Mass General Brigham
Health Plan

Ophthalmic NSAID
Effective 02/23/2015

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☐ Prior Authorization ☐ Quantity Limit ☒ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ 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: Medications listed on first-line are covered without prior-authorization.
Second-Line: Second-line medications will pay if the member has filled at least two different first-line medications or a second-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 had a documented inadequate response or side effect to at least two different 1st-line topical corticosteroids.

FIRST-LINE	SECOND-LINE
diclofenac 0.1% (Voltaren®)	bromfenac (compare to Xibrom®) 0.09%
flurbiprofen 0.03% (Ocufen®)	Acuvail® (ketorolac) 0.45%
ketorolac 0.4% (Acular® LS)	Ilevro® (nepafenac) 0.3%
ketorolac 0.5% (Acular®)	Nevanac® (nepafenac) 0.1%
	Prolensa® (bromfenac) 0.07%

Limitations

1. Approvals will be granted for 12 months within the quantity limit.
2. The following quantity limits apply:

diclofenac 0.1% (Voltaren®)	5 mL
flurbiprofen 0.03% (Ocufen®)	5 mL
ketorolac 0.4% (Acular® LS)	5 mL
ketorolac 0.5% (Acular®)	10 mL per 25 days
bromfenac 0.09% (Compare to Xibrom®)	5 mL
Acuvail® (ketorolac) 0.45%	60 single-use vials (2 boxes)
Ilevro® (nepafenac) 0.3%	1.7 mL
Nevanac® (nepafenac) 0.1%	3 mL
Prolensa® (bromfenac) 0.07%	3.2 mL

References

N/A

Review History

Implementation Date: 04/04/11
Reviewed: 02/28/11; 02/27/12; 02/25/13; 02/23/15 P&T Mtg
Reviewed & updated: 02/24/14 P&T Mtg
Updated: 06/20/11 (gen Xibrom 6/6/11 file); 01/13/14 (Prolensa added; 05/06/13 file)
06/22/2022: Reviewed for Jun P&T; no clinical changes.