Draft Revision Policy: Do Not Implement

Verteporfin (Visudyne®)

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
Visudyne for injection is indicated for the treatment of patients with predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration, pathologic myopia or presumed ocular histoplasmosis.

Compendial Uses
- Classic subfoveal choroidal neovascularization due to chronic central serous chorioretinopathy
- Choroidal hemangioma

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

PRESCRIBER SPECIALTIES

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

COVERAGE CRITERIA

Choroidal Neovascularization

Authorization of 6 months may be granted for treatment of predominantly classic subfoveal choroidal neovascularization (CNV) when both of the following criteria are met:
- Member has predominantly classic subfoveal choroidal neovascularization due to ONE of the following:
  - Wet age-related macular degeneration
  - Pathologic myopia
  - Presumed ocular histoplasmosis
  - Chronic central serous chorioretinopathy (also includes retinal pigment epithelial leakage without evident CNV)
- The treatment spot size is less than or equal to 6.4 mm in diameter.

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Choroidal Hemangioma

Authorization of 6 months may be granted for treatment of choroidal hemangioma.

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment of an indication listed in coverage criteria section for members who have demonstrated a positive clinical response to therapy.

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).

REFERENCES

1. Visudyne [package insert]. Charleston, SC: Alcami Carolinas Corporation; February 2023.
2. van Rijssen, T.J., van Dijk, E.H.C., Yzer, S., Ohno-Matsui, K., Keunen, J.E.E., Schlingemann, R.O., Sivaprasad, S., Querques, G., Downes, S.M., Fauser, S., Hoyng, C.B., Piccolino, F.C., Chhablani, J.K., Lai, T.Y.Y., Lotery, A.J., Larsen, M., Holz, F.G., Freund, K.B., Yannuzzi, L.A., Boon, C.J.F., Central serous chorioretinopathy: Towards an evidence-based treatment guideline, Progress in Retinal and Eye Research (2019), doi: https://doi.org/10.1016/j.preteyeres.2019.07.003.
3. Tsipursky MS, Golchet PR, Jampol LM. Photogynamic therapy of choroidal hemangioma in sturge-weber syndrome, with a review of treatments for diffuse and circumscribed choroidal hemangiomas. Surv Ophthalmol. 2011; 56 (1): 68-85.

EFFECTIVE DATE

ID_CHS_2026