Lucentis (ranibizumab)

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

Original Effective Date:
10/01/2015
Current Effective Date:
01/01/2018

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

Lucentis is indicated for the treatment of patients with:

- Neovascular (Wet) age-related macular degeneration
- Macular edema following retinal vein occlusion
- Diabetic macular edema
- Diabetic retinopathy
- Myopic choroidal neovascularization

B. CRITERIA FOR APPROVAL

1. **Neovascular (Wet) Age-Related Macular Degeneration**
   Authorization of 12 months may be granted for members prescribed Lucentis for the treatment of neovascular (wet) age-related macular degeneration.

2. **Macular Edema Following Retinal Vein Occlusion**
   Authorization of 12 months may be granted for members prescribed Lucentis for the treatment of macular edema following retinal vein occlusion.

3. **Diabetic Macular Edema**
   Authorization of 12 months may be granted for members prescribed Lucentis for the treatment of diabetic macular edema.

4. **Diabetic Retinopathy**
   Authorization of 12 months may be granted for members prescribed Lucentis for the treatment of diabetic retinopathy.

5. **Myopic Choroidal Neovascularization**
   Authorization for 12 months may be granted for members prescribed Lucentis for the treatment of myopic choroidal neovascularization.

C. CONTINUATION OF THERAPY

1. No previous authorization/precertification:
   All members (including members currently receiving treatment without prior authorization) must meet criteria for initial approval in section B.
2. Reauthorization:
   Authorization of 12 months may be granted to members requesting authorization for continuation of therapy if Lucentis was previously authorized by HMSA/CVS and member has achieved or maintained a positive clinical response to therapy.

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. ADMINISTRATIVE GUIDELINES

Precertification is required. Please refer to the HMSA medical policy web site for the fax form.

F. 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.

G. REFERENCES

1. Lucentis [package insert]. South San Francisco, CA: Genentech, Inc.; April 2017.
2. American Academy of Ophthalmology Retinal/Vitreous Panel. Preferred Practice Pattern Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; 2015. Available at: www.aao.org/ppp.
3. American Academy of Ophthalmology Retinal/Vitreous Panel. Preferred Practice Pattern Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology; 2015. Available at: www.aao.org/ppp.

Document History

10/01/2015	Original effective date
12/2016	Annual review
02/2017	Added myopic choroidal neovascularization (new FDA-approved indication)
04/10/2017	Revision effective date
05/2017	Expanded diabetic retinopathy (label update)
05/22/2017	Revision effective date
05/2017	Annual review
01/01/2018	Revision effective date