TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Anti-Infective Medications, Ophthalmic

Effective: July 14, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink[SM] – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Zirgan® (ganciclovir) is indicated for the treatment of acute herpetic keratitis (dendritic ulcers).

Natacyn® (natamycin) is indicated for fungal keratitis, blepharitis or conjunctivitis.

Alternative therapies for herpetic keratitis covered on the Tufts Health Together PDL include trifluridine 1% ophthalmic solution and oral acyclovir.

COVERAGE GUIDELINES

The plan may authorize coverage of an ophthalmic anti-infective medication for a member when the following criteria are met

Zirgan (ganciclovir):

1. The member is diagnosed with a herpetic ophthalmic infection

AND

2. The provider indicates the member failed an alternative therapy, or the provider indicates clinical inappropriateness of therapy with an alternative medication.

Natacyn (natamycin):

1. The member is diagnosed with a fungal ophthalmic infection.

LIMITATIONS

1. Requests for brand-name products, which have AB-rated generics, will be reviewed according to the Brand Name criteria.

CODES

None

REFERENCES

1. Natacyn (natamycin) [prescribing information]. Fort Worth, TX: Alcon Laboratories; April 2018.
2. Zirgan (ganciclovir) [prescribing information]. Tampa, FL: Bausch & Lomb; September 2019.
3. Liesegang TJ. Herpes simplex virus epidemiology and ocular importance. Cornea 2001; 20:1.
4. Benz MS, Glaser JS, Davis JL. Progressive outer retinal necrosis in immunocompetent patients treated initially for optic neuropathy with systemic corticosteroids. Am J Ophthalmol 2003; 135:551.
5. Kaye SB, Baker K, Bonshek R, et al. Human herpesviruses in the cornea. Br J Ophthalmol 2000; 84:563.
6. Kaye S, Choudhary A. Herpes simplex keratitis. Prog Retin Eye Res 2006; 25:355.

APPROVAL HISTORY

December 8, 2015: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. November 15, 2016: Added "requests for brand-name products, which have AB-rated generics, will be reviewed according to the Brand Name criteria" to the limitations section.
2. May 9, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
3. November 14, 2017: No changes.
4. December 11, 2018: Administrative changes made to template.
5. October 15, 2019: No changes.
6. July 14, 2020: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.