Mass General Brigham
Health Plan

Glaucoma Step Therapy: Bimatoprost 0.01% Iyuzeh Rocklatan Rhopressa Tafluprost 0.0015% Travoprost 0.004% Effective 02/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☐ Prior Authorization ☐ Quantity Limit ☒ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 **Non-Specialty Medications** All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
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.

FIRST-LINE	SECOND-LINE	THIRD-LINE
Latanoprost 0.005%	Bimatoprost 0.01% Travoprost 0.004% Tafluprost 0.0015%	Rhopressa Rocklatan Iyuzeh

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
Authorization may be granted for members new to the plan within the last 90 days who are currently receiving treatment with a second- or third-line agent, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

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 an inadequate response or side effect to one first-line medication OR one second-line medication
- Approval of a third-line medication will be granted if the member has had an inadequate response or side effect to one second-line medication OR one third-line medication

Limitations

1. Approvals will be granted for 36 months

References

1. Iyuzeh (latanoprost) [prescribing information]. Waltham, MA: Thea Pharma Inc; April 2024.
2. Lumigan (bimatoprost) [prescribing information]. North Chicago, IL: Abbvie Inc; June 2024.
3. Rhopressa (netarsudil) [prescribing information]. Irvine, CA: Aerie Pharmaceuticals; March 2019.
4. Rocklatan (netarsudil/latanoprost) [prescribing information]. Irvine, CA: Aerie Pharmaceuticals, Inc; June 2020.
5. Travatan Z (travoprost) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2020.
6. Xalatan (latanoprost) [prescribing information]. Morgantown, WV: Viatris Specialty LLC; May 2023.
7. Zioptan (tafluprost) [prescribing information]. Waltham, MA: Thea Pharma Inc; May 2023.

Review History

09/18/2019 – Reviewed.
12/13/2023 – Reviewed and Updated for Dec P&T; Added new drug Iyuzeh to criteria as third line agent. Removed Lumigan and Travatan as products are NF and have been replaced by generics. Effective 2/1/2024.
11/13/2024 – Reviewed and updated for November P&T. Updated approval criteria to mirror the automated step requirements. Effective 02/01/2025.