Drug Coverage Policy

Effective Date 5/1/2024
Coverage Policy Number.....IP0543
Policy Title..... Ranibizumab Products

Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Ranibizumab Products

- Byooviz™ (ranibizumab-nuna intravitreal injection – Biogen)
- Cimerli™ (ranibizumab-eqrn intravitreal injection – Coherus)
- Lucentis® (ranibizumab intravitreal injection – Genentech)

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.

Medical Necessity Criteria

Coverage for Ranibizumab Products (Byooviz, Cimerli, and Lucentis) varies across plans and requires the use of preferred products in addition to the criteria listed below. Refer to the customer's benefit plan document for coverage details.

Ranibizumab products are considered medically necessary when the following criteria are met:

1. Individual meets **ALL** of the following criteria:
    A. Treatment of **ONE** of the following
        i. Diabetic Macular Edema
        ii. Diabetic Retinopathy
        iii. Macular Edema following retinal vein occlusion
        iv. Myopic Choroidal Neovascularization
        v. Neovascular (wet) Age-Related Macular Degeneration
        vi. Ocular Histoplasmosis Syndrome
        vii. Other Neovascular Diseases of the Eye (for example, neovascular glaucoma, retinopathy of prematurity, sickle cell neovascularization, choroidal neovascular conditions)
    B. Medication is administered by, or under the supervision of, an ophthalmologist
    C. Preferred product criteria is met for the products as listed in the below table(s)

Employer and Individual and Family Plan:

Product	Criteria
Byooviz (ranibizumab-nuna) for intravitreal injection	**ONE** of the following: 1. Currently receiving Byooviz, Cimerli, or Lucentis 2. **ONE** of the following: a. Documentation of failure, contraindication, or intolerance to repackaged bevacizumab b. If, in the professional opinion of the prescriber, the safety of using the repackaged bevacizumab or the supplier of the repackaged bevacizumab is of significant concern 3. Diabetic retinopathy
Cimerli (ranibizumab-eqrn) for intravitreal injection	**ONE** of the following: 1. Currently receiving Cimerli, Byooviz, or Lucentis 2. **ONE** of the following: a. Documentation of failure, contraindication, or intolerance to repackaged bevacizumab b. If, in the professional opinion of the prescriber, the safety of using the repackaged bevacizumab or the supplier of the repackaged bevacizumab is of significant concern 3. Diabetic retinopathy
Lucentis (ranibizumab) for intravitreal injection	**ONE** of the following: 1. Currently receiving Lucentis, Byooviz, or Cimerli 2. **ONE** of the following: a. Documentation of failure, contraindication, or intolerance to repackaged bevacizumab b. If, in the professional opinion of the prescriber, the safety of using the repackaged bevacizumab or the supplier of the repackaged bevacizumab is of significant concern 3. Diabetic retinopathy

Dosing. The recommended dose of Ranibizumab Products (Byooviz, Cimerli, Lucentis) for Diabetic Macular Edema and Diabetic Retinopathy, is:

1. 0.3 mg administered by intravitreal injection for each eye being treated
2. The dosing interval is not more frequent than once every 28 days for each eye being treated

Dosing. The recommended dose of Ranibizumab Products (Byooviz, Cimerli, Lucentis) for Macular Edema Following Retinal Vein Occlusion, Myopic Choroidal Neovascularization, Neovascular (Wet) Age-Related Macular Degeneration, Ocular Histoplasmosis and Other Neovascular Diseases of the Eye (for example, neovascular glaucoma, retinopathy of prematurity, sickle cell neovascularization, choroidal neovascular conditions), is:

1. 0.5 mg administered by intravitreal injection for each eye being treated
2. The dosing interval is not more frequent than once every 28 days for each eye being treated

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Reauthorization Criteria

Continuation of Ranibizumab Products (Byooviz, Cimerli, Lucentis) is considered medically necessary for ALL Covered Diagnoses when initial criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration: up to 12 months
Reauthorization approval duration: up to 12 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven.

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J2778	Injection, ranibizumab, 0.1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (Byooviz), 0.1 mg
Q5128	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg (Code effective 04/01/2023)

Background

OVERVIEW
Lucentis and Cimerli (interchangeable biosimilar to Lucentis) are vascular endothelial growth factor (VEGF) inhibitors indicated for the following uses:[1,7]

- **Diabetic macular edema**.
- **Diabetic retinopathy**.
- **Macular edema following retinal vein occlusion**.
- **Myopic choroidal neovascularization**.
- **Neovascular (wet) age-related macular degeneration**.

Byooviz (interchangeable biosimilar to Lucentis) is indicated for the following uses:[6]

- **Macular edema following retinal vein occlusion**.
- **Myopic choroidal neovascularization**.
- **Neovascular (wet) age-related macular degeneration**.

The recommended dosing for each of the indication is as follows:[1,6,7]

- **Diabetic macular edema, diabetic retinopathy:** 0.3 mg administered by intravitreal injection once every month (approximately 28 days) [Cimerli and Lucentis)
- **Macular edema following retinal vein occlusion, neovascular (wet) age-related macular degeneration:** 0.5 mg administered by intravitreal injection once every month (approximately 28 days).
- **Myopic choroidal neovascularization:** 0.5 mg administered by intravitreal injection once every month (approximately 28 days) for up to 3 months; patients may be retreated if needed.

Other Uses with Supportive Evidence
Overproduction of VEGF may lead to other eye conditions, including neovascular glaucoma, retinopathy of prematurity, and other retinal and choroidal neovascular conditions affecting the eye.[2,3] The VEGF inhibitors have the potential to be used off-label to reduce or slow visual impairment or vision loss associated with other eye conditions related to increased VEGF production.[2,4,5] The use of anti-VEGF agents have been shown to stop the angiogenic process and maintain visual acuity and improve vision in patients with certain neovascular ophthalmic conditions; therefore, research is rapidly evolving on the use of VEGF inhibitors in other neovascular ophthalmic conditions which threaten vision.

References

1. Lucentis® intravitreal injection [prescribing information]. South San Francisco, CA: Genentech; August 2023.
2. Barakat MR, Kaiser PK. VEGF inhibitors for the treatment of neovascular age-related macular degeneration. *Expert Opin Investig Drugs*. 2009;18(5):637-646.
3. Tolentino M. Systemic and ocular safety of intravitreal anti-VEGF therapies for ocular neovascular disease. *Surv Ophthalmol*. 2011;56(2):95-113.
4. Kinnunen K, Ylä-Herttuala S. Vascular endothelial growth factors in retinal and choroidal neovascular diseases. *Ann Med*. 2012;44(1):1-17.
5. Horsley MB, Kahook MY. Anti-VEGF therapy for glaucoma. *Curr Opin Ophthalmol*. 2010;21(2):112-117.
6. Byooviz™ intravitreal injection [prescribing information]. Cambridge, MA: Biogen; October 2023.
7. Cimerli™ intravitreal injection [prescribing information]. Redwood City, CA: Coherus; August 2022.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	For all indications/uses, the dosing interval was changed from 25 days to 28 days to align with the prescribing information	5/1/2024

The policy effective date is in force until updated or retired.