Mass General Brigham
Health Plan

Glaucoma Agents
Effective 07/31/2023

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations			
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	Durysta implant is available through medical benefits only.		

Overview

No PA	Drugs that require PA
Alpha-adrenergic Agents	
Alphagan P® # (brimonidine 0.1%, 0.15% eye drops)	
brimonidine 0.2% eye drops	
Iopidine® # (apraclonidine)	
Beta-adrenergic Agents	
betaxolol 0.5%	Betimol® (timolol)
Betoptic S® (betaxolol 0.25%)	Timoptic Ocudose® (timolol ophthalmic unit dose solution)* BP
carteolol	Timoptic-XE® (timolol ophthalmic gel forming solution)*
Istalol® # (timolol)	
levobunolol	
Timoptic® # (timolol)	
Carbonic Anhydrase Inhibitors	
Azopt® # (brinzolamide)	
Trusopt® # (dorzolamide)	
Combination Products	
Combigan® # (brimonidine/timolol, ophthalmic)†	Cosopt® PF (dorzolamide/timolol, preservative free)* BP

Cosopt® # (dorzolamide/timolol) Simbrinza® (brinzolamide/brimonidine)	Rocklatan® (netarsudil/latanoprost)
Miotics	
Miochol-E® (acetylcholine chloride) MB	
Miostat® (carbachol 0.01%) MB	
Isopto Carpine® # (pilocarpine 1%, 2%, 4% ophthalmic solution)	
Phospholine Iodide (echothiophate iodide 0.125%)	
Prostaglandin Analogs	
Lumigan® (bimatoprost 0.01% ophthalmic solution)	bimatoprost 0.03% ophthalmic solution
Travatan Z® # (travoprost 0.004% eye drop)	Durysta® (bimatoprost implant) MB
Xalatan® # (latanoprost solution)	Vyzulta® (latanoprostene)
	Xelpros® (latanoprost emulsion)
	Zioptan® (tafluprost)* BP
Rho Kinase Inhibitors	
	Rhopressa® (netarsudil)

This is a brand-name drug with FDA "A"–rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"–rated generic equivalent.
BP Brand Preferred over generic equivalents. In general, requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.
* A-rated generic available. Both brand and A-rated generic require PA.
†Available as an authorized generic.
MB This drug is available under medical benefit through the health care professional who administers the drug or in an outpatient or inpatient hospital setting.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with 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:

Betimol® (timolol)
Timoptic Ocudose® (timolol ophthalmic unit dose solution)
ALL of the following:
1. Diagnosis of **ONE** of the following:
    a. Open-angle glaucoma
    b. Ocular hypertension
2. **ONE** of the following:
    a. Paid claims for physician attestation of inadequate response or adverse reaction to an ophthalmic timolol product available without PA
    b. For timolol ophthalmic unit dose solution, sensitivity to benzalkonium chloride

Timoptic-XE® (timolol ophthalmic gel forming solution)
ONE of the following:
1. **ALL** of the following:
    a. Diagnosis of **ONE** of the following:

i. Open-angle glaucoma
ii. Ocular hypertension

b. Paid claims or physician attestation of inadequate response or adverse reaction to an ophthalmic timolol-containing product available without PA

2. Diagnosis of infantile hemangioma (off-label)

bimatoprost 0.03% ophthalmic solution
ALL of the following:

1. Diagnosis of **ONE** of the following:
    a. Open-angle glaucoma
    b. Ocular hypertension
2. Paid claims or physician attestation of inadequate response or adverse reaction to Lumigan® (bimatoprost 0.01% ophthalmic solution)

Durysta® (bimatoprost implant)
ALL of the following:

1. Diagnosis of **ONE** of the following:
    a. Open-angle glaucoma
    b. Ocular hypertension
2. **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response or adverse reaction to Lumigan® (bimatoprost 0.01% ophthalmic solution)
    b. Medical necessity for the use of an implantable formulation as noted by **ONE** of the following:
        i. Limited dexterity
        ii. Visual impairment
        iii. Intellectual disability
3. Affected eye(s) have not previously been treated with Durysta® (bimatoprost implant)

Cosopt PF® (dorzolamide/timolol preservative free)
Xelpros ® (latanoprost emulsion)
ALL of the following:

1. Diagnosis of **ONE** of the following:
    a. Open-angle glaucoma
    b. Ocular hypertension
2. Sensitivity to benzalkonium chloride or any other preservative used in ophthalmic preparations

Rhopressa® (netarsudil)
ALL of the following:

