Macugen (pegaptanib)

Line(s) of Business:  
HMO; PPO; QUEST Integration
Akamai Advantage

Effective Date:  
10/01/2015

POLICY

A. INDICATIONS
   The indications below including FDA-approved indications and compendial uses are considered a 
covered benefit provided that all the approval criteria are met and the member has no exclusions to 
the prescribed therapy.

   FDA-Approved Indications
   • Macugen is indicated for the treatment of patients with neovascular (wet) age-related macular 
     degeneration.

   Compendial Use
   • Treatment of diabetic macular edema

B. CRITERIA FOR APPROVAL
   1. Neovascular (Wet) Age-Related Macular Degeneration
      Authorization for indefinite approval may be granted for members prescribed Macugen for the 
      treatment of neovascular (wet) age-related macular degeneration.

   2. Diabetic Macular Edema
      Authorization for indefinite approval may be granted for members prescribed Macugen for the 
      treatment of diabetic macular edema.

C. CONTINUATION OF THERAPY
   All members (including new members) requesting authorization for continuation of therapy must 
   meet ALL initial authorization criteria.

D. DOSAGE AND ADMINISTRATION
   Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted 
   compendia, and/or evidence-based practice guidelines.
E. IMPORTANT REMINDER

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that CVS/caremark reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

F. REFERENCES