

Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors

Policy Number: 2021D0042Q
Effective Date: January 1, 2021

[➔ Instructions for Use](#)

Table of Contents	Page
Coverage Rationale	1
Definitions	2
Applicable Codes	2
Background	24
Benefit Considerations	24
Clinical Evidence	24
U.S. Food and Drug Administration	35
Centers for Medicare and Medicaid Services	36
References	36
Policy History/Revision Information	40
Instructions for Use	40

Related Commercial Policies
<ul style="list-style-type: none"> Macular Degeneration Treatment Procedures Maximum Dosage Policy Oncology Medication Clinical Coverage
Community Plan Policy
<ul style="list-style-type: none"> Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors
Related Medicare Advantage Policy
<ul style="list-style-type: none"> Medicare Part B Step Therapy Programs

Coverage Rationale

[➔ See Benefit Considerations](#)

This policy provides information about the use of certain specialty pharmacy medications administered by the intravitreal route for ophthalmologic conditions.

This policy refers to the following drug products, all of which are vascular endothelial growth factor (VEGF) inhibitors:

- Avastin® (bevacizumab)
- Beovu® (brolucizumab-dbll)
- Eylea® (aflibercept)
- Lucentis® (ranibizumab)
- Macugen® (pegaptanib)
- Mvasi™ (bevacizumab-awwb)
- Zirabev® (bevacizumab-bvzr)

“Bevacizumab” will be used to refer to Avastin, Mvasi, & Zirabev.

Proven

Beovu (brolucizumab) is proven and medically necessary for the treatment of:

- Neovascular age-related macular degeneration (AMD)

Bevacizumab is proven and medically necessary for the treatment of:

- Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS)
- Diabetic macular edema (DME)
- Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
- Neovascular age-related macular degeneration (AMD)
- Neovascular glaucoma

- Neovascularization of the iris (NVI) (rubeosis iridis)
- Proliferative diabetic retinopathy
- Type I retinopathy of prematurity

Eylea (afibercept) is proven and medically necessary for the treatment of:

- Diabetic macular edema (DME)
- Diabetic retinopathy
- Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
- Neovascular age-related macular degeneration (AMD)

Lucentis (ranibizumab) is proven and medically necessary for the treatment of:

- Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS)
- Diabetic macular edema (DME)
- Diabetic retinopathy
- Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
- Neovascular age-related macular degeneration (AMD)

Macugen (pegaptanib) is proven and medically necessary for the treatment of:

- Diabetic macular edema
- Neovascular age-related macular degeneration (AMD)

Additional Information

Avastin (bevacizumab) is supplied in sterile vials containing a solution of 25 mg/mL. Doses utilized in ophthalmic conditions generally range from 6.2 mcg to 2.5 mg. Therefore, bevacizumab in vials is often divided into single-dose, prefilled syringes for intravitreal use by compounding pharmacies. Compounding pharmacies must comply with United States Pharmacopeia (USP) Chapter 797, which sets standards for the compounding, transportation, and storage of compounded sterile products (CSP).¹ The Pharmacy Compounding Accreditation Board can verify that the pharmacy is adhering to these standards.²

The American Society of Retinal Specialists (ASRS) is committed to ensuring that retina specialists have access to compounded drugs (such as Avastin) that are prepared with high-quality material following good quality controls and sound engineering design by appropriately trained personnel. Refer to their information page at <https://www.asrs.org/advocacy-practice/access-to-safe-compounded-agents> for resources pertaining to access of safe compounded agents.¹⁴

Refer to the US Food and Drug Administration (FDA) Section of this policy for information related to contamination of compounded bevacizumab. In an effort to guard against contamination during the compounding process, the United States Veterans Health Administration (USVHA) requires that only USVHA pharmacies may dispense bevacizumab for intravitreal administration to Veterans Administration beneficiaries. The medication must be dispensed directly to the VA ophthalmologist, who will then be responsible for preparing and administering the bevacizumab dose for each patient. In addition to strict labeling and storage requirements, the ophthalmologist is required to prepare only one dose of medication from each vial; if both eyes are to be treated, a separate vial and syringe must be utilized.³

Definitions

Type I Retinopathy of Prematurity (ROP), also known as “high-risk prethreshold ROP”, is defined as any of the following:

- Any stage ROP with plus disease in zone I
- Stage 3 ROP without plus disease in zone I
- Stage 2 or 3 ROP with plus disease in zone II

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may

require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description	Brand Name
J0178	Injection, aflibercept, 1 mg	Eylea
J0179	Injection, brolucizumab-dblb, 1 mg	Beovu
J2503	Injection, pegaptanib sodium, 0.3 mg	Macugen
J2778	Injection, ranibizumab, 0.1 mg	Lucentis
J9035	Injection, bevacizumab, 10 mg	Avastin
Q5107	Injection, bevacizumab-awwb, biosimilar (Mvasi), 10 mg	Mvasi
Q5118	Injection, bevacizumab-bvzr, biosimilar (Zirabev), 10 mg	Zirabev

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
B39.4	Histoplasmosis capsulati, unspecified				x	x
B39.5	Histoplasmosis duboisii				x	x
B39.9	Histoplasmosis, unspecified				x	x
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema	x		x	x	x
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema	x			x	
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E08.3219	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E08.3299	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E08.3319	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E08.3399	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E08.3419	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E08.3499	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E08.3519	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	x		x	x	x
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	x		x	x	x
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	x		x	x	x
E08.3529	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	x		x	x	x
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	x		x	x	x
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	x		x	x	x
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	x		x	x	x
E08.3539	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	x		x	x	x
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	x		x	x	x
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
	traction retinal detachment and rhegmatogenous retinal detachment, left eye					
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	x		x	x	x
E08.3549	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	x		x	x	x
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye	x		x	x	x
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye	x		x	x	x
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral	x		x	x	x
E08.3559	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, unspecified eye	x		x	x	x
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye	x			x	x
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye	x			x	x
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral	x			x	x
E08.3599	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, unspecified eye	x			x	x
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye				x	x
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye				x	x
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral				x	x
E08.37X9	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, unspecified eye				x	x
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E09.3219	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E09.3299	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E09.3319	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E09.3399	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E09.3419	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E09.3492	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E09.3493	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E09.3499	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E09.3519	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	x		x	x	x
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	x		x	x	x
E09.3529	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	x		x	x	x
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	x		x	x	x
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	x		x	x	x
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	x		x	x	x
E09.3539	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	x		x	x	x
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	x		x	x	x
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	x		x	x	x
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	x		x	x	x
E09.3549	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	x		x	x	x
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye	x		x	x	x
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye	x		x	x	x
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	x		x	x	x
E09.3559	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	x			x	x
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	x			x	x
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	x			x	x
E09.3599	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	x			x	x
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye				x	x
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye				x	x
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral				x	x
E09.37X9	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye				x	x
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema	x		x	x	x
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	x		x	x	x
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	x		x	x	x
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	x		x	x	x
E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	x		x	x	x
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	x		x	x	x
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	x		x	x	x
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	x		x	x	x
E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	x		x	x	x
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	x		x	x	x
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	x		x	x	x
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	x		x	x	x
E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	x		x	x	x
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	x		x	x	x
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	x		x	x	x
E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	x		x	x	x
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	x			x	x
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	x			x	x
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	x			x	x
E10.3599	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	x			x	x
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye				x	x
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye				x	x
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral				x	x
E10.37X9	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye				x	x
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	x		x	x	x
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	x		x	x	x
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	x		x	x	x
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	x		x	x	x
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	x		x	x	x
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	x		x	x	x
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	x		x	x	x
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	x		x	x	x
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	x		x	x	x
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	x		x	x	x
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	x		x	x	x
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	x		x	x	x
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye	x		x	x	x
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye	x		x	x	x
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	x		x	x	x
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	x		x	x	x
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	x			x	x
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	x			x	x
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	x			x	x
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	x			x	x
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye				x	x
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye				x	x
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral				x	x
E11.37X9	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye				x	x
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema	x		x	x	x
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E13.3219	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E13.3299	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E13.3319	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E13.3399	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E13.3419	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye	x		x	x	x
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye	x		x	x	x
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral	x		x	x	x
E13.3499	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye	x		x	x	x
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye	x		x	x	x
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye	x		x	x	x
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral	x		x	x	x
E13.3519	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye	x		x	x	x
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye	x		x	x	x
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye	x		x	x	x
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral	x		x	x	x
E13.3529	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye	x		x	x	x
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye	x		x	x	x
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye	x		x	x	x
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral	x		x	x	x
E13.3539	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye	x		x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye	x		x	x	x
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye	x		x	x	x
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral	x		x	x	x
E13.3549	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye	x		x	x	x
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye	x		x	x	x
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye	x		x	x	x
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral	x		x	x	x
E13.3559	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye	x		x	x	x
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye	x			x	x
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye	x			x	x
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral	x			x	x
E13.3599	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye	x			x	x
E13.37X1	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, right eye				x	x
E13.37X2	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, left eye				x	x
E13.37X3	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral				x	x
E13.37X9	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye				x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
H21.1X1	Other vascular disorders of iris and ciliary body, right eye					x
H21.1X2	Other vascular disorders of iris and ciliary body, left eye					x
H21.1X3	Other vascular disorders of iris and ciliary body, bilateral					x
H21.1X9	Other vascular disorders of iris and ciliary body, unspecified eye					x
H32	Chorioretinal disorders in diseases classified elsewhere				x	x
H34.8110	Central retinal vein occlusion, right eye, with macular edema	x			x	x
H34.8111	Central retinal vein occlusion, right eye, with retinal neovascularization	x			x	x
H34.8112	Central retinal vein occlusion, right eye, stable	x			x	x
H34.8120	Central retinal vein occlusion, left eye, with macular edema	x			x	x
H34.8121	Central retinal vein occlusion, left eye, with retinal neovascularization	x			x	x
H34.8122	Central retinal vein occlusion, left eye, stable	x			x	x
H34.8130	Central retinal vein occlusion, bilateral, with macular edema	x			x	x
H34.8131	Central retinal vein occlusion, bilateral, with retinal neovascularization	x			x	x
H34.8132	Central retinal vein occlusion, bilateral, stable	x			x	x
H34.8190	Central retinal vein occlusion, unspecified eye, with macular edema	x			x	x
H34.8191	Central retinal vein occlusion, unspecified eye, with retinal neovascularization	x			x	x
H34.8192	Central retinal vein occlusion, unspecified eye, stable	x			x	x
H34.821	Venous engorgement, right eye	x			x	x
H34.822	Venous engorgement, left eye	x			x	x
H34.823	Venous engorgement, bilateral	x			x	x
H34.829	Venous engorgement, unspecified eye	x			x	x
H34.8310	Tributary (branch) retinal vein occlusion, right eye, with macular edema	x			x	x
H34.8311	Tributary (branch) retinal vein occlusion, right eye, with retinal neovascularization	x			x	x
H34.8312	Tributary (branch) retinal vein occlusion, right eye, stable	x			x	x
H34.8320	Tributary (branch) retinal vein occlusion, left eye, with macular edema	x			x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
H34.8321	Tributary (branch) retinal vein occlusion, left eye, with retinal neovascularization	x			x	x
H34.8322	Tributary (branch) retinal vein occlusion, left eye, stable	x			x	x
H34.8330	Tributary (branch) retinal vein occlusion, bilateral, with macular edema	x			x	x
H34.8331	Tributary (branch) retinal vein occlusion, bilateral, with retinal neovascularization	x			x	x
H34.8332	Tributary (branch) retinal vein occlusion, bilateral, stable	x			x	x
H34.8390	Tributary (branch) retinal vein occlusion, unspecified eye, with macular edema	x			x	x
H34.8391	Tributary (branch) retinal vein occlusion, unspecified eye, with retinal neovascularization	x			x	x
H34.8392	Tributary (branch) retinal vein occlusion, unspecified eye, stable	x			x	x
H35.051	Retinal neovascularization, unspecified, right eye				x	x
H35.052	Retinal neovascularization, unspecified, left eye				x	x
H35.053	Retinal neovascularization, unspecified, bilateral				x	x
H35.059	Retinal neovascularization, unspecified, unspecified eye				x	x
H35.101	Retinopathy of prematurity, unspecified, right eye					x
H35.102	Retinopathy of prematurity, unspecified, left eye					x
H35.103	Retinopathy of prematurity, unspecified, bilateral					x
H35.109	Retinopathy of prematurity, unspecified, unspecified eye					x
H35.111	Retinopathy of prematurity, stage 0, right eye					x
H35.112	Retinopathy of prematurity, stage 0, left eye					x
H35.113	Retinopathy of prematurity, stage 0, bilateral					x
H35.119	Retinopathy of prematurity, stage 0, unspecified eye					x
H35.121	Retinopathy of prematurity, stage 1, right eye					x
H35.122	Retinopathy of prematurity, stage 1, left eye					x
H35.123	Retinopathy of prematurity, stage 1, bilateral					x
H35.129	Retinopathy of prematurity, stage 1, unspecified eye					x
H35.131	Retinopathy of prematurity, stage 2, right eye					x
H35.132	Retinopathy of prematurity, stage 2, left eye					x
H35.133	Retinopathy of prematurity, stage 2, bilateral					x
H35.139	Retinopathy of prematurity, stage 2, unspecified eye					x
H35.141	Retinopathy of prematurity, stage 3, right eye					x
H35.142	Retinopathy of prematurity, stage 3, left eye					x
H35.143	Retinopathy of prematurity, stage 3, bilateral					x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
H35.149	Retinopathy of prematurity, stage 3, unspecified eye					x
H35.151	Retinopathy of prematurity, stage 4, right eye					x
H35.152	Retinopathy of prematurity, stage 4, left eye					x
H35.153	Retinopathy of prematurity, stage 4, bilateral					x
H35.159	Retinopathy of prematurity, stage 4, unspecified eye					x
H35.161	Retinopathy of prematurity, stage 5, right eye					x
H35.162	Retinopathy of prematurity, stage 5, left eye					x
H35.163	Retinopathy of prematurity, stage 5, bilateral					x
H35.169	Retinopathy of prematurity, stage 5, unspecified eye					x
H35.171	Retrolental fibroplasia, right eye					x
H35.172	Retrolental fibroplasia, left eye					x
H35.173	Retrolental fibroplasia, bilateral					x
H35.179	Retrolental fibroplasia, unspecified eye					x
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified	x	x	x	x	x
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization	x	x	x	x	x
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization	x	x	x	x	x
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar	x	x	x	x	x
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified	x	x	x	x	x
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization	x	x	x	x	x
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization	x	x	x	x	x
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar	x	x	x	x	x
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified	x	x	x	x	x
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization	x	x	x	x	x
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization	x	x	x	x	x
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar	x	x	x	x	x
H35.3290	Exudative age-related macular degeneration, unspecified eye, stage unspecified	x	x	x	x	x
H35.3291	Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization	x	x	x	x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
H35.3292	Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization	x	x	x	x	x
H35.3293	Exudative age-related macular degeneration, unspecified eye, with inactive scar	x	x	x	x	x
H35.33	Angioid streaks of macula	x		x	x	x
H35.81	Retinal edema	x			x	x
H40.89	Other specified glaucoma				x	x
H44.20	Degenerative myopia, unspecified eye				x	x
H44.21	Degenerative myopia, right eye				x	x
H44.22	Degenerative myopia, left eye				x	x
H44.23	Degenerative myopia, bilateral				x	x
H44.2A1	Degenerative myopia with choroidal neovascularization, right eye				x	x
H44.2A2	Degenerative myopia with choroidal neovascularization, left eye				x	x
H44.2A3	Degenerative myopia with choroidal neovascularization, bilateral eye				x	x
H44.2A9	Degenerative myopia with choroidal neovascularization, unspecified eye				x	x
H44.2B1	Degenerative myopia with macular hole, right eye				x	x
H44.2B2	Degenerative myopia with macular hole, left eye				x	x
H44.2B3	Degenerative myopia with macular hole, bilateral eye				x	x
H44.2B9	Degenerative myopia with macular hole, unspecified eye				x	x
H44.2C1	Degenerative myopia with retinal detachment, right eye				x	x
H44.2C2	Degenerative myopia with retinal detachment, left eye				x	x
H44.2C3	Degenerative myopia with retinal detachment, bilateral eye				x	x
H44.2C9	Degenerative myopia with retinal detachment, unspecified eye				x	x
H44.2D1	Degenerative myopia with foveoschisis, right eye				x	x
H44.2D2	Degenerative myopia with foveoschisis, left eye				x	x
H44.2D3	Degenerative myopia with foveoschisis, bilateral eye				x	x
H44.2D9	Degenerative myopia with foveoschisis, unspecified eye				x	x
H44.2E1	Degenerative myopia with other maculopathy, right eye				x	x
H44.2E2	Degenerative myopia with other maculopathy, left eye				x	x

