POLICY: Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Lucentis

- Lucentis® (ranibizumab intravitreal injection – Genentech)
- Cimerli™ (ranibizumab-eqrn intravitreal injection – Coherus)
- Byooviz™ (ranibizumab-nuna intravitreal injection – Biogen)

EFFECTIVE DATE: 1/1/2022
LAST REVISION DATE: 09/16/2024

COVERAGE CRITERIA FOR: All Aspirus Medicare Plans

OVERVIEW

Lucentis and Cimerli (biosimilar to Lucentis), a vascular endothelial growth factor (VEGF) inhibitor, is indicated for the following uses:[1]

- **Diabetic macular edema**.
- **Diabetic retinopathy**.
- **Macular edema following retinal vein occlusion**.
- **Myopic choroidal neovascularization**.
- **Neovascular (wet) age-related macular degeneration**.

Byooviz, a biosimilar to Lucentis, is indicated for the following uses:[6]

- **Macular edema following retinal vein occlusion**.
- **Myopic choroidal neovascularization**.
- **Neovascular (wet) age-related macular degeneration**.

The recommended dose for Lucentis and Cimerli in diabetic macular edema and diabetic retinopathy is 0.3 mg administered by intravitreal injection once every month (approximately 28 days). The recommended dose for Byooviz, Cimerli, and Lucentis in neovascular (wet) age-related macular degeneration, macular edema following retinal vein occlusion, and myopic choroidal neovascularization is 0.5 mg administered by intravitreal injection once every month (approximately 28 days).

Other Uses with Supportive Evidence

Overproduction of VEGF may lead to other eye conditions, including neovascular glaucoma, retinopathy of prematurity, and other retinal and choroidal neovascular conditions affecting the eye, the VEGF inhibitors also have the potential to be used off-label and reduce vision loss associated with other eye conditions related to increased VEGF production.[2,3] The use of anti-VEGF agents have been shown to stop the angiogenic process and maintain visual acuity and improve vision in patients with certain neovascular ophthalmic conditions; therefore, research is rapidly evolving on the use of VEGF inhibitors in other

neovascular ophthalmic conditions which threaten vision.[4,5] Anti-VEGF therapy has the potential to be used off-label in other neovascular conditions affecting the eye and may prevent or slow visual impairment.[2,4,5]

POLICY STATEMENT

Prior authorization is recommended for medical benefit coverage of Lucentis. Approval is recommended for those who meet the Criteria and Dosing for the listed indication(s). All approvals are provided for the duration noted below.

This policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), as well as in companion policy articles and other guidance applicable to the relevant service areas. These documents are cited in the References section of this policy. In some cases, this guidance includes specific lists of HCPCS and ICD-10 codes to help inform the coverage determination process. The Articles that include specific lists for billing and coding purposes will be included in the Reference section of this policy. However, to the extent that this policy cites such lists of HCPCS and ICD-10 codes, they should be used for reference purposes only. The presence of a specific HCPCS or ICD-10 code in a chart or companion article to an LCD is not by itself sufficient to approve coverage. Similarly, the absence of such a code does <u>not</u> necessarily mean that the applicable condition or diagnosis is excluded from coverage.

<u>Note</u>: Conditions for coverage outlined in this Medicare Advantage Medical Policy may be less restrictive than those found in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles. Examples of situations where this clinical policy may be less restrictive include, but are not limited to, coverage of additional indications supported by CMS-approved compendia and the exclusion from this policy of additional coverage criteria requirements outlined in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles.

Indications with a ^ below are also covered (and, if applicable, further detailed/referenced) in the corresponding Commercial Care Continuum (CC) Policy. Note: Additional criteria requirements for coverage of the same indication as outlined in the Commercial CC Policy and this Medicare Advantage CC Policy may NOT be the same.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Lucentis, Cimerli or Byooviz is recommended for requests meeting both the step therapy requirements and indication requirements:

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Step Therapy Requirements (New Starts Only)

Criteria. *<u>The patient must meet the following criteria (A, B, or C)</u>:*

A) For patients new to Lucentis, Cimerli or Byooviz therapy only, must have a trial of repackaged Avastin prior to approval of Lucentis, Cimerli or Byooviz New starts to therapy defined as no use of Lucentis, Cimerli or Byooviz within the past 365 days for Medicare patients and includes use in either eye.
B) Patient has diabetic retinopathy (without diabetic macular edema).
C) Patient has a contraindication or other clinical reason why repackaged Avastin cannot be tried before Lucentis, Cimerli or Byooviz.

Note: Step therapy only required for indications compendia supported for both Lucentis, Cimerli or Byooviz and Avastin.

FDA-Approved Indications

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1. Neovascular (Wet) Age-Related Macular Degeneration. ^

Criteria. Approve for 1 year.

Dosing. Approve if the requested dosing meets the following (A and B):
A) The dose is ≤ 0.5 mg administered by intravitreal injection for each eye being treated; AND
B) The dosing interval is not more frequent than once every 28 days for each eye being treated.

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2. Macular Edema Following Retinal Vein Occlusion. ^

Criteria. Approve for 1 year.

Dosing. Approve if the dose meets both criteria (A and B):
A) The dose is ≤ 0.5 mg administered by intravitreal injection for each eye being treated; AND
B) The dosing interval is not more frequent than once every 28 days for each eye being treated.

