Draft New Policy: Do Not Implement

Bevacizumab-vikg (Lytenava™)

Requires Step Therapy See "Step Therapy Requirements for Provider Administered Specialty Medications" Document at: https://www.bcbst.com/docs/providers/Comm_BC_PAD_Step_Therapy_Guide.pdf

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:
POLICY

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

Lytenava is indicated for treatment of patients with neovascular (wet) age-related macular degeneration.

Compendial Uses

- Diabetic macular edema
- Retinal vein occlusion with macular edema
- Proliferative diabetic retinopathy
- Choroidal neovascularization
- Neovascular glaucoma
- Retinopathy of prematurity

All other indications are considered experimental/investigational and not medically necessary.

PRESCRIBER SPECIALITIES

This medication must be prescribed by or in consultation with an ophthalmologist.

COVERAGE CRITERIA

Indication

Diabetic Macular Edema

Authorization of 12 months may be granted for the treatment of diabetic macular edema.

Neovascular (Wet) Age-Related Macular Degeneration

Authorization of 12 months may be granted for the treatment of neovascular (wet) age-related macular degeneration including polypoidal choroidopathy.

Macular Edema Following Retinal Vein Occlusion

Authorization of 12 months may be granted for the treatment of macular edema following retinal vein occlusion.

Proliferative Diabetic Retinopathy

Authorization of 12 months may be granted for the treatment of proliferative diabetic retinopathy.

Choroidal Neovascularization

Authorization of 12 months may be granted for the treatment of choroidal neovascularization.

Neovascular Glaucoma

Authorization of 12 months may be granted for the treatment of neovascular glaucoma.

Retinopathy of Prematurity

Authorization of 12 months may be granted for the treatment of retinopathy of prematurity.

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when the member has demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss).

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

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EFFECTIVE DATE

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