Diagnosis Code	Description	Applies to HCPCS Code				
		J0178	J0179	J2503	J2778	J9035 Q5107 Q5118
H44.2E3	Degenerative myopia with other maculopathy, bilateral eye				x	x
H44.2E9	Degenerative myopia with other maculopathy, unspecified eye				x	x

Background

Vascular endothelial growth factor (VEGF) is a protein that stimulates the growth, proliferation and survival of vascular endothelial cells. VEGF plays a critical role in the development of new blood vessels (angiogenesis), increases vascular permeability in small blood vessels and prevents apoptosis of vascular endothelial cells in immature blood vessels. VEGF has been implicated in blood retinal barrier breakdown and pathological ocular neovascularization.⁴

Benefit Considerations

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. See the Policy and Procedure addressing the treatment of serious rare diseases.

Clinical Evidence

Proven

Neovascular Age-Related Macular Degeneration (AMD)

Aflibercept, brolucizumab, pegaptanib, and ranibizumab are indicated for the treatment of neovascular age-related macular degeneration.^{5-7, 71}

Solomon et al evaluated the ocular and systemic effects of, and quality of life associated with, intravitreally injected anti-VEGF agents (pegaptanib, ranibizumab, and bevacizumab) for the treatment of neovascular AMD compared with no anti-VEGF treatment; and the relative effects of one anti-VEGF agent compared with another when administered in comparable dosages and regimens.¹⁰ A database search identified 12 randomized controlled trials which included 5496 patients with neovascular AMD. Patients treated with any of the three anti-VEGF agents more often experienced improved vision, less often lost vision, and were less likely to be legally blind than patients treated with control interventions after one year of treatment. Additionally, these patients also showed improvements in structural areas of the eye that doctors use to monitor disease progression and treatment response compared with untreated patients. Compared with control treatments, treatment with ranibizumab or bevacizumab yielded larger improvements than pegaptanib. No trial compared pegaptanib directly with other anti-VEGF agents. When bevacizumab and ranibizumab were compared with each other, there were no major differences with respect to vision-related outcomes; there was, however, a large difference in cost between the two agents. Inflammation and increased pressure in the eye were the most common vision-related adverse events with anti-VEGF agents. Endophthalmitis was reported in < 1% of anti-VEGF-treated patients and no cases were reported in control groups. The occurrence of serious adverse health effects, such as high blood pressure and internal bleeding, was comparable across anti-VEGF-treated groups and control groups; however, the number of events was small relative to the number of people in the studies making it difficult to detect any meaningful differences between groups. Few data were available for visual function (e.g., reading speed and critical print size), quality of life, and economic outcomes. The overall quality of the evidence was very good, with most trials having an overall low risk of bias. The results of the review indicated the effectiveness of anti-VEGF agents (pegaptanib, ranibizumab, and bevacizumab) in terms of maintaining visual acuity; ranibizumab and bevacizumab were also shown to improve visual acuity.

The information available on the adverse effects of each medication do not suggest a higher incidence of potentially vision-threatening complications with intravitreal injection compared with control interventions; however, clinical trial sample sizes may not have been sufficient to detect rare safety outcomes.

In a multicenter, prospective, noninferiority, double-masked, randomized clinical trial, the relative efficacy and safety profile of bevacizumab versus ranibizumab intravitreal injections for the treatment of neovascular age-related macular degeneration (AMD) was evaluated.⁶² Patients (n=501) aged ≥ 50 years were eligible if they presented with subfoveal neovascular AMD, with best-corrected visual acuity (BVCA) in the study eye of between 20/32 and 20/320 measured on the Early Treatment of Diabetic Retinopathy Study chart, and a lesion area of less than 12 optic disc areas (DA). Subjects were randomly assigned to intravitreal administration of bevacizumab (1.25 mg) or ranibizumab (0.50 mg), then followed for one year. A loading dose of three monthly intravitreal injections was administered to all subjects, followed by an as-needed regimen (one injection in case of active disease) for the remaining 9 months with monthly follow-up. The main outcome measure was the mean change in visual acuity at one year, with a noninferiority limit of five letters. In the per protocol analysis, bevacizumab was noninferior to ranibizumab (bevacizumab minus ranibizumab +1.89 letters; 95% confidence interval [CI], -1.16 to +4.93, $p < 0.0001$). The intention-to-treat analysis was concordant. The mean number of injections was 6.8 in the bevacizumab group and 6.5 in the ranibizumab group ($p = 0.39$). Both drugs reduced the central subfield macular thickness, with a mean decrease of 95 μm for bevacizumab and 107 μm for ranibizumab ($p = 0.27$). There were no significant differences in the presence of subretinal or intraretinal fluid at final evaluation, dye leakage on angiogram, or change in choroidal neovascular area. The proportion of patients with serious adverse events was 12.6% in the bevacizumab group and 12.1% in the ranibizumab group ($p = 0.88$). The proportion of patients with serious systemic or ocular adverse events was similar in both groups. Based on these results, bevacizumab was determined to be noninferior to ranibizumab for visual acuity at one year with similar safety profiles. Ranibizumab tended to have a better anatomic outcome.

A multi-center, single-blind, non-inferiority study was conducted by the CATT Research Group in 1,208 patients with neovascular age-related macular degeneration (AMD).⁸ Participants were randomly assigned to receive intravitreal injections of either ranibizumab or bevacizumab on a monthly schedule or as needed with monthly evaluations. The primary outcome of the study was the mean change in visual acuity at one year, with a non-inferiority limit of 5 letters on the eye chart. The investigators reported that monthly administration of bevacizumab was equivalent to monthly administration of ranibizumab, with 8.0 and 8.5 letters gained, respectively. Results of as needed administration of the agents were determined to be equivalent, with bevacizumab recipients gaining 5.9 letters and ranibizumab recipients gaining 6.8 letters. Ranibizumab as needed was equivalent to monthly ranibizumab, while the comparison between bevacizumab as needed and monthly bevacizumab was inconclusive. The mean decrease in central retinal thickness was greater in the ranibizumab-monthly group (196 μm) than in the other groups (152 to 168 μm , $p = 0.03$ by analysis of variance). Rates of death, myocardial infarction, and stroke were similar for patients receiving either treatment ($p > 0.20$). However, the proportion of patients with serious systemic adverse events (primarily hospitalizations) was higher with bevacizumab than with ranibizumab (24.1% vs. 19.0%; risk ratio, 1.29; 95% confidence interval, 1.01 to 1.66), with excess events broadly distributed in disease categories not identified in previous studies as areas of concern. Therefore, the investigators recommended that differences in rates of serious adverse events should be further studied. At one year, bevacizumab and ranibizumab had equivalent effects on visual acuity when administered according to the same schedule. Ranibizumab given as needed with monthly evaluation had effects on vision that were equivalent to those of ranibizumab administered monthly.

