Pharmacy Medical Necessity Guidelines: Glaucoma Medications

Effective: January 10, 2017

| 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 |

This pharmacy medical necessity guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

Fax Numbers:

RXUM: 617-673-0988

OVERVIEW

**FDA-APPROVED INDICATIONS**

The ophthalmic alpha adrenergic agonists, carbonic anhydrase inhibitors and prostaglandin agonists are indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

The following table summarizes the formulary status for Tufts Health Together Members.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>PDL Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alpha-adrenergic Agonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brimonidine 0.2% <em>(Alphagan)</em></td>
<td>Brimonidine</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Brimonidine 0.15% <em>(Alphagan P)</em></td>
<td>Brimonidine</td>
<td>PA; Tier 1</td>
</tr>
<tr>
<td>Alphagan P 0.1%</td>
<td>Brimonidine</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td><strong>Carbonic Anhydrase Inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dorzolamide 2% <em>(Trusopt)</em></td>
<td>Dorzolamide</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Azopt 1%</td>
<td>Brinzamide</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td><strong>Prostaglandin Agonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latanoprost 0.005% <em>(Xalatan)</em></td>
<td>Latanoprost</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Lumigan 0.01%, 0.03%</td>
<td>Bimatoprost</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td>Zioptan 0.0015%</td>
<td>Tafluprost</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td>Travatan Z 0.004%</td>
<td>Travoprost</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td>Rescula 0.15%</td>
<td>Unoprostone Isopropyl</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td><strong>Combination Medications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dorzolamide/Timolol 2-0.5% <em>(Cosopt)</em></td>
<td>Dorzolamide HCl-Timolol</td>
<td>Tier 1</td>
</tr>
<tr>
<td>Combigan 0.2/0.5%</td>
<td>Brimonidine -Timolol</td>
<td>PA; Tier 2</td>
</tr>
<tr>
<td>Simbrinza 1-0.2%</td>
<td>Brinzamide-Brimonidine</td>
<td>PA; Tier 2</td>
</tr>
</tbody>
</table>

* Preferred medications covered without prior authorization
Brand name medications with AB-rated generics are non-covered. They are included in the table to serve as a reference. Requests for the brand-name products, with AB-rated generics, will also require review according to Brand Name criteria.

**COVERAGE GUIDELINES**

The plan may authorize coverage of a nonpreferred ophthalmic medication for Members when the following criterion for a particular regimen is met and limitations do not apply:

**For brimonidine 0.1% *(Alphagan P)* or 0.15%**

1. The member tried and failed therapy with brimonidine 0.2%, or the provider indicates clinical inappropriateness of therapy with brimonidine 0.2%
**For Azopt (brinzolamide).**
1. The member tried and failed therapy with dorzolamide, or the provider indicates clinical inappropriateness of therapy with dorzolamide

**For a prostaglandin agonist.**
1. The member tried and failed therapy with latanoprost, or the provider indicates clinical inappropriateness of therapy with latanoprost.

**For a combination product (Combigan or Simbrinza)**
1. The member tried and failed concomitant therapy with brimonidine 0.2% and an alternative agent, or the provider indicates clinical inappropriateness of concomitant therapy with brimonidine 0.2% and an alternative agent, such as timolol or dorzolamide.

**LIMITATIONS**
1. Requests for brand-name products, with AB-rated generics, will also be reviewed according to Brand Name criteria.

**CODES**
None

**REFERENCES**
2. FDA News and Events. FDA approves Zioptan to treat elevated eye pressure. [http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm291966.htm](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm291966.htm)

**APPROVAL HISTORY**
June 4, 2014: Reviewed by Pharmacy & Therapeutics Committee.

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Subsequent endorsement date(s) and changes made:
- March 10, 2015: Approval duration modified to one year.
- September 16, 2015: Approval duration approved for life of plan.
- January 1, 2016: Administrative change to rebranded template.
- January 12, 2016: No changes.
- January 10, 2017: No changes.
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template

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. They are used in conjunction with a member’s benefit document and in coordination with the member’s physician(s). 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.
This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan members or to certain delegated service arrangements. Unless otherwise noted in the member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink℠ members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.
For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.
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.