Mass General Brigham
Health Plan

Glaucoma Step Therapy
Effective 02/01/2024

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.

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%	Bimatoprost 0.01% Travoprost 0.004% Tafluprost 0.0015%	Rhopressa Rocklatan Iyuzeh

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
7. Iyuzeh (latanoprost) [prescribing information]. Lexington, MA: Thea Pharma Inc; December 2022.

Review History

09/18/19 – 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