HAWK and HARRIER were two double-masked, multicenter, active-controlled, randomized phase 3 trials that compared brolocizumab, with aflibercept to treat neovascular age-related macular degeneration (nAMD). In the studies, patients (N = 1817) had untreated, active choroidal neovascularization due to age-related macular degeneration in the study eye. Patients were randomized to intravitreal brolocizumab 3 mg or 6 mg or aflibercept 2 mg. After loading with 3 monthly injections, brolocizumab-treated eyes received an injection every 12 weeks. If disease activity was present, dosing was adjusted to every 8 weeks. Patients receiving aflibercept were dosed every 8 weeks. The study was evaluating noninferiority in mean best-corrected visual acuity (BCVA) change from baseline to 48 weeks. Other key end points included the percentage of patients who maintained every 12 week dosing through 48 weeks and anatomic outcomes. At 48 weeks, each brolocizumab arm demonstrated noninferiority to aflibercept in BCVA change from baseline. Greater than 50% of brolocizumab 6 mg-treated eyes were maintained on every 12 week dosing for 48 weeks. At 16 weeks, after the same treatment exposure, fewer brolocizumab 6 mg-treated eyes had disease activity versus aflibercept in HAWK (24.0% vs. 34.5%; $P = 0.001$) and HARRIER (22.7% vs. 32.2%; $P = 0.002$). Greater central subfield thickness reductions from baseline to 48 weeks were observed with brolocizumab 6 mg versus aflibercept in HAWK (LS mean -172.8 μm vs. -143.7 μm ; $P = 0.001$) and HARRIER (LS mean -193.8 μm vs. -143.9 μm ; $P < 0.001$). Anatomic retinal fluid outcomes favored brolocizumab over aflibercept. Overall, adverse event rates were generally the

same with the two agents. The authors concluded that brolocizumab was noninferior to aflibercept in visual function at 48 weeks, and >50% of brolocizumab 6 mg-treated eyes were maintained on every 12 week dosing through 48 weeks. Anatomic outcomes favored brolocizumab over aflibercept. Overall safety was similar for the two agents.⁷¹

Diabetic Macular Edema

Aflibercept and ranibizumab are indicated for the treatment of diabetic macular edema (DME).^{5,7}

Virgili et al. evaluated the effects in preserving and improving vision and acceptability, including the safety, compliance with therapy and quality of life, of antiangiogenic therapy with anti-VEGF modalities for the treatment of diabetic macular oedema (DMO).⁶¹ A database search was conducted which included randomized controlled trials (RCTs) comparing any antiangiogenic drugs with an anti-VEGF mechanism of action versus another treatment, sham treatment or no treatment in people with DMO. The primary outcome measured was the proportion of people improving or losing vision by three or more lines. Eighteen studies were included in this review. Approximately one in five people gained 3 lines of vision, using antiangiogenic therapy compared with laser, using seven to nine intraocular injections in the first year, and three or four injections in the second year. Benefits were also detected when the drug was compared to no treatment and when it was added to photocoagulation and compared to photocoagulation alone. Antiangiogenic treatment was well tolerated in these studies, with few reported injection-related adverse events and no increase in the number of reported overall and cardiovascular adverse events. Researchers concluded that the evidence utilized in the review was of high quality regarding efficacy compared to laser photocoagulation, the standard treatment, because the effects were large and consistent between studies. The evidence was also of moderate quality regarding safety, since safety had to be confirmed in patients with higher morbidity, particularly regarding cardiovascular risk

Bevacizumab

Shoebi et al. reported the long-term results of intravitreal bevacizumab (IVB) injection alone or combined, at the time of first IVB injection, with intravitreal triamcinolone acetonide (IVT) for treatment of refractory diabetic macular edema (DME).⁶³ This randomized clinical trial enrolled 115 eyes of 101 patients with refractory DME and utilized three study arms: the IVB group (41 eyes) received three consecutive injections of 1.25 mg IVB at 6-week intervals; the IVB/IVT group (37 eyes) additionally received 2 mg of IVT at the time of first IVB injection; and the control (sham injection) group. Patients in the IVB and IVB/IVT groups were followed for a mean of 13.3 months and received retreatment with IVB alone whenever indicated. Main outcome measures were best corrected visual acuity (BCVA) and central macular thickness (CMT). The investigators found that at last follow up, CMT decreased significantly in the IVB group ($p=0.013$) but it was not significant ($p=0.13$) in the IVB/IVT group. Mean CMT improvement was 91 (95% CI, 20 to 161) microns and 57 (95% CI, -18 to 133) microns in the IVB and IVB/IVT groups, respectively. Mean BCVA improvement from baseline was 0.28 (95% CI, 0.18 to 0.38) logMAR ($P=0.017$) in the IVB group and 0.19 (95% CI, 0.08 to 0.30) logMAR ($P=0.001$) in the IVB/IVT group. There was no difference between the two groups in terms of visual improvement ($p=0.42$). In generalized linear mixed model, only the time interval between the last injection and CMT measurement was statistically significant ($P=0.04$). The same results were repeated for visual acuity ($P=0.03$). Based upon these findings, the authors concluded that three loading doses of IVB (added doses if required) have long-term beneficial effects for treatment of refractory DME and that adding triamcinolone to this regimen provides no additional long-term benefit.

Nepomuceno et al. compared visual acuity and spectraldomain optical coherence tomography (SDOCT) outcomes associated with intravitreal (IV) bevacizumab versus IV ranibizumab for the management of diabetic macular edema (DME) in a prospective, randomized trial.⁶⁴ Forty-eight patients (63 eyes) with center-involved DME were randomly assigned to receive 1.5 mg (0.06 cc) IV bevacizumab or 0.5 mg (0.05 cc) IV ranibizumab at baseline and monthly if central subfield thickness was greater than 275 μm . Forty-five patients (60 eyes) completed 48 weeks of follow-up. At baseline, mean \pm standard error best-corrected visual acuity (BCVA) (logMAR) was 0.60 (20/80) \pm 0.05 in the IV bevacizumab group and 0.63 (20/85) \pm 0.05 in the IV ranibizumab group. A significant improvement in mean BCVA was observed in both groups at all study visits ($P < 0.05$); this improvement was significantly greater in the IV ranibizumab group compared with the IV bevacizumab group at weeks 8 ($P = 0.032$) and 32 ($P = 0.042$). A significant reduction in mean central subfield thickness was observed in both groups at all study visits compared with baseline ($P < 0.05$), with no significant difference in the magnitude of macular thickness reduction between groups. The mean number of injections was significantly higher ($P = 0.005$) in the IV bevacizumab group (9.84) than in the IV ranibizumab group (7.67). The investigators concluded that IV bevacizumab and IV ranibizumab are associated with similar effects on central subfield thickness in patients with DME through 1 year of follow-up. IV ranibizumab is associated with greater improvement in BCVA at some study visits, and the mean number of injections is higher in the IV bevacizumab group.

Pegaptanib

Sultan et al. conducted a randomized, multicenter, parallel-group trial to confirm safety and compare efficacy of intravitreal pegaptanib sodium versus placebo in subjects with diabetic macular edema (DME) involving the center of the macula associated with vision loss not due to ischemia.¹² During year one of the study, subjects received pegaptanib 0.3 mg or placebo every 6 weeks (total = 9 injections) and were eligible to receive focal/grid photocoagulation beginning at week 18. Subjects received injections as often as every 6 weeks per pre-specified criteria in the second year of the study. The primary efficacy endpoint was the proportion of subjects gaining ≥ 10 letters of visual acuity (VA) from baseline to year one. In total, 260 (pegaptanib, n=133; placebo, n=127) and 207 (pegaptanib, n=107; placebo, n=100) subjects were included in years 1 and 2 intent-to-treat analyses, respectively. A total of 49 of the 133 (36.8%) subjects from the pegaptanib group and 25 of the 127 (19.7%) from the placebo group experienced a VA improvement of ≥ 10 letters at week 54 compared with baseline (odds ratio [OR], 2.38; 95% confidence interval, 1.32-4.30; p=0.0047). In the pegaptanib-treated subjects, change in mean VA from baseline by visit was superior (p<0.05) to sham at weeks 6, 24, 30, 36, 42, 54, 78, 84, 90, 96, and 102. At week 102, pegaptanib-treated subjects gained, on average, 6.1 letters versus 1.3 letters for placebo (p<0.01). Fewer pegaptanib- than placebo-treated subjects received focal/grid laser treatment (week 54, 31/133 [23.3%] vs 53/127 [41.7%], respectively, p=0.002; week 102, 27/107 [25.2%] vs 45/100 [45.0%], respectively, p=0.003). The pegaptanib treatment group showed significantly better results on the National Eye Institute-Visual Functioning Questionnaire than sham for subscales important in this population. Pegaptanib was well tolerated; the frequencies of discontinuations, adverse events, treatment-related adverse events, and serious adverse events were comparable in the pegaptanib and placebo groups.

In a randomized, double-masked, multicenter, dose-ranging, controlled trial, Cunningham et al. evaluated the safety and efficacy of pegaptanib sodium injection in the treatment of diabetic macular edema (DME).¹³ Study subjects (n=172) included those with a best-corrected visual acuity (VA) between 20/50 and 20/320 in the study eye, DME involving the center of the macula, and for whom the investigator judged photocoagulation could be safely withheld for 16 weeks. The primary outcome measures were best-corrected VA, central retinal thickness at the center point of the central subfield as assessed by optical coherence tomography measurement, and the need for additional therapy with photocoagulation between weeks 12 and 36. Intravitreal pegaptanib 0.3 mg (n=44), pegaptanib 1 mg (n=44), pegaptanib 3 mg (n=42), or placebo (n=42) injections were administered upon study entry, at week 6, and at week 12 with additional injections and/or focal photocoagulation as needed for another 18 weeks. Final assessments were conducted at week 36. Median VA was better at week 36 with 0.3 mg (20/50), as compared with placebo (20/63) (p=0.04). A larger proportion of those receiving 0.3 mg gained VAs of ≥ 10 letters (approximately 2 lines) (34% vs. 10%, p=0.003) and ≥ 15 letters (18% vs. 7%, p=0.12). Mean central retinal thickness decreased by 68 microm with 0.3 mg, versus an increase of 4 microm with placebo (p=0.02). Larger proportions of those receiving 0.3 mg had an absolute decrease of both ≥ 100 microm (42% vs. 16%, p=0.02) and ≥ 75 microm (49% vs. 19%, p=0.008). Photocoagulation was deemed necessary in fewer subjects in each pegaptanib arm (0.3 mg vs. placebo, 25% vs. 48%; p=0.04). All pegaptanib doses were well tolerated. Endophthalmitis occurred in 1 of 652 injections (0.15% per injection; i.e., 1/130 [0.8%] pegaptanib subjects) and was not associated with severe visual loss. Overall, subjects assigned to pegaptanib had better VA outcomes, were more likely to show reduction in central retinal thickness, and were deemed less likely to need additional therapy with photocoagulation at follow-up.

Macular Edema Secondary to BRVO/CRVO

Aflibercept and ranibizumab are indicated for the treatment of macular edema following retinal vein occlusion (RVO).^{5,7}

The efficacy and safety of intravitreal bevacizumab injections into eyes with macular edema secondary to central retinal vein occlusion (CRVO) was evaluated in a prospective clinical trial (n=45 eyes) by Zhang et al.¹⁵ Study subjects were treated with 3 initial intravitreal bevacizumab injections of 1.25 mg at monthly intervals. Retreatment was based on central retinal thickness (CRT) measured by optical coherence tomography (OCT) performed monthly, while fluorescein angiography was performed every 3 months. Main outcome parameters were visual acuity (VA, using the Early Treatment of Diabetic Retinopathy Study protocol) and CRT in an 18-month follow-up period. Mean VA increased from 40.9 letters at baseline to 61.9 letters (+21 letters; p<0.001) at month 18; CRT decreased from 572.3 μm at baseline to 273.2 μm at month 18 (-299.1 μm ; p<0.001). Neither age, duration of CRVO, baseline VA, nor baseline CRT was correlated with the change in VA. No drug-related systemic or ocular side effects were observed following intravitreal bevacizumab treatment.

