Clinical Policy Title:	verteporfin
Policy Number:	RxA.554
Drug(s) Applied:	Visudyne®
Original Policy Date:	03/06/2020
Last Review Date:	10/19/2023
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Choroidal Neovascularization (must meet all):

1. Diagnosis of subfoveal CNV due to one of the following (a, b, or c):
   a. AMD;
   b. Pathologic myopia;
   c. Presumed ocular histoplasmosis;
2. Prescribed by or in consultation with an ophthalmologist;
3. Age ≥ 18 years;
4. Member has failed an intravitreal anti-vascular endothelial growth factor (VEGF), unless contraindicated or clinically significant adverse effects are experienced;
   *Prior authorization may be required
5. Dose does not exceed 6 mg/m^2 body surface area.

Approval Duration

Commercial: 3 months (1 dose)

Medicaid: 3 months (1 dose)

II. Continued Therapy Approval

A. Choroidal Neovascularization (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
2. Member is responding positively to therapy as evidenced by one of the following (a, b, c, or d):
   a. Detained neovascularization;
   b. Improvement in visual acuity;
   c. Maintenance of corrected visual acuity from prior treatment;
   d. Supportive findings from optical coherence tomography or fluorescein angiography;
3. Recent fluorescein angiography, conducted at least 3 months after the last treatment, shows recurrent or persistent choroidal neovascular leakage;
4. If request is for a dose increase, new dose does not exceed 6 mg/m^2 body surface area.

Approval Duration

Commercial: 3 months (1 dose)

Medicaid: 3 months (1 dose)

References

1. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; September 2019. Available at: www.aao.org/ppp. Accessed September 13, 2022.
2. Diaz RI, Sigler EJ, Rafieetary MR, Calzada JI. Ocular histoplasmosis syndrome. Surv Ophthalm. 2015; 60(4): 279-295. Available at: https://www.aaopt.org/detail/knowledge-base-article/choroidal-neovascularization-with-progressive-peripapillary-atrophy-in-a-patient-with-presumed-ocular-histoplasmosis. Accessed September 13, 2022.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated. Line of business policy applies was updated to all lines of business. 2. Initial approval criteria I.A.4 updated to include anti-VEGF drug as first-line. 3. Continued therapy criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by RxAdvance…”. 4. Commercial approval duration was updated from “length of benefit” to 3 months for initial and continued approval criteria. 5. References were updated.	10/05/2020	12/07/2020
Policy was reviewed: 1. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	10/02/2021	12/07/2021
Policy was reviewed: 1. References were reviewed and updated.	9/13/2022	10/19/2022
Policy was reviewed.	10/19/2023	10/19/2023