

Clinical Policy: Latanoprostene Bunod (Vyzulta)

Reference Number: CP.PMN.108

Effective Date: 03.01.18

Last Review Date: 02.20

Line of Business: Medicaid, Commercial

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Latanoprostene bunod (Vyzulta[®]) is a prostaglandin analog that is metabolized into two moieties, latanoprost acid and a butanediol mononitrate which releases nitric oxide.

FDA Approved Indication(s)

Vyzulta is indicated for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Vyzulta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Open-Angle Glaucoma, Ocular Hypertension (must meet all):

1. Diagnosis of open-angle glaucoma or ocular hypertension;
2. Age \geq 17 years;
3. Failure of two of the following: a generic ophthalmic prostaglandin analog (e.g., latanoprost), ophthalmic beta-blocker (e.g., timolol), or ophthalmic alpha-2 adrenergic agonist (e.g., brimonidine), unless contraindicated or clinically significant adverse events are experienced;
4. Dose does not exceed one bottle every 30 days.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and CP.CPA.09 for commercial.

II. Continued Therapy

A. Open-Angle Glaucoma, Ocular Hypertension (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one bottle every 30 days.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and CP.CPA.09 for commercial.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid and CP.CPA.09 for commercial, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

IOP: intraocular pressure

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---------------------------------------|---|-------------------------------------|
| latanoprost (Xalatan [®]) | 1 drop in the affected eye(s) once daily in the evening | 1 drop/eye/day |
| timolol (Timoptic [®]) | 1 drop in the affected eye(s) BID | 2 drops/eye/day |
| brimonidine (Alphagan [®] P) | 1 drop in the affected eye(s) TID | 3 drops/eye/day |

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|--|-----------------------------------|---------------------|
| Open-angle glaucoma, ocular hypertension | 1 drop in the affected eye(s) qPM | 1 bottle/30 days |

VI. Product Availability

Ophthalmic solution: 0.024% (2.5 mL, 5 mL)

VII. References

1. Vyzulta Prescribing Information. Bridgewater, NJ: Bausch & Lomb Incorporated; October 2019. Available at: www.bausch.com. Accessed December 2, 2019.
2. Primary Open-Angle Glaucoma Preferred Practice Pattern® Guidelines. 2015. Available at: www.aaojournal.org. Accessed December 2, 2019.
3. Weinreb R, Sforzolini B, Vittitow J, et al. Latanoprostene Bunod 0.024% versus Timolol Maleate 0.5% in Subjects with Open-Angle Glaucoma or Ocular Hypertension: The APOLLO Study. Ophthalmology 2016; 123(5):965-973.
4. Medeiros F, Martin K, Peace J, et al. Comparison of Latanoprostene Bunod 0.024% and Timolol Maleate 0.5% in Open-Angle Glaucoma or Ocular Hypertension: The LUNAR Study. Am J Ophthalmol 2016; 168:250-259.
5. Weinreb R, Ong T, Sforzolini B, et al. A randomized, controlled comparison of latanoprostene bunod and latanoprost 0.005% in the treatment of ocular hypertension and open angle glaucoma: the VOYAGER study. Br J Ophthalmol 2015; 99:738-745.
6. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed December 2, 2019.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|----------|-------------------|
| Policy created | 12.12.17 | 02.18 |
| Per SDC, modified redirection to require two alternatives consistent with the non-formulary policy. | 04.30.18 | |
| 1Q 2019 annual review: no significant changes. References reviewed and updated. | 11.06.18 | 02.19 |
| 1Q 2020 annual review: policy combined for Commercial and Medicaid lines of business; Commercial: increased number of preferred ophthalmic agents from 1 to 2; references reviewed and updated. | 12.04.19 | 02.20 |

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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