The efficacy of intravitreal bevacizumab as the primary treatment of macular edema due to retinal vein occlusions was evaluated by Figueroa et al. in a study of patients diagnosed as having central retinal vein occlusion (CRVO) (n=18 eyes) or branch retinal vein occlusion (BRVO) (n=28 eyes) with visual acuity of less than 20/40 and macular edema (>300 microm

central retinal thickness).¹⁶ After an initial intravitreal injection of bevacizumab, re-treatment was performed if intraretinal or subretinal fluid with distortion of the foveal depression was found in optical coherence tomography. During a 6-month period, the mean number of injections per patient was 3.7 (BRVO group) and 4.6 (CRVO group). In the BRVO group, mean baseline logMAR visual acuity was 0.80 (SD 0.38) and macular thickness was 486.9 microm (SD 138.5 microm). After 6 months, mean logMAR visual acuity improved significantly to 0.44 (SD 0.34), $p < 0.001$. Mean macular thickness decreased significantly to 268.2 microm (SD 62.5 microm), $p < 0.001$. In the CRVO group, mean baseline logMAR visual acuity was 1.13 (SD 0.21) and macular thickness was 536.4 microm (SD 107.1 microm). Mean final logMAR visual acuity improved significantly to 0.83 (SD 0.45), $p < 0.001$. Mean macular thickness decreased significantly to 326.17 microm (SD 96.70 microm), $p < 0.001$. The investigators concluded that intravitreal bevacizumab is an effective primary treatment option for macular edema due to retinal occlusions. However, multiple injections are necessary to maintain visual and anatomic improvements.

Proliferative Diabetic Retinopathy

Aflibercept and ranibizumab are indicated for diabetic retinopathy [(Non Proliferative Diabetic Retinopathy (NPDR), Proliferative Diabetic Retinopathy (PDR)].^{5,7}

Intravitreal bevacizumab has been studied as an adjunct to laser photocoagulation, to facilitate pars plana vitrectomy, and as a monotherapy for treatment of proliferating diabetic retinopathy (PDR).^{17,59-60}

Ahmadih et al. evaluated the effect of preoperative intravitreal bevacizumab (IVB) injections on the rate of early (≤ 4 weeks) postvitrectomy hemorrhage in patients ($n=68$) with proliferative diabetic retinopathy.¹⁸ Subjects were randomly assigned to receive either 1.25 mg IVB ($n=35$) one week prior to surgery or control ($n=33$). The primary outcome measure was the incidence of early postvitrectomy hemorrhage. Secondary outcome measures included changes in best-corrected visual acuity (BCVA) and IVB-related adverse events. In the intention-to-treat analysis, the incidence of postvitrectomy hemorrhage 1 week and 1 month after surgery was significantly lower in the IVB group compared with the control group ($p=0.023$ and $p=0.001$, respectively). Mean BCVA improved from 1.88 logarithm of minimum angle of resolution (logMAR) units in both study groups before surgery to 0.91 logMAR units and 1.46 logMAR units 1 month after vitrectomy in the IVB and control groups, respectively ($p=0.001$). Resolution of vitreous hemorrhage was observed in 9 eyes (25.7%) after IVB injection, obviating the need for vitrectomy; the corresponding figure was 2 eyes (6.1%) in the control group ($p=0.028$). The per-protocol analysis included 16 eyes in the IVB group and 18 eyes in the control group; postvitrectomy hemorrhage occurred less frequently 1 week and 1 month after surgery in the IVB group compared with the control group ($p=0.033$ and $p=0.003$, respectively). Mean improvement in BCVA 1 month after vitrectomy was -1.05 logMAR units in the IVB group and -0.42 logMAR units in the control group ($p=0.004$). No IVB-related complication was observed in the treatment group. The investigators concluded that IVB one week before vitrectomy appears to reduce the incidence of early postvitrectomy hemorrhage in diabetic patients. The need for vitrectomy may be decreased significantly in these cases as well.

In order to evaluate the safety and effectiveness of intravitreal bevacizumab (IVB) as an adjunct to vitrectomy, di Lauro et al. performed a randomized controlled trial on 72 eyes of 68 patients affected by vitreous hemorrhage (VH) and tractional retinal detachment (TRD) which occurred as a consequence of active proliferative diabetic retinopathy (PDR).¹⁹ Participants were assigned in a 1:1:1 ratio to receive a placebo injection or an intravitreal injection of 1.25 mg of bevacizumab, either 7 or 20 days before the vitrectomy. Complete ophthalmic examinations and color fundus photography were performed at baseline and 1, 6, 12, and 24 weeks after the surgery. In the placebo group, intraoperative bleeding occurred in 19 cases (79.1%), the use of endodiathermy was necessary in 13 patients (54.1%), relaxing retinotomy was performed on one patient (4.1%), and in four cases (16.6%) iatrogenic retinal breaks occurred. The surgical mean time was 84 minutes (SD 12 minutes). In subjects receiving IVB seven days prior to vitrectomy, intraoperative bleeding occurred in two cases (8.3%) and the use of endodiathermy was necessary in two patients (8.3%). No iatrogenic breaks occurred during the surgery. The surgical mean time was 65 minutes (SD 18 minutes). For those subjects receiving IVB twenty days before vitrectomy, intraoperative bleeding occurred in three cases (12.5%), the use of endodiathermy was necessary in three patients (1.5%), and an iatrogenic break occurred in one patient (4.1%) while the delamination of fibrovascular tissue was being performed. The surgical mean time was 69 minutes (SD 21 minutes). The average difference in the surgical time was statistically significant between the placebo group and the 7-day IVB group ($p=0.025$), and between the placebo group and the 20-day IVB group ($p=0.031$). At completion of surgery, the retina was completely attached in all eyes. The researchers concluded that best surgical results are achieved performing the IVB 7 days preoperatively.

Neovascular Glaucoma and Rubeosis Iridis

Ghosh et al. present the outcome of concomitant treatment with diode laser cyclophotocoagulation (CPC) and intravitreal bevacizumab (IVB) in painful eyes with poor visual potential in a case series of consecutively diagnosed neovascular glaucoma (NVG).²⁰ Twelve patients (14 eyes) were treated with CPC and concurrent IVB 0.05 mL (1.25 mg). Study end-points were lowering of intraocular pressure (IOP), regression of anterior segment neovascularization, and resolution of pain. The mean preoperative IOP was 42.1 ± 11.4 and was lowered to 16.6 ± 7.1 mmHg at 1-month post-CPC. Anterior segment neovascularization regressed dramatically within 1 week of IVB in 12 eyes. Thirteen eyes reported persistent relief of ocular pain at 6 months following treatment. The authors concluded that combined IVB and CPC treatment for NVG provides rapid control of anterior segment neovascularization and may lead to improved symptomatic relief and IOP control.

To evaluate the effect of intravitreal bevacizumab injection in cases of neovascular glaucoma, Ghanem et al. studied 16 eyes of 16 patients with rubeosis iridis and secondary glaucoma.²¹ Patients were administered an intravitreal injection of bevacizumab (2.5 mg) and were followed for 2 months. Partial or complete regression of iris neovascularization was noted 1 week after injection of bevacizumab. Reproliferation of new vessels was detected in 25% of the cases after 2 months. The mean intraocular pressure (IOP) before injection was 28 ± 9.3 mm Hg under topical β -blocker and systemic acetazolamide. One week after injection, the IOP decreased to 21.7 ± 11.5 mm Hg (5 cases without anti-glaucoma drugs, 6 cases with topical β -blocker and 5 cases with both topical β -blocker and systemic acetazolamide). The authors concluded that intravitreal bevacizumab injection leads to regression of iris neovascularization with subsequent drop of IOP in eyes with neovascular glaucoma.

Moraczewski et al. report a retrospective, non-comparative, consecutive, interventional case series of the treatment of neovascular glaucoma with intravitreal bevacizumab in 56 eyes at the University of Miami, Florida, Bascom Palmer Eye Institute.²² The authors' impression both clinically and from a review of available literature is that early diagnosis and treatment of NVG with intravitreal bevacizumab may lead to improved outcomes. If bevacizumab is administered when the anterior chamber angle is open at the time of NVG diagnosis, it is postulated that IOP may be controlled without the need for surgical procedures. This study underscores the concept that, if followed long enough, the majority of patients regardless of initial angle status and initial IOP lowering, will require surgical intervention for the control of IOP. The cumulative proportion of eyes requiring a second injection of bevacizumab increases linearly with time and is related to recurrent or persistent iris neovascularization or angle neovascularization. Bevacizumab induced regression of neovascularization is often temporary and recurrence is possible, while panretinal photocoagulation provides a more permanent reduction of the ischemic angiogenic stimulus. At this institution, treatment of NVG with intravitreal bevacizumab is the standard of care, including: 1) Administering intravitreal bevacizumab at the time of diagnosis of NVG; 2) Administering panretinal photocoagulation shortly thereafter, and; 3) lowering IOP medically and via placement of a drainage device if necessary.

Choroidal Neovascularization

Choroidal Neovascularization Secondary to Pathologic Myopia

Cha DM et al compared the long-term efficacy of versus bevacizumab for myopic choroidal neovascularization (CNV) in retrospective, multicenter, comparative, non-randomized study in 64 consecutive patients [ranibizumab (n=22) or bevacizumab (n=42 patients)].⁹ Best-corrected visual acuity (BCVA) and central foveal thickness (CFT) on optical coherence tomography were evaluated before and after treatment. All the patients were followed for at least 12 months. BCVA (logarithm of the minimal angle of resolution) improved from 0.63 ± 0.30 to 0.43 ± 0.27 , 0.41 ± 0.37 , 0.40 ± 0.39 , 0.39 ± 0.43 , and 0.39 ± 0.42 at 1, 2, 3, 6, and 12 months after treatment in the ranibizumab group, and from 0.67 ± 0.28 to 0.52 ± 0.31 , 0.49 ± 0.31 , 0.47 ± 0.31 , 0.42 ± 0.32 , and 0.46 ± 0.43 in the bevacizumab group (all $P < 0.05$ compared with baseline BCVA in each group). CFT decreased by 20.21%, 19.58%, and 22.43% from the baseline 304 ± 76 μ m at 3, 6, and 12 months after treatment in the former group, and by 15.20%, 15.67%, and 15.56% from the baseline 297 ± 62 μ m in the latter group (all $P < 0.05$ compared with baseline CFT in each group). BCVA improvement and CFT reduction did not statistically differ when compared at the same periods from treatment between 2 groups. Neither ocular nor systemic safety problems appeared during follow up. Researchers concluded that the outcomes of the study showed a similar functional and anatomical improvement after treatment for ranibizumab and bevacizumab in patients with myopic CNV over a 12-month follow-up period.

In a phase III, 12-month, randomized, double-masked, multicenter, active-controlled study, researchers evaluated the efficacy and safety of ranibizumab 0.5 mg, guided by visual acuity (VA) stabilization or disease activity criteria, versus verteporfin photodynamic therapy (vPDT) in patients (n=277) with visual impairment due to myopic choroidal neovascularization (CNV).¹¹ Patients were randomized to receive ranibizumab on day 1, month 1, and thereafter as needed guided by VA stabilization criteria (group I, n = 106); ranibizumab on day 1 and thereafter as needed guided by disease activity criteria (group II, n=116); or

vPDT on day 1 and disease activity treated with ranibizumab or vPDT at investigators' discretion from month 3 (group III, n = 55). Primary outcomes measured included average best-corrected visual acuity (BCVA) change from baseline to month 1 through months 3 (primary) and 6, mean BCVA change and safety over 12 months. Ranibizumab treatment in groups I and II was superior to vPDT based on mean average BCVA change from baseline to month 1 through month 3 (group I: +10.5, group II: +10.6 vs. group III: +2.2 Early Treatment Diabetic Retinopathy Study [ETDRS] letters; both $P < 0.0001$). Ranibizumab treatment guided by disease activity was noninferior to VA stabilization-guided retreatment based on mean average BCVA change from baseline to month 1 through month 6 (group II: +11.7 vs. group I: +11.9 ETDRS letters; $P < 0.00001$). Mean BCVA change from baseline to month 12 was +13.8 (group I), +14.4 (group II), and +9.3 ETDRS letters (group III). At month 12, 63.8% to 65.7% of patients showed resolution of myopic CNV leakage. Patients received a median of 4.0 (group I) and 2.0 (groups II and III) ranibizumab injections over 12 months. No deaths or cases of endophthalmitis and myocardial infarction occurred.