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3. Diabetic Macular Edema. ^

Criteria. Approve for 1 year.

Dosing. Approve if the dose meets both criteria (A and B):
A) The dose is ≤ 0.3 mg administered by intravitreal injection for each eye being treated; AND

B) The dosing interval is not more frequent than once every 28 days for each eye being treated.

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4. Diabetic Retinopathy. ^

Criteria. Approve for 1 year.

Dosing. Approve if the dose meets both criteria (A and B):

A) The dose is ≤ 0.3 mg administered by intravitreal injection for each eye being treated; AND

B) The dosing interval is not more frequent than once every 28 days for each eye being treated.

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5. Myopic Choroidal Neovascularization. ^

Criteria. Approve for 1 year.

Dosing. Approve if the dose meets both criteria (A and B):

A) The dose is ≤ 0.5 mg administered by intravitreal injection for each eye being treated; AND

B) The dosing interval is not more frequent than once every 28 days for each eye being treated.

Other Uses with Supportive Evidence

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6. Other Neovascular Ophthalmic Conditions. ^

Criteria. Approve for 1 year.

Dosing. Approve if the dose meets both criteria (A and B):

A) The dose is ≤ 0.5 mg administered by intravitreal injection for each eye being treated; AND

B) The dosing interval is not more frequent than once every 28 days for each eye being treated.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Lucentis has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following

conditions. Rationale for non-coverage for these specific conditions is provided below. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval.)

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Lucentis® intravitreal injection [prescribing information]. South San Francisco, CA: Genentech, Inc.; April 2017.
2. Barakat MR, Kaiser PK. VEGF inhibitors for the treatment of neovascular age-related macular degeneration. *Expert Opin Investig Drugs*. 2009;18(5):637-646.
3. Tolentino M. Systemic and ocular safety of intravitreal anti-VEGF therapies for ocular neovascular disease. *Surv Ophthalmol*. 2011;56(2):95-113.
4. Kinnunen K, Ylä-Herttuala S. Vascular endothelial growth factors in retinal and choroidal neovascular diseases. *Ann Med*. 2012;44(1):1-17.
5. Horsley MB, Kahook MY. Anti-VEGF therapy for glaucoma. *Curr Opin Ophthalmol*. 2010;21(2):112-117.
6. Centers for Medicare and Medicaid Services, National Government Services, Inc, Local Coverage Determination (LCD): Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394) [original date 10/01/2015; revision effective date 11/7/2019]. Accessed on November 12, 2019.
7. Centers for Medicare and Medicaid Services, National Government Services, Inc, Local Coverage Article (LCA): Billing and Coding: Ranibizumab, Aflibercept and Brolucizumab-dbll (A52451) [original date 10/01/2015; revision effective date 1/1/2020]. Accessed on January 30, 2020.
8. Byooviz™ intravitreal injection [prescribing information]. Cambridge, MA: Biogen; September 2021.

HISTORY

Type of Revision	Summary of Changes*	Date
Policy created	New Medicare Advantage Medical Care Continuum Policy	07/11/2018
Select revision	Added Macugen to policy	11/05/2018
Select revision	Reviewed and revised original policy created 07/11/2018 in accordance with Local Coverage Article A52451 and Ophthalmology – Vascular Endothelial Growth Factor (VEGF) Inhibitor Injectables Care Continuum Utilization Review Policy.	5/22/2019
Select revision	Reviewed and revised original policy created 07/11/2018 in accordance with Local Coverage	11/06/2019

	Determination L33394 and Ophthalmology – Vascular Endothelial Growth Factor Inhibitors - Lucentis Care Continuum Utilization Review Policy.	
Select revision	Non-clinical update to policy to add the statement "This policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), as well as in companion policy articles and other guidance applicable to the relevant service areas. These documents are cited in the References section of this policy. In some cases, this guidance includes specific lists of HCPCS and ICD-10 codes to help inform the coverage determination process. The Articles that include specific lists for billing and coding purposes will be included in the Reference section of this policy. However, to the extent that this policy cites such lists of HCPCS and ICD-10 codes, they should be used for reference purposes only. The presence of a specific HCPCS or ICD-10 code in a chart or companion article to an LCD is not by itself sufficient to approve coverage. Similarly, the absence of such a code does <u>not</u> necessarily mean that the applicable condition or diagnosis is excluded from coverage."	1/30/2020
Policy revision	*Added the following to the Policy Statement "<u>Note</u>: Conditions for coverage outlined in this Medicare Advantage Medical Policy may be less restrictive than those found in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles. Examples of situations where this clinical policy may be less restrictive include, but are not limited to, coverage of additional indications supported by CMS-approved compendia and the exclusion from this policy of additional coverage criteria requirements outlined in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles." *Updated references	08/07/2020
Selected Revision	**Product:** Byooviz was added to the same conditions for approval as for Lucentis.	06/08/2022

Selected Revision	**Product:** Cimerli was added to the same conditions for approval as for the other ranibizumab products.	08/10/2022
UCare Revision	Clarified that continuation of therapy is acceptable if the requested product has been used in either eye.	10/7/2022
Annual Revision	For all indications/uses, the dosing interval was changed from “not more frequent than once every 25 days for each eye being treated” to “not more frequent than once every 28 days for each eye being treated”; the 28 days aligns with the prescribing information.	11/15/2023
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024