™ (LATANOPROST) ZIOPTAN® (tafluprost)

GLAUCOMA AGENTS – ALPHA ADRENERGIC AGONISTS/SYMPATHOMIMETICS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
BRIMONIDINE 0.2% ALPHAGAN®P (brimonidine 0.15%)	ALPHAGAN®P (brimonidine 0.1%)	APRACLONIDINE 0.5% (generic of Iopidine®) BRIMONIDINE 0.15% (generic of Alphagan® P) IOPIDINE® 1% (apraclonidine)

GLAUCOMA AGENTS – CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
DORZOLAMIDE (generic of Trusopt®)	AZOPT® (brinzolamide)	

GLAUCOMA AGENTS – COMBO BETA BLOCKER & ALPHA ADRENERGIC AGONIST

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
	COMBIGAN® (brimonidine/ timolol)	

GLAUCOMA AGENTS – COMBO BETA BLOCKER & CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
DORZOLAMIDE/TIMOLOL (generic of Cosopt®)		COSOPT® PF (dorzolamide/timolol)

COMBO ALPHA-ADRENERGIC AGONIST AND CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
SIMBRINZA™ (brinzolamide/ brimonidine)		

GLAUCOMA AGENTS – RHO KINASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
		RHOPRESSA® (netarsudil)

GLAUCOMA AGENTS – RHO KINASE AND PROSTAGLANDIN INHIBITORS COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	NON-PREFERRED "NON-PREFERRED"
		ROCKLATAN™ (netarsudil and latanoprost)

FDA approved indication(s)
Glaucoma agents are indicated for the reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Buckeye Health Plan, an affiliate of Centene Corporation® that Ophthalmic Agents: Glaucoma Agents are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

1. Prescribed indication is FDA-approved or supported by standard pharmacopeias;
2. Member must meet labeled age requirements for the medication;
3. If request is for a step therapy medication, failure of ≥ 30 days of at least one preferred medication, unless member meets one of the following (a, b, or c)
   a. Allergy to medications not requiring prior approval;
   b. Contraindication to or drug interaction with medications not requiring prior approval;
   c. History of unacceptable/toxic side effects to medications not requiring prior approval;
4. If request is for a non-preferred medication, failure of at least two preferred or step therapy medications, each for ≥ 30 days, unless member meets one of the following (a, b, or c):
   a. Allergy to medications not requiring prior approval;
   b. Contraindication to or drug interaction with medications not requiring prior approval;

c. History of unacceptable/toxic side effects to medications not requiring prior approval.

Approval Duration: 12 months

II. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy - CP.PMN.53 or evidence of coverage documents.

III. Appendices/General Information

Appendix A: Abbreviation Key

FDA: Food and Drug Administration
IOP: Intraocular pressure

Appendix B: Therapeutic Alternatives

- Dosing varies by drug product. See FDA approved dosing and administration.

Appendix C: Contraindications/Boxed Warnings

- Refer to Clinical Pharmacology or other appropriate clinical resource.

IV. Dosage and Administration

A. Varies by drug product. See FDA approved dosing and administration.

V. Product Availability

A. Varies by drug product. Please refer to Clinical Pharmacology or other appropriate clinical resource for product availability.

VI. References

Refer to package inserts.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	10/19	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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