Medica (formerly WellFirst Health)

Coverage of any drug intervention discussed in a Medica prior authorization guideline is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and applicable state and/or federal laws.

☒ Commercial (Small & Large Group) ☒ ASO ☒ Exchange/ACA
☐ Medicare Advantage (MAPD)

VYZULTA (latanoprostene bunod) PA1847
RHOPRESSA (netarsudil)

Covered Service: Yes

Prior Authorization Required: Yes

Additional Information: Must be prescribed with prior authorization through Navitus

Medicare Policy: Prior authorization is not required for Medicare Cost products (Dean Care Gold) and Medicare Supplement (Select) when this drug is provided by participating providers. Prior authorization is required if a member has Medicare primary and the plan secondary coverage. This policy is not applicable to our Medicare Replacement products.

Wisconsin Medicaid Policy Coverage of prescription drug benefits is administered by the Wisconsin Medicaid program. Coverage of medical drug benefits is administered by the Wisconsin Medicaid fee-for-service program. Medical drugs not paid on a fee-for-service basis by the Wisconsin Medicaid program are covered by the plan with no PA required.

Plan Approved Criteria:

1.0 Injections of drugs that are administered at an excessive frequency or dose are not medically necessary. Frequency or dosing are considered excessive when services are performed more frequently or at a higher dose than listed in the FDA-approved package insert, listed in this document or generally accepted by peers and the reason for additional services is not justified by submitted documentation of clinical evidence. Route of administration of injectable drugs should follow the FDA-approved package insert.

2.0 Quantity limits: VYZULTA: One bottle (2.5 mL or 5 mL) per 30 days
RHOPRESSA: One bottle (2.5 mL) per 30 days

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Initial Criteria (approved for 12 months, subject to formulary changes):

1.0 Open-Angle glaucoma or ocular hypertension:

- 1.1 Failure, contraindication, or intolerance to latanoprost
- 1.2 Failure, contraindication, or intolerance to a second formulary PGA (LUMIGAN, travoprost)
- 1.3 Failure or intolerance to a non-PGA glaucoma agent (beta blocker, carbonic anhydrase inhibitor, etc.)

Renewal criteria (approved for 12 months, subject to formulary changes):

1.0 Efficacy documented in the medical record indicating no disease progression or unacceptable toxicity

2.0 Dosing is in accordance with FDA-approved labeling

Comment(s):

1.0 **NOTE: The use of physician samples or manufacturer discounts does not guarantee later coverage under the provisions of the medical certificate and/or pharmacy benefit. All criteria must be met in order to obtain coverage of the listed drug product.**

	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Health Services Division/Pharmacy Services	December 19, 2018
Revised:	Medical Policy Committee/Health Services Division/Pharmacy Services	November 18, 2020
	Medical Policy Committee/Health Services Division/Pharmacy Services	December 15, 2021
	Medical Policy Committee/Health Services Division/Pharmacy Services	November 16, 2022
Reviewed:	Medical Policy Committee/Health Services Division/Pharmacy Services	November 20, 2019
	Medical Policy Committee/Health Services Division/Pharmacy Services	November 18, 2020
	Medical Policy Committee/Health Services Division/Pharmacy Services	December 15, 2021

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Committee/Source	Date(s)
Medical Policy Committee/Health Services Division/Pharmacy Services	November 16, 2022

Effective: 12/01/2022
Published: 12/01/2022

References:

1. Navitus Medication Utilization Policy: Rhopressa (netarsudil); November 2020. Accessed December 1, 2021.
2. Rhopressa [prescribing information]. Irvine, CA: Aerie Pharmaceuticals, Inc.; March 2019.
3. Vyzulta [prescribing information]. Tampa, FL: Bausch & Lomb, Inc.; May 2019.
4. Rhopressa [formulary dossier]. Irvine, CA: Aerie Pharmaceuticals, Inc.; March 2018.
5. Serle JB, Katz LJ, McLaurin E, et al. Two phase 3 clinical trials comparing the safety and efficacy of netarsudil to timolol in patients with elevated intraocular pressure: rho kinase elevated IOP treatment trial 1 and 2 (ROCKET-1 and ROCKET-2). *Am J Ophthalmol.* 2018;186:116-127.
6. Prum BE Jr, Rosenberg LF, Gedde SJ, et al. Primary open-angle glaucoma suspect preferred practice pattern guidelines. *Ophthalmology*. 2016;123(1):41-111.
7. International Council of Ophthalmolgy. ICO Guidelines for glaucoma eye care. Available at: http://www.icoph.org/downloads/ICOGlaucomaGuidelines.pdf. Last updated: Accessed on November 20, 2020.