

Ophthalmic NSAID
Effective 03/01/2024

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		
Specialty Limitations	N/A		
Contact Information	Medical and Specialty Medications		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
Exceptions	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029

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)	llevro® (nepafenac) 0.3%
ketorolac 0.5% (Acular®)	Nevanac® (nepafenac) 0.1%
	bromfenac (compare to Prolensa®) 0.07%

Limitations

- Approvals will be granted for 12 months within the quantity limit.
- 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 <u>per 25 days</u>
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.

2/14/2024: Reviewed and Updated for Feb P&T; Bromfenac (generic for Prolensa) was released and replaced Prolensa as second line agent, Brand Prolensa moved to NF. Effective 3/1/2024

