Mass General Brigham
Health Plan

Ophthalmic Steroids
Effective 06/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☐ Prior Authorization ☐ Quantity Limit ☒ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and 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: 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.

FIRST-LINE	SECOND-LINE
difluprednate ophthalmic emulsion	Lotemax 0.5% ophthalmic ointment
dexamethasone ophthalmic	Lotemax SM 0.38% ophthalmic gel
fluorometholone ophthalmic	loteprednol 0.5% ophthalmic gel
prednisolone ophthalmic	loteprednol 0.5% ophthalmic suspension

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted for members when all the following criteria are met:

1. Member has had an inadequate response, intolerance, or contraindication to at least two first line ophthalmic corticosteroids or one second-line ophthalmic corticosteroids

Limitations

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

Drug Name	Quantity Limit
Difluprednate 0.05% ophthalmic emulsion	5mL per 25 days

References

1. Durezol (difluprednate) [prescribing information]. Fort Worth, TX: Alcon Laboratories; April 2017.
2. Korenfeld MS, Silverstein SM, Cooke DL, Vogel R, Crockett RS, et al. Difluprednate ophthalmic emulsion 0.05% for postoperative inflammation and pain. J Cataract Refract Surg. 2009. 35;1:26-34.
3. Lotemax SM ophthalmic gel (loteprednol) [prescribing information]. Bridgewater, NJ: Bausch & Lomb Inc; February 2019.
4. Lotemax suspension (loteprednol) [prescribing information]. Tampa, FL: Bausch & Lomb Inc; September 2016.
5. Lotemax gel (loteprednol) [prescribing information]. Tampa, FL: Bausch & Lomb Inc; August 2016

Review History

08/03/09 – Implemented
06/15/09 – Reviewed
04/26/10 – Reviewed
04/25/11 – Reviewed
04/23/12 – Reviewed
04/22/13 – Reviewed & revised
04/28/14 – Reviewed
04/27/15 – Reviewed
04/25/16 – Reviewed
06/19/19 – Added Lotemax and removed indication requirement
07/21/2021: Reviewed at July P&T; Durezol PA criteria retired, added to ophthalmic steroid criteria. Lotemax formulations that have generics replaced brand formulations. Effective 11/01/2021.
03/12/2025 – Reviewed and Updated at March P&T. Moved generic Durezol to first-line. Updated prior authorization criteria to include language for members who are new to the plan. Effective 06/01/2025.