Mass General Brigham
Health Plan

# Ophthalmic Steroids
# Effective 07/01/2026

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| **Plan** | ☐ MassHealth UPPL<br>☒ Commercial/Exchange | **Program Type** | ☐ Prior Authorization<br>☐ Quantity Limit<br>☒ Step Therapy |
| **Benefit** | ☒ Pharmacy Benefit<br>☐ Medical Benefit | | |
| **Specialty Limitations** | N/A | | |
| **Contact Information** | **Medical Benefit**<br>**Pharmacy Benefit** | Phone: 833-895-2611<br>Phone: 800-711-4555 | Fax: 888-656-6671<br>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<br>dexamethasone ophthalmic<br>fluorometholone ophthalmic<br>prednisolone ophthalmic | Lotemax SM 0.38% ophthalmic gel<br>loteprednol 0.5% ophthalmic gel |

**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 the requested drug, 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. 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.
2. Lotemax SM ophthalmic gel (loteprednol) [prescribing information]. Bridgewater, NJ: Bausch & Lomb Inc; February 2019.
3. Lotemax suspension (loteprednol) [prescribing information]. Tampa, FL: Bausch & Lomb Inc; September 2016.
4. 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.
04/15/2026 – Reviewed and updated at April P&T. Updating policy to remove loteprednol 0.5% suspension and Lotemax 5% ointment from policy, as agents are moving to nonformulary status. Effective 07/01/2026.