Mass General Brigham
Health Plan

Ophthalmic NSAIDs
Effective 01/01/2026

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 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.

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
diclofenac 0.1% (Voltaren®)	bromfenac (compare to Xibrom®) 0.09%
flurbiprofen 0.03% (Ocufen®)	Acuvail® (ketorolac) 0.45%
ketorolac 0.4% (Acular® LS)	Ilevro® (nepafenac) 0.3%
ketorolac 0.5% (Acular®)	bromfenac (compare to Prolensa®) 0.07%

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 program.
OR
Approval will be granted when the following criteria are met:

1. Member meets ONE of the following:
    a. Member had an inadequate response, adverse reaction, or contraindication to TWO first-line ophthalmic NSAIDs
    b. Member had an inadequate response, adverse reaction or contraindication to ONE second-line ophthalmic NSAID

Limitations

1. Approvals will be granted for 12 months within the quantity limit.

2. The following quantity limits apply:

Drug Name	Quantity Limit
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 per 25 days
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
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
10/08/2025 – Reviewed and updated for September P&T. Removed Nevanac from policy as agent is moving to nonformulary status. Updated prior authorization language to mirror that of the step therapy program. Effective 01/01/2026.