Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MBP 243.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Durysta (bimatoprost intraocular implant)

I. Policy:
Durysta (bimatoprost intraocular implant)

II. Purpose/Objective:
To provide a policy of coverage regarding Durysta (bimatoprost intraocular implant)

III. Responsibility:
A. Medical Directors
B. Medical Management
C. Pharmacy Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment
Medically Necessary — A service, item, procedure, or level of care compensable under the Medical Assistance program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

i. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
ii. Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
iii. Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:
Bimatoprost is a synthetic prostaglandin analog that decreases intraocular pressure by increasing the outflow of aqueous humor.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Durysta (bimatoprost intraocular implant) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the following criteria are met:

- Prescription written by or in consultation with an ophthalmologist **AND**
- Medical Record documentation of a diagnosis of open-angle glaucoma (OAG) or ocular hypertension (OHT) **AND**
- Medical record documentation that patient has not received a previous administration of Durysta to the requested eye **AND**
- Medical record documentation of intolerance to, contraindication to, or therapeutic failure on three ophthalmic prostaglandin analogs, one of which must be bimatoprost*

*step therapy required

AUTHORIZATION DURATION/LIMITATIONS: One implant per eye per lifetime (Facets RX count 10 per eye per lifetime, Darwin RX count 1 per eye per lifetime)

Durysta (bimatoprost intraocular implant) will be considered medically necessary for the Medicare line of business when all of the following criteria are met:

- Prescription written by or in consultation with an ophthalmologist **AND**
- Medical Record documentation of a diagnosis of open-angle glaucoma (OAG) or ocular hypertension (OHT) **AND**
- Medical record documentation that patient has not received a previous administration of Durysta to the requested eye

AUTHORIZATION DURATION/LIMITATIONS: One implant per eye per lifetime (Facets RX count 10 per eye per lifetime)

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

REFERENCES:
1. Durysta implant [prescribing information]. Madison, NJ: Allergan USA Inc; November 2020.

This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 9/21/21

Revised: 9/12/23 (LOB carve out, Medicaid business segment), 12/28/23 (references added), 1/16/24 (com/exch/CHIP form alt)

Reviewed: 9/20/22

MA UM Committee approval: 12/31/23