

Glaucoma Step Therapy
Effective 10/1/2019

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input checked="" type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:

First-Line: Medication(s) listed on first-line are covered without prior-authorization.

Second-Line: Second-line medications will pay if the member has filled a first-line medication or a second-line medication within the past 180 days.

Third-Line: Third-line medications will pay if the member has filled a second-line medication or a third-line medication within the past 180 days.

Coverage Guidelines

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member has a documented inadequate response or side effect to the first-line medication. Approval of a third-line medication will be granted if the member has a documented inadequate response or side effect to the first-line medication and one second-line medication.

FIRST-LINE	SECOND-LINE	THIRD-LINE
Latanoprost 0.005%	Lumigan 0.01% Travatan Z 0.004% Zioptan 0.0015%	Rhopressa Rocklatan

Limitations

1. Approvals will be granted for 36 months

References

1. Xalatan (latanoprost) [prescribing information]. New York, NY: Pfizer; April 2017
2. Lumigan (bimatoprost) [prescribing information]. Irvine, CA: Allergan; July 2017
3. Rhopressa (netarsudil) [prescribing information]. Irvine, CA: Aerie Pharmaceuticals; March 2019
4. Rocklatan (netarsudil/latanoprost) [prescribing information]. Irvine, CA: Aerie Pharmaceuticals, Inc; March 2019
5. Travatan Z (travoprost) [product monograph]. Dorval, Quebec, Canada: Novartis Pharmaceuticals Canada Inc; February 2019
6. Zioptan (tafluprost) [prescribing information]. Lake Forest, IL: Akorn, Inc; January 2018

Review History

09/18/19 – Reviewed.