CONCLUSIONS: Ranibizumab treatment, irrespective of retreatment criteria, provided superior BCVA gains versus vPDT up to month 3. Ranibizumab treatment guided by disease activity criteria was noninferior to VA stabilization criteria up to month 6. Over 12 months, individualized ranibizumab treatment was effective in improving and sustaining BCVA and was generally well tolerated in patients with myopic CNV.

Yoon et al. compared visual outcomes after treatment with intravitreal anti-vascular endothelial growth factor (anti-VEGF) injection or photodynamic therapy (PDT) in patients with myopic choroidal (CNV).²³ One hundred and forty-two eyes of 128 consecutive patients treated with anti-VEGF (ranibizumab or bevacizumab) and/or PDT for myopic choroidal neovascularization were retrospectively reviewed. Patients were categorized into 3 groups: PDT (51 eyes), anti-VEGF (63 eyes), and a combination group (PDT with anti-VEGF) (28 eyes). Corrected visual acuity values at baseline and 3, 6, 9, and 12 months after treatment were compared. The anti-VEGF group showed significant postoperative improvement in visual acuity compared with the PDT and combination groups ($p = 0.01$ and 0.04 , respectively). The anti-VEGF group demonstrated visual improvement from baseline at every follow-up visit after treatment ($p = 0.04$, 0.02 , 0.01 , and 0.002 , respectively). The anti-VEGF group showed visual improvement (Snellen equivalent) from 0.57 logarithm of the minimum angle of resolution (0.27) to 0.33 logarithm of the minimum angle of resolution (0.47) ($p = 0.01$). Furthermore, 98.4% of patients in the anti-VEGF group and 92.8% of those in the combination group lost < 15 letters from baseline visual acuity compared with 72.6% in the PDT group ($p = 0.001$ and 0.02 , respectively). In the anti-VEGF group, 39.7% of patients improved from baseline by 15 or more letters compared with 17.7% in the PDT group ($p = 0.02$) and 21.4% in the combination group ($p = 0.07$). Based on these findings, the investigators concluded that intravitreal anti-VEGF injection is superior to PDT alone or a combination of PDT with anti-VEGF for treating myopic choroidal neovascularization.

Vadalà et al. assessed the efficacy and safety of ranibizumab in the treatment of choroidal neovascularisation (CNV) caused by pathologic myopia (PM) in a prospective, multicentre, interventional case series.²⁴ Forty eyes of 39 consecutive patients with PM and CNV were treated with 'on demand' intravitreal injection of ranibizumab 0.5 mg. Final best corrected visual acuity (BCVA) and its change from baseline were the main outcome measures. Median follow-up was 13.3 ± 2 (range 12-18) months. Fifteen eyes (37.5%) had previously been treated with photodynamic therapy (PDT). The mean baseline logarithm of the minimum angle of resolution (logMAR) BCVA was 0.68 ± 0.34 (Snellen equivalent 20/131) and 21 ± 16 letters. The final mean logMAR BCVA was 0.27 ± 0.2 ($p = 0.008$) (20/42) and 40.5 ± 14 letters ($p = 0.01$). Mean final VA improved in 82.5% of patients, in 60% by 3 or more lines (median number of lines gained 2.9). Age and previous PDT did not influence the results ($p > 0.05$). The mean number of injections was 2.8 ± 1.2 (range 1-6). No ocular or systemic side effects were observed. Ranibizumab was an effective treatment for stabilizing and improving vision with a low number of injections in 92.5% of patients with myopic CNV in a long-term follow-up.

Choroidal Neovascularization Secondary to Angioid Streaks/Pseudoxanthoma Elasticum

Finger et al. investigated the long-term effectiveness of intravitreal bevacizumab for treating active choroidal neovascularizations in pseudoxanthoma elasticum (PXE).²⁵ Fourteen patients (16 eyes) received intravitreal bevacizumab (1.5 mg), were evaluated monthly, and received further treatments depending on disease activity. Examinations included best-corrected visual acuity, biomicroscopy, optical coherence tomography, fluorescein angiography and indocyanine green angiography, fundus autofluorescence, and digital fundus photography. Areas of atrophy of the retinal pigment epithelium and retinal fibrosis were quantified using semiautomated detection on fundus autofluorescence images. Mean age of the cohort was 55 ± 13 years, and mean best-corrected visual acuity at baseline was 20/80 (logarithm of the minimum angle of resolution, 0.56, SD, 0.51). At last follow-up, after an average of 6.5 ± 5.7 injections over 28 months, best-corrected visual acuity was 20/40 (logarithm of the minimum angle of resolution, 0.31, SD, 0.32; $p = 0.04$). Central retinal thickness was reduced from $254 \pm 45 \mu\text{m}$ to $214 \pm 40 \mu\text{m}$ ($p = 0.035$). The size of retinal pigment epithelial atrophy and retinal fibrosis measured on fundus autofluorescence images increased in both the treated eye and the fellow eye ($p < 0.05$). Best-corrected visual acuity of patients with early disease

compared with that of those with advanced disease improved significantly more over the treatment course (20/25 vs. 20/63; $p=0.008$). The authors reported that intravitreal bevacizumab therapy demonstrates long-term effectiveness by preserving function in advanced disease and improving function in early disease. Best results of treating active choroidal neovascularizations in PXE are achieved when treatment starts as early in the disease as possible.

El Matri et al. evaluated the efficacy and safety of intravitreal bevacizumab for the treatment of choroidal neovascularization associated with angioid streaks in a retrospective case series of eighteen eyes of 17 patients treated between October 2006 and May 2008.²⁶ Ophthalmic evaluation, including best corrected visual acuity (BCVA), slit lamp biomicroscopic examination, optical coherence tomography (OCT) and fluorescein angiography, was performed before and after treatment. Retreatment was allowed every 4–6 weeks in case of persistent symptoms or CNV activity on OCT. Main outcome measures were changes in BCVA and central retinal thickness on OCT. The mean number of injections was 4.8 at one year. Twelve eyes (66.6%) received five injections or more. The mean BCVA at baseline was 20/80 (range 20/400 to 20/32) and improved to 20/44 (range 20/160 to 20/20) at 1 year ($p=0.014$). The BCVA improved by three or more lines in eleven eyes (61.11%) and remained within two lines of baseline in seven eyes (38.8%). Mean central retinal thickness was 404.2 μm (range 160–602 μm) at baseline and decreased to 300.5 μm (range 150–523 μm) at 1 year ($p=0.022$). No ocular or systemic complications were noted. The 1-year outcomes suggest intravitreal bevacizumab to be a promising treatment for CNV associated with angioid streaks, resulting in both functional and anatomical improvements. Repeated injections are needed to maintain these results. Further long term studies are required to confirm these findings.

Mimoun et al. retrospectively analyzed the efficacy of intravitreal ranibizumab injections for the management of choroidal neovascularization (CNV) in patients with angioid streaks.²⁷ In a nonrandomized, double-center, retrospective, interventional case series, patients were treated with intravitreal ranibizumab injections (0.5 mg/0.05 mL). The primary end point was the percentage of eyes with stable or improved visual acuity at the end of follow-up. Secondary end points were the percentage of eyes with stable or decreased macular thickness on optical coherence tomography and the percentage of eyes with persistent leakage on fluorescein angiography at the last follow-up examination. Thirty-five eyes of 27 patients were treated with repeated intravitreal ranibizumab injections (mean, 5.7 injections; range, 2 to 14 injections) for a mean of 24.1 months (range, 6 to 37 months). At the end of follow-up, visual acuity was stabilized or improved in 30 (85.7%) of 35 eyes. Macular thickness had stabilized or decreased in 18 (51.5%) of 35 eyes. At the last follow-up examination, on fluorescein angiography, no further leakage was observed in 23 (65.7%) of 35 eyes.

Myung et al. reported long-term results of intravitreal anti-vascular endothelial growth factor therapy in the management of choroidal neovascularization in patients with angioid streaks associated with pseudoxanthoma elasticum.²⁸ Nine eyes of nine consecutive patients were managed with either bevacizumab 1.25 mg/0.05 mL or ranibizumab 0.5 mg/0.05 mL. The main outcome measures were visual acuity and greatest lesion height as measured by optical coherence tomography. During the mean follow-up period of 28.6 months, eyes received an average of 8.4 injections. At baseline, the mean visual acuity was 20/368 (median, 20/60) and improved to 20/281 (median, 20/40) at the last visit ($p=0.14$). Visual acuity either improved or stabilized in all 9 eyes (100%). Serial optical coherence tomography measurements showed a mean of 353 μm at baseline and decreased to 146 μm at the last visit ($p=0.005$). No complications were noted. These long-term results support the use of intravitreal anti-vascular endothelial growth factor therapy for the management of choroidal neovascularization in patients with pseudoxanthoma elasticum.

Choroidal Neovascularization Secondary to Ocular Histoplasmosis Syndrome (OHS)

Cionni et al. conducted a retrospective, comparative case series of 150 eyes in 140 patients treated with intravitreal bevacizumab (IVB) for choroidal neovascularization (CNV) secondary to presumed ocular histoplasmosis syndrome (POHS).²⁹ Subjects received either IVB monotherapy ($n=117$ eyes) or combination IVB and verteporfin photodynamic therapy (IVB/PDT) ($n=34$ eyes). Visual acuity (VA) at 12 and 24 months was analyzed. Secondary outcome measures included the number of injections per year and treatment-free intervals. For all patients, the average pretreatment logarithm of minimum angle of resolution (logMAR) was 0.63 (Snellen equivalent 20/86) with a 12-month logMAR VA of 0.45 (Snellen equivalent 20/56) and a 24-month logMAR VA of 0.44 (Snellen equivalent 20/55). The mean follow-up was 21.1 months with an average of 4.24 IVB injections per year. There was no significant difference in initial VA, VA at 12 months, VA at 24 months, or number of eyes with a 3-line gain between the IVB monotherapy and IVB/PDT groups. Thirty-eight percent (39/104) of eyes gained 3 lines or more, and 81.2% (84/104) of subjects had maintained or improved their starting VA at 1 year. The proportion of subjects maintaining a 3-line gain in VA was relatively preserved at 2 years (29.8%, 17/57) and 3 years (30.3%, 10/32) follow-up. There was no increase in the proportion of subjects losing 3 lines or more over 3 years of follow-up. The authors concluded that there is no

significant difference in VA outcomes between IVB monotherapy versus IVB/PDT combination therapy. The use of IVB alone or in combination with PDT results in significant visual stabilization in the majority of patients with CNV secondary to POHS.

Shadlu et al. conducted a retrospective chart review of 28 eyes of 28 patients who underwent intravitreal administration of bevacizumab for treatment of choroidal neovascularization secondary to OHS.³⁰ The mean follow-up period was 22.43 weeks with patients receiving an average of 1.8 intravitreal injections. The investigators found that the treatment was of benefit to improve or stabilize the visual acuity in a significant majority (24 eyes, 85.7%) of patients with neovascular complications of OHS.

In a retrospective chart review of 54 eyes, Nielsen et al. studied the effect of treatment with intravitreal anti-VEGF therapy for choroidal neovascularization in ocular histoplasmosis syndrome.³¹ Either bevacizumab or ranibizumab were administered on an average of 4.5 injections per patient per year of follow-up. Mean visual acuity improved from 20/53 to 20/26 over an average of 26.8 months. Vision loss was seen in only three eyes with loss limited to a single line of vision. Patients experienced no serious complications from treatment. Long-term intravitreal anti-VEGF therapy with bevacizumab or ranibizumab is beneficial in treatment of choroidal neovascularization in ocular histoplasmosis syndrome.

