Travoprost Intracameral Implant (iDose TR®)

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.

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

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

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

DOCUMENTATION REQUIREMENTS

Submission of the following information is necessary to initiate the prior authorization review:

- Documentation of baseline and subsequent central corneal endothelial cell density using an appropriate measurement method (e.g., specular, or confocal microscopy).
- For continuation requests, chart notes or medical record documentation supporting positive clinical response.

EXCLUSIONS

The patient does **NOT** have any of the following:

- Ocular or periocular infection
- Corneal endothelial dystrophy
- Prior corneal transplantation
- Hypersensitivity to Travoprost

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when all of the following criteria are met:

- The requested medication is being used for the reduction of intraocular pressure (IOP) in a patient who has a diagnosis of Open-Angle Glaucoma (OAG) or Ocular Hypertension (OHT)
- Baseline measurement of central corneal endothelial cell density was obtained prior to the initial implant administration (Appendix A)

CONTINUATION OF THERAPY

Authorization for 12 months may be granted when a member is requesting continued use of iDose TR and all of the following conditions are met:

- The member has a diagnosis of open-angle glaucoma (OAG) or ocular hypertension (OHT)
- The member is benefitting from treatment with the requested medication but continues to require intraocular pressure reduction
- It has been more than 12 months since the member has received iDose TR in the affected eye
- The member's corneal endothelial cell density has been re-checked and confirms all of the following:
  - The affected eye has not lost 10% or more of its corneal endothelial cells compared to baseline after adjusting for normal age-related loss and prior cataract surgery if applicable (Appendix A)
    - Note: If a baseline measurement was not taken documentation of the corneal endothelial cell density of the un-implanted contralateral eye may be used to determine eligibility. The difference between eyes must also be less than 10%
- The member's previous iDose TR implant that has not become dislocated

APPENDIX

Appendix A: Travoprost Intracameral Implant Recommended Minimum Central Corneal Endothelial Cell Density Prior to Initial Dose and Prior to Each Re-administration:

Central Corneal Endothelial Cell Density		
Age	Phakic Eyes, cells/mm(2)	Pseudophakic Eyes, cells/mm(2)
45 years or younger	2200	1540
46 to 55 years	2000	1400
56 to 65 years	1800	1260
Older than 65years	1600	1120

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. iDose TR - travoprost intracameral implant [package insert]. San Clemente, CA: Glaukos Corp., 2026. Accessed February 2026.
2. iDoseTR. In: Clinical Pharmacology. Tampa (FL): Elsevier. Revised February. 2026. Accessed February 2026.
3. Lexi-Comp Online. (2026, February). AHFS DI. Travoprost. Retrieved February, 20, 2025.

4. MICROMEDEX Healthcare Series. Drugdex Evaluations. (2026, February). Travoprost. Retrieved February 2026 from MICROMEDEX Healthcare Series.

EFFECTIVE DATE 7/31/2026

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