1. Diagnosis of **ONE** of the following:
    a. Open-angle glaucoma
    b. Ocular hypertension
2. Member is $\geq$ 18 years of age
3. Physician attestation of **ONE** of the following:
    a. Inadequate response to combination therapy with a prostaglandin analog and an ophthalmic beta-blocker
    b. Contraindication or adverse reaction to prostaglandin analogs and ophthalmic beta-blockers
    c. **BOTH** of the following:
        i. Contraindication to ophthalmic beta-blockers

ii. Inadequate response or adverse reaction to a prostaglandin analog in combination with **ONE** of the following:
1. ophthalmic alpha-2 adrenergic agonist (e.g., brimonidine)
2. parasympathomimetic (e.g., pilocarpine)
3. carbonic anhydrase inhibitor (e.g., dorzolamide)

d. **BOTH** of the following:
i. Contraindication to prostaglandin analogs
ii. Inadequate response or adverse reaction to an ophthalmic beta-blocker in combination with **ONE** of the following:
1. ophthalmic alpha-2 adrenergic agonist (e.g., brimonidine)
2. parasympathomimetic (e.g., pilocarpine)
3. carbonic anhydrase inhibitor (e.g., dorzolamide)

Rocklatan® (netarsudil/latanoprost)
ALL of the following:
1. Diagnosis of **ONE** of the following:
a. Open-angle glaucoma
b. Ocular hypertension
2. Member is ≥ 18 years of age
3. Physician attestation of **ONE** of the following:
a. Inadequate response to combination therapy with a prostaglandin analog and an ophthalmic beta-blocker
b. **BOTH** of the following:
i. Contraindication to ophthalmic beta-blockers
ii. Inadequate response or adverse reaction to a prostaglandin analog in combination with **ONE** of the following:
1. Ophthalmic alpha-2 adrenergic agonist (e.g., brimonidine)
2. Parasympathomimetic (e.g., pilocarpine)
3. Carbonic anhydrase inhibitor (e.g., dorzolamide)

Vyzulta® (latanoprostene)
ALL of the following:
1. Diagnosis of **ONE** of the following:
a. Open-angle glaucoma
b. Ocular hypertension
2. Member is ≥ 17 years of age
3. **ONE** of the following:
a. Physician attestation of inadequate response to combination therapy with latanoprost solution and an ophthalmic beta-blocker
b. **BOTH** of the following:
i. Physician attestation of inadequate response to latanoprost solution
ii. Contraindication or adverse reaction to an ophthalmic beta-blocker

Zioptan® (tafluprost)
ALL of the following:
1. Diagnosis of **ONE** of the following:
a. Open-angle glaucoma
b. Ocular hypertension

2. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to Xelpros® (latanoprost emulsion) *(Note: if member has sensitivity to potassium sorbate 0.47% preservative, this trial may be bypassed)*
3. **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to latanoprost solution
    b. Sensitivity to benzalkonium chloride or any other preservative used in ophthalmic preparations

Continuation of Therapy

Reauthorization requires physician documentation of the following:

1. **For Durysta®:** Durysta® use will be for previously untreated eye
2. **For indication of infantile hemangiomas:** documentation of positive response to therapy
3. **All other requests:** resubmission will infer a positive response to therapy

Limitations

1. Initial and reauthorization approvals will be granted for the following durations:
    a. **For Durysta® (***no more than one implant per eye)***:** 12 months
    b. **For timolol gel-forming solution for indication of infantile hemangiomas:** 6 months
    c. **All other requests:** 12 months
2. **Requests for Brand Name when generic is preferred:** In addition to any prior authorization requirements that may be listed above, if an A-rated generic equivalent is available, such prior authorization requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the generic equivalent drug (history of allergic reaction to the inactive ingredients used in the manufacturing process of a certain drug is acceptable).
3. **Requests for generic when Brand Name is preferred:** There are some drugs for which the Plan has determined it will be cost effective to prefer the use of the Brand Name formulation. In this case, the generic equivalent formulation is considered non-preferred and requires prior authorization. These requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the Brand Name formulation. For the most up to date list of drugs where the Brand Name formulation is preferred, see the MassHealth Brand Name Preferred Over Generic Drug List (BOGL) at www.mass.gov/druglist.

Appendix

Sensitivity to Preservatives

If a request is for one of the following agents and the prescriber documents that the member has had sensitivity to benzalkonium chloride, please **approve**:

- Cosopt PF®
- Timoptic Ocudose®
- Xelpros®

Documented corneal epithelium damage

If a request states that the member has existing corneal epithelium damage and the prescriber wants to avoid the use of therapy containing a preservative, requests for a Preservative-Free formulation above may be **approved**.

