AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: iDose® TR (travoprost intracameral implant) **75 mcg (J2508) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Left Eye ❑ Right Eye ❑ Both Eyes

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Dosing Limits:

- iDose® is an intracameral implant containing 75 mcg travoprost, pre-loaded in a single-dose inserter
- Maximum of 1 single implant per eye per lifetime. Do not readminister to an eye that has received a prior implant
- **Re-Treatment of Previously Treated Eye(s).** **NOT COVERED**. iDose® is approved for one-time use in each treated eye. Repeat administration in previously treated eye(s) will **NOT** be approved

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 6 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by, or in consultation with, an Ophthalmologist
- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Open-Angle Glaucoma (OAG)
  - ❑ Ocular Hypertension (OHT)
- ❑ Member has **NO** history of any of the following:
  - Prior corneal or endothelial cell transplants
  - Active or suspected ocular/periocular infection or corneal endothelial cell dystrophy
  - Absent or ruptured posterior lens capsule
  - Any eye/laser surgeries within the past 6 months in the affected eye(s)
- ❑ Member has documented treatment failure, intolerance, or contraindication of **TWO** ophthalmic prostaglandin analogs (e.g., bimatoprost, latanoprost, or travoprost) **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member has documented treatment failure, intolerance, or contraindication of at least **TWO** ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes for the treatment of OAG or OHT **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Alpha-agonist (e.g., brimonidine)
  - ❑ Beta-blockers (e.g., betaxolol, timolol)
  - ❑ Carbonic anhydrase inhibitors (e.g., brinzolamide, dorzolamide)
  - ❑ Rho kinase inhibitor (e.g., netarsudil)
- ❑ Member has documented treatment failure, intolerance, or contraindication to Durysta™ **(verified by chart notes and/or medical claims)**

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 5/23/2024
REVISED/UPDATED/REFORMATTED: ~~5/8/2024~~; **6/5/2024**