Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (for Indiana Only)

Policy Number: CSIND0042.01
Effective Date: November 1, 2021

Instructions for Use

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Related Policies

- Maximum Dosage and Frequency (for Indiana Only)
- Oncology Medication Clinical Coverage (for Indiana Only)

Application

This Medical Benefit Drug Policy only applies to the state of Indiana.

Coverage Rationale

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)

The following information pertains to medical necessity review:

General Requirements

For initial and continuation of therapy, intravitreal VEGF inhibitor administration is no more than 12 doses per year per eye, regardless of diagnosis.

Diagnosis-Specific Requirements

Lucentis is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria for Lucentis, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology Ranibizumab (Lucentis).

Click here to view the InterQual® criteria.

Eylea is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria for Eylea, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology Aflibercept (Eylea).

Click here to view the InterQual® criteria.

Beovu is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria for Beovu, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology Brolucizumab (Beovu).

Click here to view the InterQual® criteria.

Macugen is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria for Macugen, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology Pegaptanib sodium (Macugen).

Click here to view the InterQual® criteria.

Avastin (bevacizumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria for Avastin, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology Bevacizumab (Avastin) Intravitreal.

Click here to view the InterQual® criteria.

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 federal, state, or contractual requirements 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-dbll, 1 mg	Beovu
J2503	Injection, pegaptanib sodium, 0.3 mg	Macugen
J2778	Injection, ranibizumab, 0.1 mg	Lucentis
J9035	Injection, bevacizumab, 10 mg	Avastin

Policy History/Revision Information

Date	Summary of Changes
05/01/2022	Related Policies • Removed reference link to the Medical Policy titled *Macular Degeneration Treatment Procedures (for Indiana Only)* (retired)
11/01/2021	• New Medical Benefit Drug Policy

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a

conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The 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.