Drug Coverage Policy

Effective Date.....4/1/2025
Coverage Policy Number.....IP0720
Policy Title..... Eysuvis for IFP

Ophthalmology – Dry Eye Disease – Eysuvis for Individual and Family Plans

- Eysuvis® (loteprednol etabonate 0.25% ophthalmic suspension – Alcon)

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 Healthcare Coverage Policy

OVERVIEW
Eysuvis, an ophthalmic corticosteroid, is indicated for the **short-term (up to 2 weeks) treatment of the signs and symptoms of dry eye disease**.[1]

Guidelines

Eysuvis is not addressed in guidelines. The American Academy of Ophthalmology (AAO) Dry Eye Syndrome Preferred Practice Pattern® (2024) notes dry eye syndrome is also known as dry eye disease or keratoconjunctivitis sicca.[2] Dry eye is generally classified according to both symptoms and signs (i.e., mild, moderate, or severe); however, there is an emphasis on symptoms over signs. Management of dry eye is listed as a four-step staged approach, but specific therapies may be chosen from any step, regardless of the level of disease severity, depending on provider experience and patient preference. Ophthalmic corticosteroids, among other therapies, are helpful for the treatment of mild and moderate dry eye. Ophthalmic corticosteroids have reported to reduce ocular irritation symptoms. The PPP notes that commercially available loteprednol etabonate 0.25% was studied in a prospective randomized study over 2 weeks and demonstrated improvement in symptoms and conjunctival hyperemia. However, extending the treatment to 4 weeks did not provide further beneficial effects or increase adverse effects. Low-dose ophthalmic corticosteroids can be used at infrequent intervals for short periods of time (i.e., several weeks) to suppress ocular surface inflammation. Patients using ophthalmic corticosteroids should be monitored for adverse effects, such as increased intraocular pressure and cataract formation.

Medical Necessity Criteria

Eysuvis is considered medically necessary when the following criteria are met:

FDA-Approved Indication

1. **Dry Eye Disease (Short-Term Treatment).** Approve for 1 month if the patient has tried artificial tears.
2. **Preferred product criteria are met for the product(s) as listed in the below table.**

Individual and Family Plans:

Product	Criteria
Eysuvis (loteprednol etabonate 0.25% ophthalmic suspension)	Patient has tried one artificial tear substitute **AND** one other ophthalmic loteprednol etabonate-containing product.

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.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

References

1. Eysuvis® ophthalmic suspension [prescribing information]. Fort Worth, TX: Alcon; November 2023.

2. Amescua G, Ahmad S, Cheung AY, et al. American Academy of Ophthalmology, Dry Eye Syndrome Preferred Practice Pattern®. *Ophthalmology*. 2024;131(4): P1-P49.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy.	4/1/2025

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