There are additional small published studies and reports that provide support for the use of both bevacizumab and ranibizumab to treat choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS).³²⁻⁴⁶

Retinopathy of Prematurity

Geloneck et al. conducted a prospective, stratified, randomized, controlled, masked, multicenter clinical trial examining the efficacy of bevacizumab versus laser therapy for the treatment of zone I or zone II posterior stage 3+ retinopathy of prematurity (ROP) or aggressive posterior ROP (APROP) in preterm infants. Infants either received intravitreal bevacizumab or laser therapy, randomized by infant, also underwent cycloplegic retinoscopic refraction at an average age of 2.5 years. Pediatric and vitreoretinal ophthalmologists in 15 level 3 neonatal intensive care units in academic centers participated. Of the originally enrolled 150 infants (300 eyes) in the clinical trial, 13 infants (26 eyes) died (6 received intravitreal bevacizumab; 7 received laser) and 19 eyes had intraocular surgery (6 infants bilaterally). Thus, 45 eyes (19 infants bilaterally) were excluded, leaving 131 infants (255 eyes, including 21 eyes that received a successful second treatment for recurrence). The primary outcomes were spherical equivalent refractive outcomes and their distribution by ROP zone and treatment. Of the 131 eligible infants, refractions were available for only 109 (83.2%) and 211 of 255 eyes (82.7%). Mean (SD) spherical equivalent refractions were as follows: zone I, -1.51 (3.42) diopters (D) in 52 eyes that received intravitreal bevacizumab and -8.44 (7.57) D in 35 eyes that received laser treatment ($P < .001$); and zone II posterior, -0.58 (2.53) D in 58 eyes that received intravitreal bevacizumab and -5.83 (5.87) D in 66 eyes that received laser treatment ($P < .001$). Very high myopia (-8.00 D) occurred in zone I in 2 of 52 (3.8%) eyes that received intravitreal bevacizumab and in 18 of 35 (51.4%) eyes that received laser treatment ($P < .001$). Very high myopia occurred in zone II posterior in 1 of 58 (1.7%) eyes that received intravitreal bevacizumab and in 24 of 66 (36.4%) eyes that received laser treatment ($P < .001$). The authors concluded that more very high myopia was found in eyes that received laser treatment than in eyes that received intravitreal bevacizumab. This difference is possibly related to anterior segment development that is present with intravitreal bevacizumab but minimal or absent following laser treatment.

In a prospective, controlled, randomized, stratified, multicenter trial, Mintz-Hittner et al. studied the efficacy of intravitreal bevacizumab monotherapy for zone I or zone II posterior stage 3+ retinopathy of prematurity (ROP). One hundred fifty infants were randomized to receive intravitreal bevacizumab (0.625 mg/0.025 ml) or conventional laser therapy, bilaterally. The primary ocular outcome was recurrence of ROP in one or both eyes requiring retreatment before 54 weeks' postmenstrual age. Of the 150 infants, 143 survived to 54 weeks. The 7 infants who died were not included in the primary outcome analysis. ROP recurred in 4 infants in the bevacizumab group (6 of 140 eyes [4%]) and 19 infants in the laser-therapy group (32 of 146 eyes [22%]), $P=0.002$. A significant treatment effect was found for zone I ROP ($P=0.003$) but not for zone II disease ($p=0.27$). The authors concluded that intravitreal bevacizumab monotherapy, as compared with conventional laser therapy, in infants with stage 3+ retinopathy of prematurity showed a significant benefit for zone I but not zone II disease. Development of peripheral retinal vessels continued after treatment with intravitreal bevacizumab, but conventional laser therapy led to permanent destruction of the peripheral retina.

Professional Societies

Royal College of Ophthalmologists

The Royal College of Ophthalmologists released a scientific statement on bevacizumab use in medical ophthalmology in December 2011.⁵² A working group of the Scientific Committee of the College considered the published literature relating to the efficacy and safety of bevacizumab (Avastin) and ranibizumab (Lucentis) in the treatment of the neovascular form of age-related macular degeneration (AMD). The College view is that the current published literature is consistent with the conclusion that bevacizumab and ranibizumab are equally effective in the treatment of neovascular age-related macular degeneration and there is no convincing evidence of a clinically significant difference in the incidence of serious adverse events between the two groups. Since then, the College has made a revised statement stating there is clear evidence that, despite the lack of a licence, bevacizumab is a safe and effective drug for the treatment of neovascular AMD.

American Society of Retina Specialists (ASRS)

According to the American Society of Retina Specialists (ASRS), bevacizumab is being used by a large number of retinal specialists who believe that it is reasonable and medically necessary for the treatment of some patients with macular edema and abnormal retinal and iris neo-vascularization.⁵³

American Academy of Ophthalmology (AAO)

The American Academy of Ophthalmology (AAO) supports the use of intravitreal injection therapy using anti-vascular endothelial growth factor (VEGF) agents (e.g., aflibercept, bevacizumab and ranibizumab) is the most effective way to manage neovascular AMD and represents the first line of treatment.⁵⁴

In their Diabetic Retinopathy Preferred Practice Pattern, the AAO states that intravitreal injections of anti-vascular endothelial growth factor (VEGF) agents have been shown to be an effective treatment for center-involving diabetic macular edema and also as an alternative therapy for proliferative diabetic retinopathy.⁵⁵

In their Retinal Vein Occlusions Preferred Practice Pattern, the AAO states that Macular edema may complicate both CRVOs and BRVOs. The safest treatment for the associated macular edema is the use of anti-vascular endothelial growth factors (anti-VEGFs). Intravitreal corticosteroids, with the associated risk of glaucoma and cataract formation, have demonstrated efficacy. Also, laser photocoagulation in BRVO has a potential role in treatment.⁵⁵

In 2014 the AAO released a clinical statement entitled ‘Verifying the Source of Compounded Bevacizumab for Intravitreal Injections – 2014.’⁵⁶ Their recommendations are as follows:

- To reduce the risk of infection to patients, the following steps are recommended when sourcing bevacizumab (Avastin) for intravitreal injections:
 - Select a compounding pharmacy accredited by the [PCAB](#), which adheres to quality standards for aseptic compounding of sterile medications (USP <797>).
Note: PCAB does not track or keep record of specific medications that a pharmacy can compound.
 - Record the lot numbers of the medication in the patient’s record and in a logbook or spreadsheet in case the numbers are needed for tracking later.

In addition, [Ophthalmic Mutual Insurance Company’s \(OMIC\) Risk Management Recommendations for Preparations of Avastin](#) specify:

- Using proper aseptic technique during the preparation and administration of the injection.
- “Credentialing” the compounding pharmacy where you send the prescription for intravitreal bevacizumab (Avastin) by:
 - Verifying that the compounding pharmacy is licensed/registered in the state it is dispensing.
 - Inquiring how the pharmacy compounds bevacizumab (Avastin). (The pharmacy should state that it complies with USP <797>.)
 - Asking the pharmacy if it is an accredited compounding pharmacy.
- Requesting that the compounding pharmacy prepare the medication for ophthalmic use, confirms the dose and sterility, identifies a syringe suitable for the protein, provides storage and “beyond-use” instructions, and indicates the vial lot number.

The informed consent process with the patient should include a discussion of the risks and benefits of treatment and treatment alternatives where the off-label status of bevacizumab (Avastin) for neovascular AMD should be included in the discussion.

Technical Assessments

Retinopathy of Prematurity

In 2017, the American Academy of Ophthalmology (AAO) published an Ophthalmic Technology Assessment (OTA) to review and evaluate the evidence on the ocular safety and efficacy of anti-VEGF agents for the treatment of retinopathy of prematurity (ROP) compared with laser photocoagulation therapy. The OTA compared retinal structural outcomes, visual and refractive outcomes, ocular complications and systemic morbidity. The OTA included 13 citations, out of 37 citations that were deemed clinically relevant for review. A panel methodologist assigned ratings (I to III) to the selected articles according to the level of evidence. Of the 13 citations, articles on 5 randomized clinical trials provided level II evidence supporting the use of anti-VEGF agents, either as monotherapy or in combination with laser therapy. The primary outcome for these articles included recurrence of ROP and the need for retreatment (3 articles), retinal structure (2 articles), and refractive outcome (1 article). Seven articles were comparative case series that provided level III evidence. The primary outcomes included the effects of anti-VEGF treatment on development of peripheral retinal vessels (1 article), refractive outcomes (1 article), or both structural and refractive or visual outcomes (5 articles). The authors concluded that the recent literature suggests that the short-term efficacy and ocular safety are similar to those of laser photocoagulation therapy. The advantages of using anti-VEGF agents include less time to administer treatment, faster improvement in plus disease and regression of ROP, less treatment-related destruction of the peripheral retina, and a lower likelihood of myopia, high myopia, and astigmatism. The disadvantages of anti-VEGF therapy include a longer required follow-up as a result of delayed or incomplete vascularization, significant rates of recurrence and the potential need for later retreatment, and the possibility of developmentally abnormal or atypical retinal vascular patterns. With respect to the severity of ROP, there seems to be several potential advantages for primary treatment with anti-VEGF agents for eyes with zone I ROP or eyes with aggressive posterior ROP. However, there is no clear advantage over laser photocoagulation for eyes with more peripheral zone II ROP, and there is no clear advantage for first-line combination therapy.

In 2018, a Cochrane review was published to evaluate the efficacy and safety of anti-VEGF drugs when used either as monotherapy (without concomitant cryotherapy or laser therapy) or in combination with planned cryo/laser therapy in preterm infants with type 1 retinopathy of prematurity (ROP), (defined as zone I any stage with plus disease, zone I stage 3 with or without plus disease, or zone II stage 2 or 3 with plus disease). The review included randomised or quasi-randomised controlled trials that evaluated the efficacy or safety of administration, or both, of anti-VEGF agents compared with conventional therapy in preterm infants with ROP.

Six trials involving a total of 383 infants fulfilled the inclusion criteria. Five trials compared intravitreal bevacizumab (n = 4) or ranibizumab (n = 1) with conventional laser therapy (monotherapy), while the sixth study compared intravitreal pegaptanib plus conventional laser therapy with laser/cryotherapy (combination therapy). When used as monotherapy, bevacizumab/ranibizumab did not reduce the risk of complete or partial retinal detachment (3 studies; 272 infants; risk ratio (RR) 1.04, 95% confidence interval (CI) 0.21 to 5.13; risk difference (RD) 0.00, 95% CI -0.04 to 0.04; very low-quality evidence), mortality before discharge (2 studies; 229 infants; RR 1.50, 95% CI 0.26 to 8.75), corneal opacity requiring corneal transplant (1 study; 286 eyes; RR 0.34, 95% CI 0.01 to 8.26), or lens opacity requiring cataract removal (3 studies; 544 eyes; RR 0.15, 95% CI 0.01 to 2.79). The risk of recurrence of ROP requiring retreatment also did not differ between groups (2 studies; 193 infants; RR 0.88, 95% CI 0.47 to 1.63; RD -0.02, 95% CI -0.12 to 0.07; very low-quality evidence). Subgroup analysis showed a significant reduction in the risk of recurrence in infants with zone I ROP (RR 0.15, 95% CI 0.04 to 0.62), but an increased risk of recurrence in infants with zone II ROP (RR 2.53, 95% CI 1.01 to 6.32). Pooled analysis of studies that reported eye-level outcomes also revealed significant increase in the risk of recurrence of ROP in the eyes that received bevacizumab (RR 5.36, 95% CI 1.22 to 23.50; RD 0.10, 95% CI 0.03 to 0.17). Infants who received intravitreal bevacizumab had a significantly lower risk of refractive errors (very high myopia) at 30 months of age (1 study; 211 eyes; RR 0.06, 95% CI 0.02 to 0.20; RD -0.40, 95% CI -0.50 to -0.30; low-quality evidence). When used in combination with laser therapy, intravitreal pegaptanib was found to reduce the risk of retinal detachment when compared to laser/cryotherapy alone (152 eyes; RR 0.26, 95% CI 0.12 to 0.55; RD -0.29, 95% CI -0.42 to -0.16; low-quality evidence). The incidence of recurrence of ROP by 55 weeks' postmenstrual age was also lower in the pegaptanib + laser therapy group (76 infants; RR 0.29, 95% CI 0.12 to 0.7; RD -0.35, 95% CI -0.55 to -0.16; low-quality evidence). There was no difference in the risk of perioperative retinal haemorrhages between the two groups (152 eyes; RR 0.62, 95% CI 0.24 to 1.56; RD -0.05, 95% CI -0.16 to 0.05; very low-quality evidence). However, the risk of delayed systemic adverse effects with any of the three anti-VEGF drugs is not known.

