

## PHARMACY POLICY STATEMENT

### Ohio Medicaid

|   |   |
|---|---|
| DRUG NAME   | Durysta (bimatoprost intracameral implant)  |
| BILLING CODE  | J3490   |
| BENEFIT TYPE  | Medical   |
| SITE OF SERVICE ALLOWED                                     | Office  |
| COVERAGE REQUIREMENTS                                       | Prior Authorization Required (Non-Preferred Product)<br>QUANTITY LIMIT—1 implant per eye per lifetime |
| LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY | <a href="#">Click Here</a>  |

Durysta (bimatoprost) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

#### OPEN-ANGLE GLAUCOMA (OAG) OR OCULAR HYPERTENSION (OHT)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a diagnosis of OAG or OHT, including documentation of elevated intraocular pressure (IOP); AND
4. Chart notes must document inadequate IOP reduction following trials of no less than 30 days of at least 1 prostaglandin analog eye drop (e.g. latanoprost, travoprost) as monotherapy, and in combination with an eye drop from another drug class (e.g. timolol, brimonidine, dorzolamide); AND
5. Member must not have had prior Durysta administration to the affected eye(s).
6. **Dosage allowed:** 10 mcg per eye.

***If member meets all the requirements listed above, the medication will be approved 1 time only. (The approval will be active for 30 days).***

For **reauthorization**: Not applicable.

**CareSource considers Durysta (bimatoprost) not medically necessary for the treatment of the diseases that are not listed in this document.**

| DATE       | ACTION/DESCRIPTION              |
|------------|---------------------------------|
| 07/10/2020 | New policy for Durysta created. |



References:

1. Durysta [package insert]. Madison, NJ: Allergan; 2020.
2. Prum BE, Rosenberg LF, Gedde SJ, et al. Primary Open-Angle Glaucoma Preferred Practice Pattern® Guidelines. *Ophthalmology*. 2015;123(1):41-111. doi:10.1016/j.ophtha.2015.10.053
3. Recommendations: Glaucoma: diagnosis and management: Guidance. NICE. <https://www.nice.org.uk/guidance/ng81/chapter/Recommendations>. Published November 1, 2017. Accessed July 10, 2020.

Effective date: 10/20/2020

Revised date: 07/10/2020