References

1. Jacobs D. Open-angle glaucoma: Epidemiology, clinical presentation, and diagnosis. In: Gardiner MF (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 [cited 2022 Feb 16]. Available from: http://www.utdol.com/utd/index.do.
2. Gedde SJ, Vinod K, Wright MM, Muir KW, Lind JT, Chen PP, et al. Primary Open-Angle Glaucoma Suspect Preferred Practice Pattern® Guidelines. Ophthalmology. 2020 Nov; 128(1):P71-150.
3. Prum BE Jr, Rosenberg LF, Gedde SJ, Mansberger SL, Stein JD, Moroi SE, et al. Primary Open-Angle Glaucoma Preferred Practice Pattern® Guidelines. Ophthalmology. 2016 Jan;123(1):P41-P111.
4. Jacobs DS. Open-angle glaucoma: Treatment. In Gardiner MF (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 [cited 202**2** Feb 16]. Available from: http://www.utdol.com/utd/index.do.
5. National Institute for Health and Clinical Excellence (NICE): Clinical Guidelines. Glaucoma: diagnosis and management of chronic open angle glaucoma and ocular hypertension [guideline on the internet]. London, England: National Institute of health and Clinical Excellence; 2017 Oct [cited 2021 May 12]. Available from: https://www.nice.org.uk/guidance/ng81.
6. American Optometric Association. Optometric Clinical Practice Guideline. Care of the Patient with Open Angle Glaucoma. 2010 [cited 2015 Oct 19]. Available from: http://www.aoa.org/documents/optometrists/CPG-9.pdf.
7. Timoptic Ocudose® [package insert]. Bridgewater (NJ): Valeant Pharmaceuticals North America LLC; 2020 Jan.
8. Timoptic® XE [package insert]. Bridgewater (NJ): Valeant Pharmaceuticals North America LLC; 2021 Feb.
9. Azopt® [package insert]. Fort Worth (TX): Alcon Laboratories, Inc; 2021 Jun.
10. Cosopt® PF [package insert]. Lake Forest (IL): Merck & Co., Inc.; 2020 Oct.
11. Simbrinza® [package insert]. Fort Worth (TX): Alcon Laboratories, Inc.; 2021 May.
12. Latisse® [package insert]. Madison (NJ): Allergan, Inc; 2021 Aug.
13. Lumigan® [package insert]. Madison (NJ): Allergan, Inc.; 2020 Sept.
14. Rhopressa® [package insert on the internet]. Irvine (CA): Aerie Pharmaceuticals, Inc; 2019 Mar.
15. Xalatan® [package insert]. New York (NY): Pfizer Labs; 2020 Sep.
16. Zioptan® [package insert]. Lake Forest (IL): Merck & Co., Inc.; 2018 Nov.
17. Vyzulta® [package insert]. Bridgewater (NJ): Bausch & Lomb, Inc; 2019 May.
18. Rocklatan® [package insert]. Irvine (CA): Aerie Pharmaceuticals, Inc.; 2020 Jun.
19. Micromedex® Solutions [database on the Internet]. Greenwood Village (CO): Truven Health Analytics; Updated periodically [cited 2022 Feb 16]. Available from: http://www.micromedexsolutions.com/.
20. Xelpros® [package insert on the internet]. Cranberry (NJ): Sun Pharmaceutical Industries; 2022 Feb.
21. Drug information. In: Basow DS (Ed). UpToDate [database on the Internet].
22. Noecker RJ, Herrygers LA, Anwaruddin R. Corneal and conjunctival changes caused by commonly used glaucoma medications. Cornea 2004; 23:490-496.
23. Baudouin C. Detrimental effect of preservatives in eyedrops: implications for the treatment of glaucoma. Acta Ophthalmol 2008; 86:716-26.
24. Metry DW. Infantile hemangiomas: Management. In Levy ML (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 [cited 2022 Feb 16]. Available from: http://www.utdol.com/utd/index.do.

Review History

01/30/2022 - Reviewed and created for P&T. Matched MH UPPL criteria to be in compliance with Masshealth unified formulary requirements. Effective 4/1/23.

05/10/23 – Reviewed and updated for P&T. Zioptan has been designated as a brand preferred product. Effective 6/5/23.

07/12/23 – Reviewed and updated for P&T. Phospholine Iodide® (echothiophate iodide) added to covered drugs without PA. Added MB designation to Durysta®(bimatoprost implant), Miochol-E®(acetylcholine chloride), and Miostat®(carbachol) 0.01%. Verbiage for Durysta®(bimatoprost implant) was updated to maintain consistency with other guidelines. Reference table updated for Combigan® to note availability of A-rated generic. Added appendix for Brand/generic preferred verbiage. Effective 07/31/23.