The authors concluded that intravitreal bevacizumab/ranibizumab, when used as monotherapy, reduces the risk of refractive errors during childhood but does not reduce the risk of retinal detachment or recurrence of ROP in infants with type 1 ROP. Bevacizumab/ranibizumab can potentially result in higher risk of recurrence requiring retreatment in those with zone II ROP. Intravitreal pegaptanib, when used in conjunction with laser therapy, reduces the risk of retinal detachment as well as the recurrence of ROP in infants with type 1 ROP. However, the quality of the evidence was very low to low for most outcomes due to risk of detection bias and other biases. The effects on other critical outcomes and, more importantly, the long-term systemic adverse effects of the drugs are not known. Insufficient data precludes strong conclusions favoring routine use of intravitreal anti-VEGF agents - either as monotherapy or in conjunction with laser therapy - in preterm infants with type 1 ROP.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Avastin (bevacizumab)

The statements below are for information only. Oncology indications for bevacizumab are listed in the NCCN Drugs & Biologics Compendium.

- Bevacizumab, in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for first- or second-line treatment of patients with metastatic carcinoma of the colon or rectum.⁵⁷
- Bevacizumab, in combination with fluoropyrimidine- irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients with metastatic colorectal cancer who have progressed on a first-line bevacizumab-containing regimen.⁵⁷
- Bevacizumab, in combination with carboplatin and paclitaxel, is indicated for first-line treatment of patients with unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer.⁵⁷
- Bevacizumab for treatment of glioblastoma, is indicated for the treatment of recurrent glioblastoma.⁵⁷
- Bevacizumab, in combination with paclitaxel and cisplatin or paclitaxel and topotecan in persistent, recurrent, or metastatic cervical cancer.⁵⁷
- Bevacizumab, in combination with interferon alfa, is indicated for the treatment of metastatic renal cell carcinoma.⁵⁷
- Bevacizumab, in combination with carboplatin and paclitaxel or in combination with carboplatin and gemcitabine, followed by bevacizumab as a single agent, is indicated for the treatment of platinum-sensitive recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer.⁵⁷
- Bevacizumab, in combination with carboplatin and paclitaxel, followed by bevacizumab as a single agent, for stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection.⁵⁷
- Bevacizumab, in combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan for platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received no more than 2 prior chemotherapy regimens.⁵⁷

Mvasi (bevacizumab-awwb)

Bevacizumab-awwb is indicated for the treatment of metastatic colorectal cancer, in combination with intravenous fluorouracil-based chemotherapy for first- or second-line treatment and metastatic colorectal cancer, in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line bevacizumab product-containing regimen.

Zirabev (bevacizumab-bvzr)

Bevacizumab-bvzr is indicated for the treatment of metastatic colorectal cancer, in combination with intravenous fluorouracil-based chemotherapy for first- or second-line treatment and metastatic colorectal cancer, in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line bevacizumab product-containing regimen.

A biosimilar product is a biologic product that is approved based on demonstrating that it is highly similar to an FDA-approved biologic product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products. The chart below highlights the applicable reference product and respective biosimilar product.

Reference Product	Biosimilar Product
Avastin	Mvasi (bevacizumab-awwb) Zirabev (bevacizumab-bvzr)

Administration of bevacizumab infusions or intravitreal injections for the treatment of ophthalmologic conditions is considered off-label.

A 2018 final guidance for industry sets forth FDA's policy regarding the mixing, diluting and repackaging of certain types of biologics outside an approved biologics license application (BLA), including the repackaging of Avastin. The final guidance requires 503B outsourcing facilities to repackage in accordance with cGMP and perform specific stability indicating tests to establish the beyond use date (BUD) of repackaged biological products, as well as conduct specific batch release testing. The stability tests must be conducted by outsourcers to assure consistency with the approved labeling and must include appearance, color and clarity, visible particulates, pH, sub-visible particles (per USP Chapter <788>, Particulate Matter for Injections or USP Chapter <789>, Particulate Matter for Ophthalmic Solutions, whichever is appropriate for route of administration), protein content, impurities, potency and sterility. The full guidance can be reviewed at [FDA.gov](https://www.fda.gov).

Beovu (brolucizumab)

Brolucizumab is indicated for the treatment of neovascular (wet) age-related macular degeneration (AMD).⁷¹

Eylea (aflibercept)

Aflibercept is indicated for the treatment of patients with neovascular (wet) age-related macular degeneration (AMD), macular edema following retinal vein occlusion (RVO), diabetic macular edema (DME), and diabetic retinopathy.⁵

Lucentis (ranibizumab)

Ranibizumab is indicated for the treatment of patients with neovascular (wet) age-related macular degeneration (AMD), macular edema following retinal vein occlusion (RVO), diabetic macular edema (DME), and diabetic retinopathy.⁷

Macugen (pegaptanib)

Pegaptanib is indicated for the treatment of patients with neovascular (wet) age-related macular degeneration (AMD).⁶

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for the use of vascular endothelial growth factor (VEGF) inhibitors; such as Avastin® (bevacizumab), Eylea® (aflibercept), Lucentis® (ranibizumab) and Macugen® (pegaptanib). Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist; see the LCDs/LCAs for [Vascular Endothelial Growth Factor Inhibitors for the Treatment of Ophthalmological Diseases](#), [Ranibizumab, Aflibercept and Brolucizumab-dblI](#), [Aflibercept \(Eylea®\)](#), [Drugs and Biologicals, Coverage of, for Label and Off-Label Uses](#), [Bevacizumab: Avastin](#), and [Intraocular Bevacizumab](#).

In general, Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §50 - Drugs and Biologicals](#). (Accessed May 14, 2020)

References

1. United States Pharmacopeia: 2008-2009 USP Pharmacists' Pharmacopeia. 2nd ed. 5th supplement. Chapter <797> Pharmaceutical Compounding-Sterile Preparations. Rockville, MD: United States Pharmacopeia Convention. April 21-24, 2010. Washington, DC.
2. PCAB Standards. Pharmacy Compounding Accreditation Board. Washington DC. Accessed September 12, 2013.
3. United States Veterans Health Administration. Updated Interim Guidance on the Use of Intravitreal Bevacizumab. October 31, 2011. Available at: http://www.pbm.va.gov/linksotherresources/ezminutes/Oct2011/EzMinutesAugOct2011.htm#Intravitreal_bevacizumab_Update.

4. Folkman J. Angiogenesis. In Braunwald E, et al., eds. *Harrison's Principles of Internal Medicine*, 15th ed. New York, McGraw-Hill, 2001:517-530.
5. Eylea® [prescribing information]. Tarrytown, NY; Regeneron Pharmaceuticals, Inc.; August 2019.
6. Macugen® [prescribing information]. San Dimas, CA; Gilead Sciences, Inc.; July 2016.
7. Lucentis® [prescribing information]. South San Francisco, CA; Genentech, Inc.; March 2018.
8. CATT Research Group, Martin DF, Maguire MG, et al. Ranibizumab and Bevacizumab for Neovascular Age-Related Macular Degeneration. *N Engl J Med*. 2011 May 19;364(20):1897-908.
9. Cha DM, Kim TW, Heo JW, et al. Comparison of 1-year therapeutic effect of ranibizumab and bevacizumab for myopic choroidal neovascularization: a retrospective, multicenter, comparative study. *BMC Ophthalmol*. 2014 May 21;14:69.
10. Solomon SD, Lindsley K, Vedula SS, et al. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. *Cochrane Database Syst Rev*. 2014 Aug 29;8:CD005139.
11. Wolf S, Balciuniene VJ, Laganovska G, et al. RADIANCE: a randomized controlled study of ranibizumab in patients with choroidal neovascularization secondary to pathologic myopia. *Ophthalmology*. 2014 Mar;121(3):682-92.e2.
12. Sultan MB, Zhou D, Loftus J, et al. A phase 2/3, multicenter, randomized, double-masked, 2-year trial of pegaptanib sodium for the treatment of diabetic macular edema. *Ophthalmology*. 2011 Jun;118(6):1107-18.
13. Cunningham ET Jr, Adamis AP, Altaweel M, et al. A phase II randomized double-masked trial of pegaptanib, an anti-vascular endothelial growth factor aptamer, for diabetic macular edema. *Ophthalmology*. 2005 Oct;112(10):1747-57.
14. American Society of Retina Specialists Web site. <https://www.asrs.org/advocacy-practice/access-to-safe-compounded-agents>.
15. Zhang H, Liu ZL, Sun P, Gu F. Intravitreal Bevacizumab for Treatment of Macular Edema Secondary to Central Retinal Vein Occlusion: Eighteen-Month Results of a Prospective Trial. *J Ocul Pharmacol Ther*. 2011 Dec;27(6):615-21.
16. Figueroa MS, Contreras I, Noval S, Aurrabarrena C. Results of Bevacizumab as the Primary Treatment for Retinal Vein Occlusions. *Br J Ophthalmol*. 2010 Aug;94(8):1052-6.
17. Arevalo JF, Wu L, Sanchez JG, et al. Intravitreal bevacizumab (Avastin) for proliferative diabetic retinopathy: 6-months follow-up. *Eye (Lond)*. 2009 Jan;23(1):117-23.
18. Ahmadi H, Shoeibi N, Entezari M, Monshizadeh R. Intravitreal Bevacizumab for Prevention of Early Postvitrectomy Hemorrhage in Diabetic Patients: a Randomized Clinical Trial. *Ophthalmology*. 2009 Oct; 116(10):1943-8.
19. di Lauro R, De Ruggiero P, di Lauro R, et al. Intravitreal Bevacizumab for Surgical Treatment of Severe Proliferative Diabetic Retinopathy. *Graefes Arch Clin Exp Ophthalmol*. 2010 Jun; 248(6):785-91.
20. Ghosh S, Singh D, Ruddle JB, et al. Combined Diode Laser Cyclophotocoagulation and Intravitreal Bevacizumab (Avastin) in Neovascular Glaucoma. *Clin Experiment Ophthalmol*. 2010 May; 38(4):353-7.
21. Ghanem AA, El-Kannishy AM, El-Wehidy AS, El-Agamy AF. Intravitreal Bevacizumab (Avastin) as an Adjuvant Treatment in Cases of Neovascular Glaucoma. *Middle East Afr J Ophthalmol*. 2009 Apr;16(2):75-9.
22. Moraczewski AL, Lee RK, Palmberg PF, et al. Outcomes of Treatment of Neovascular Glaucoma with Intravitreal Bevacizumab. *Br J Ophthalmol*. 2009 May;93(5):589-93.
23. Yoon JU, Buyn YJ, Koh HJ. Intravitreal Anti-VEGF Versus Photodynamic Therapy With Verteporfin for Treatment of Myopic Choroidal Neovascularization. *Retina*. 2010 Mar; 30(3):418-24.
24. Vadalà M, Pece A, Cipolla S, et al. Is ranibizumab effective in stopping the loss of vision for choroidal neovascularisation in pathologic myopia? A long-term follow-up study. *Br J Ophthalmol*. 2011 May; 95(5):657-61.
25. Finger RP, Charbel Issa P, Schmitz-Valckenberg S, et al. Long-Term Effectiveness of Intravitreal Bevacizumab for Choroidal Neovascularization Secondary to Angioid Streaks in Pseudoxanthoma Elasticum. *Retina*. 2011 Jul-Aug;31(7):1268-78.
26. El Matri L, Kort F, Bouraoui R, et al. Intravitreal Bevacizumab for the Treatment of Choroidal Neovascularization Secondary to Angioid Streaks: One Year Follow-Up. *Acta Ophthalmol*. 2011 Nov; 89(7):641-6.
27. Mimoun G, Tilleul J, Leys A, et al. Intravitreal ranibizumab for choroidal neovascularization in angioid streaks. *Am J Ophthalmol*. 2010 Nov; 150(5):692-700.e1.

