STEP THERAPY POLICY

POLICY: Ophthalmic – Glaucoma – Alpha-Adrenergic Agonists Step Therapy Policy

- Alphagan® P (brimonidine tartrate 0.1% ophthalmic solution; 0.15% ophthalmic solution – Allergan, generic)
- Apraclonidine 0.5% ophthalmic solution (generic only)
- Brimonidine tartrate 0.2% ophthalmic solution (generic only)
- Iopidine® (apraclonidine 1% ophthalmic solution – Alcon)

REVIEW DATE: 10/23/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

The brimonidine tartrate ophthalmic products (0.1%, 0.15%, and 0.2% strengths) are indicated for the **reduction of elevated intraocular pressure** (IOP) in patients with open-angle glaucoma or ocular hypertension.[1,2] Apraclonidine 0.5% ophthalmic solution is indicated as short-term adjunctive therapy in patients on maximally tolerated medical therapy who require additional **IOP reduction**.[3] Patients on maximally tolerated medical therapy who are treated with apraclonidine 0.5% ophthalmic solution to delay surgery should have frequent follow-up examinations and treatment should be discontinued if the IOP rises significantly. Iopidine 1% is indicated to **control or prevent post-surgical elevations in IOP that occur in patients after argon laser trabeculoplasty, argon laser iridotomy or Nd:YAG posterior capsulotomy**.[4]

Brimonidine 0.1% ophthalmic solution and brimonidine 0.15% ophthalmic solution (generics for Alphagan P) contain the preservative Purite® 0.005%.[1] Brimonidine 0.2% ophthalmic solution contains the preservative benzalkonium chloride

0.005%.[2] Iopidine 1% and apraclonidine 0.5% ophthalmic solution contain the preservative benzalkonium chloride 0.01%.[3,4]

POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration.

Step 1: generic apraclonidine 0.5% ophthalmic solution, generic brimonidine tartrate 0.1% ophthalmic solution, generic brimonidine tartrate 0.15% ophthalmic solution, generic brimonidine tartrate 0.2% ophthalmic solution

Step 2: Alphagan P 0.1%, Alphagan P 0.15%, Iopidine 1%

Ophthalmic – Glaucoma – Alpha-Adrenergic Agonists Step Therapy Policy product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.

CRITERIA

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.

2. If the patient is undergoing argon laser trabeculoplasty, argon laser iridotomy or Nd:YAG posterior capsulotomy, approve Iopidine 1%.

REFERENCES

1. Alphagan P 0.1% and 0.15% [prescribing information]. North Chicago, IL: Abbvie; June 2024.
2. Brimonidine 0.2% ophthalmic solution [prescribing information]. Gurnee, IL: Akorn; May 2022.
3. Apraclonidine 0.5% ophthalmic solution [prescribing information]. Gurnee, IL: Akorn; January 2022.
4. Iopidine® 1% ophthalmic solution [prescribing information]. Nashville, TN: Harrow Eye; February 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Generic brimonidine tartrate 0.1% ophthalmic solution:** This product was added to Step 1.	10/04/2023
Annual Revision	No criteria changes.	10/23/2024