

Glaucoma Step Therapy:
Bimatoprost 0.01%
Rocklatan
Rhopressa
Tafluprost 0.0015%
Travoprost 0.004%
Effective 07/01/2026

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		<input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Specialty Limitations	N/A		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 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

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 member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with requested drug, 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. .
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.

04/15/2026 – Reviewed and updated at April P&T. Removed Iyuzeh from the policy, as agent is moving to nonformulary status. Effective 07/01/2026.