28. Myung JS, Bhatnagar P, Spaide RF, et al. Long-term outcomes of intravitreal anti-vascular endothelial growth factor therapy for the management of choroidal neovascularization in pseudoxanthoma elasticum. *Retina*. 2010 May; 30(5):748-55.
29. Cionni DA, Lewis SA, Peterson MR, et al. Analysis of Outcomes for Intravitreal Bevacizumab in the Treatment of Choroidal Neovascularization Secondary to Ocular Histoplasmosis. *Ophthalmology*. 2011 Nov 29.
30. Schadlu R, Blinder KJ, Shah GK, et al. Intravitreal Bevacizumab for Choroidal Neovascularization in Ocular Histoplasmosis. *Am J Ophthalmol*. 2008;145: 875-878.
31. Nielsen JS, Fick TA, Saggau DD, Barnes CH. Intravitreal anti-vascular endothelial growth factor therapy for choroidal neovascularization secondary to ocular histoplasmosis syndrome. *Retina*. 2011 Jul 30.
32. Chan W, Lai TY, Liu DT. Intravitreal Bevacizumab for Myopic Choroidal Neovascularization: Six Month Results of a Prospective Pilot Study. *Ophthalmology*. 2007; 114:2190-96.
33. Gharbiya M, Giustolisi R, Allievi F, et al. Choroidal neovascularization in pathologic myopia: intravitreal ranibizumab versus bevacizumab—a randomized controlled trial. *Am J Ophthalmol*. 2010 Mar; 149(3):458-64.e1.
34. Lalloum F, Souied EH, Bastuji-Garin S, et al. Intravitreal ranibizumab for choroidal neovascularization complicating pathologic myopia. *Retina*. 2010 Mar; 30(3):399-406.
35. Monés JM, Amselem L, Serrano A, et al. Intravitreal ranibizumab for choroidal neovascularization secondary to pathologic myopia: 12-month results. *Eye (Lond)*. 2009 Jun; 23(6):1275-80.
36. Lai TY, Chan WM, Liu DT, Lam DS. Intravitreal ranibizumab for the primary treatment of choroidal neovascularization secondary to pathologic myopia. *Retina*. 2009 Jun; 29(6):750-6.
37. Konstantinidis L, Mantel I, Pournaras JA, et al. Intravitreal ranibizumab (Lucentis) for the treatment of myopic choroidal neovascularization. *Graefes Arch Clin Exp Ophthalmol*. 2009 Mar; 247(3):311-8.
38. Silva RM, Ruiz-Moreno JM, Nascimento J, et al. Short-term efficacy and safety of intravitreal ranibizumab for myopic choroidal neovascularization. *Retina*. 2008 Oct;28(8):1117-23.
39. Wiegand TW, Rogers AH, McCabe F, et al. Intravitreal Bevacizumab (Avastin) Treatment of Choroidal Neovascularization in Patients with Angioid Streaks. *Br J Ophthalmol*. 2009; 93:47-51.
40. Donati MC, Virgili G, Bini A, et al. Intravitreal Bevacizumab (Avastin) for Choroidal Neovascularization in Angioid Streaks: A Case Series. *Ophthalmologica*. 2009; 223:24-27.
41. Vadalà M, Pece A, Cipolla S, et al. Angioid streak-related choroidal neovascularization treated by intravitreal ranibizumab. *Retina*. 2010 Jun; 30(6):903-7.
42. Finger RP, Charbel Issa P, Hendig D, et al. Monthly ranibizumab for choroidal neovascularizations secondary to angioid streaks in pseudoxanthoma elasticum: a one-year prospective study. *Am J Ophthalmol*. 2011 Oct; 152(4):695-703.
43. Artunay O, Yuzbasioglu E, Rasier R, et al. Combination treatment with intravitreal injection of ranibizumab and reduced fluence photodynamic therapy for choroidal neovascularization secondary to angioid streaks: preliminary clinical results of 12-month follow-up. *Retina*. 2011 Jul-Aug; 31(7):1279-86.
44. Ehrlich R, Ciulla TA, Maturi R, et al. Intravitreal Bevacizumab for Choroidal Neovascularization Secondary to Presumed Ocular Histoplasmosis Syndrome. *Retina*. 2009;29(10); 1418-1423.
45. Han DP, McAllister JT, Weinberg DV, et al. Combined intravitreal anti-VEGF and verteporfin photodynamic therapy for juxtafoveal and extrafoveal choroidal neovascularization as an alternative to laser photocoagulation. *Eye (Lond)*. 2010 Apr; 24(4):713-6.
46. Heier JS, Brown D, Ciulla T, et al. Ranibizumab for choroidal neovascularization secondary to causes other than age-related macular degeneration: a phase I clinical trial. *Ophthalmology*. 2011 Jan; 118(1):111-8. Epub 2010 Aug 3.
47. Haigh JJ. Role of VEGF in organogenesis. *Organogenesis*. 2008 Oct;4(4):247-56.
48. Mintz-Hittner HA, Kennedy KA, Chuang AZ, et al. Efficacy of Intravitreal Bevacizumab for Stage 3+ Retinopathy of Prematurity. *N Engl J Med*. 2011 Feb 17; 364(7):603-15.
49. Hard AL and Hellstrom A. On the Use of Antiangiogenic Medications for Retinopathy of Prematurity. *Acta Paediatr*. 2011 Aug;100(8):1063-5.

50. Sato T, Wada K, Arahori H, et al. Serum Concentrations of Bevacizumab (Avastin) and Vascular Endothelial Growth Factor in Infants With Retinopathy of Prematurity. *Am J Ophthalmol*. 2011 Sep 17.
51. Micieli JA, Surkont M, and Smith AF. A Systematic Analysis of the Off-Label Use of Bevacizumab for Sever Retinopathy of Prematurity. *Am J Ophthalmol*. 2009; 148:536–543.
52. Royal College of Ophthalmologists Scientific Statement on Bevacizumab (Avastin) Use in Medical Ophthalmology. 14th December 2011. Available at www.rcophth.ac.uk.
53. American Society of Retinal Specialists Bevacizumab Position Paper. American Society of Retinal Specialists; 2008 June.
54. American Academy of Ophthalmology (AAO) Retina Panel. Preferred Practice Pattern[®] Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; 2017.
55. American Academy of Ophthalmology (AAO) Retina/Vitreous Panel. Preferred Practice Pattern[®] Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology. 2017.
56. American Academy of Ophthalmology (AAO) Clinical Statement. [Verifying the Source of Compounded Bevacizumab for Intravitreal Injections - 2014](#). San Francisco, CA: American Academy of Ophthalmology (AAO); 2014.
57. Avastin [prescribing information]. South San Francisco, CA: Genentech, Inc; February 2019.
58. U.S. Food and Drug Administration. Mixing, Diluting, or Repackaging Biological Products Outside the Scope of an Approved Biologics License Application Guidance for Industry. Guidance Document. January 18, 2018.
59. Rizzo S, Genovesi-Ebert F, Di Bartolo E, et al. Injection of intravitreal bevacizumab (Avastin) as a preoperative adjunct before vitrectomy surgery in the treatment of severe proliferative diabetic retinopathy (PDR). *Graefes Arch Clin Exp Ophthalmol*. 2008 Jun; 246(6):837-42.
60. Tonello M, Costa RA, Almeida FP, et al. Panretinal photocoagulation versus PRP plus intravitreal bevacizumab for high-risk proliferative diabetic retinopathy (IBeHi study). *Acta Ophthalmol*. 2008 Jun; 86(4):385-9.
61. Virgili G, Parravano M, Menchini F, Evans JR. Anti-vascular endothelial growth factor for diabetic macular oedema, *Cochrane Database Syst Rev*. 2014 Oct 24;10:CD007419.
62. Kodjikian L, Souied EH, Mimoun G, et al. Ranibizumab versus Bevacizumab for Neovascular Age-related Macular Degeneration: Results from the GEFAL Noninferiority Randomized Trial. *Ophthalmology*. 2013 Aug 2. pii: S0161-6420(13)00524-1.
63. Shoebi N, Ahmadi H, Entezari M, and Yaseri M. Intravitreal Bevacizumab with or without Triamcinolone for Refractory Diabetic Macular Edema: Long-Term Results of a Clinical Trial. *J Ophthalmic Vis Res*. 2013; 8 (2): 99-106.
64. Nepomuceno AB, Takaki E, De Almeida FPP, et al. A Prospective Randomized Trial of Intravitreal Bevacizumab Versus Ranibizumab for the Management of Diabetic Macular Edema. *Am J Ophthalmol*. 2013; 156:502–510.
65. American Academy of Ophthalmology (AAO) Retina/Vitreous Panel. Preferred Practice Pattern[®] Guidelines. Retinal Vein Occlusion. San Francisco, CA: American Academy of Ophthalmology. 2015.
66. Sankar MJ, Sankar J, Mehta M, et al. Anti-vascular endothelial growth factor (VEGF) drugs for treatment of retinopathy of prematurity. *Cochrane Database Syst Rev* 2016;2:CD009734
67. Royal College of Ophthalmologists Scientific Statement on Bevacizumab (Avastin) Use in age realted macular degeneration. 15th December 2014. Available at www.rcophth.ac.uk.
68. Mvasi[™] [prescribing information]. Thousand Oaks, CA; Amgen, Inc.; June 2019.
69. Zirabev[™] [prescribing information]. New York, NY; Pfizer, Inc.; June 2019.
70. Beovu[®] [prescribing information]. East Hanover, NJ; Novartis Pharmaceuticals Corporation; October 2019.
71. Dugel PU, Koh A, Ogura Y, Jaffe GJ, Schmidt-Erfurth U, Brown DM, Gomes AV, Warburton J, Weichselberger A, Holz FG. HAWK and HARRIER: Phase 3, Multicenter, Randomized, Double-Masked Trials of Brolucizumab for Neovascular Age-Related Macular Degeneration. *Ophthalmology*. 2019 Apr 12.
72. International Committee for the Classification of Retinopathy of Prematurity. The International Classification of Retinopathy of Prematurity revisited. *Arch Ophthalmol* 2005; 123:991.
73. Coats DK. Retinopathy of prematurity: Treatment and prognosis. Armsby C, Ed. UpToDate. Waltham, MA: UpToDate Inc. <https://www.uptodate.com> (Accessed on February 20, 2020.)

74. Mintz-Hittner HA, Kennedy KA, Chuang AZ, BEAT-ROP Cooperative Group. Efficacy of intravitreal bevacizumab for stage 3+ retinopathy of prematurity. *N Engl J Med.* 2011;364(7):603.
75. Sankar MJ, Sankar J, Chandra P. Anti-vascular endothelial growth factor (VEGF) drugs for treatment of retinopathy of prematurity. *Cochrane Database Syst Rev.* 2018;1:CD009734.
76. Geloneck MM, Chuang AZ, Clark WL, et al. Refractive outcomes following bevacizumab monotherapy compared with conventional laser treatment: a randomized clinical trial. *JAMA Ophthalmol.* 2014 Nov;132(11):1327-33.
77. VanderVeen DK, Melia M, Yang MB, et al. Anti-Vascular Endothelial Growth Factor Therapy for Primary Treatment of Type 1 Retinopathy of Prematurity: A Report by the American Academy of Ophthalmology. *Ophthalmology.* 2017 May;124(5):619-633.

Policy History/Revision Information

Date	Summary of Changes
01/01/2021	<p>Related Policies</p> <ul style="list-style-type: none"> ● Added reference link to the Medicare Advantage Medical Benefit Injectable Policy titled <i>Medicare Part B Step Therapy Programs</i> <p>Supporting Information</p> <ul style="list-style-type: none"> ● Updated <i>CMS</i> and <i>References</i> sections to reflect the most current information ● Archived previous policy version 2020D0042P

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.