RX.PA.055.CCH VISUDYNE (VERTEPORFIN)

The purpose of this policy is to define the prior authorization process for verteporfin (Visudyne®).

Visudyne® (verteporfin)
- Age related macular degeneration – Choroidal retinal neovascularization
- Histoplasmosis associated with classic subfoveal choroidal neovascularization
- Myopia associated with classic subfoveal choroidal neovascularization

POLICY
It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

Visudyne® (verteporfin) is subject to the prior authorization process.

PROCEDURE
Initial Authorization Criteria:

Must meet all the criteria listed:

Visudyne (verteporfin)
- Must be prescribed by a retinal specialist (ophthalmologist acceptable)
- Must be age 18 years or older
- Must have a diagnosis of subfoveal choroidal neovascularization due to 1 of the following:
    - Age-related macular degeneration
    - Pathologic myopia
    - Presumed ocular histoplasmosis
- Must not have porphyria
- Member has a documented inadequate response or intolerable adverse event with the preferred product bevacizumab (Avastin).

Reauthorization Criteria:
All prior authorization renewals are reviewed on an annual basis to determine the

Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon chart documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial

If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.

HCPCS Code

CODE	Brand	DESCRIPTION
J3396	VISUDYNE	INJECTION, VERTEPORFIN, 0.1 MG

REFERENCES

1. Visudyne [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; June 2016.
2. American Academy of Ophthalmology Retina Panel. Preferred Pattern® Guidelines age-related macular degeneration. San Fransico, CA: American Academy of Ophthalmology; 2008. Accessed November 23, 2011. Available at: www.aao.org/ppp.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Initial Review	3/22