PART B DRUG MEDICAL/PHARMACY	ASPIRE HEALTH	Effective Date January 1, 2024	
	RANIBIZUMAB PRODUCTS BYOOVIZ; CIMERLI; LUCENTIS; SUSVIMO (IMPLANT 1ST FILL); SUSVIMO (IMPLANT REFILL)	**Policy #** Ranibizumab	
		Review Date 09/27/2023	**Applicable to:** ☑ Medicare Advantage ☐ Commercial ☐ Elevance Health HMO ☐ Blue Shield Trio
	Approver's Name & Title QI & UM Drug Subcommittee		

Aspire Health Plan applies medical drug clinical criteria as a reference for medical policy information only. Federal and state laws or requirements, contract language, and Plan benefit may take precedence over the application of these clinical criteria. Please consult the applicable certificate or contract for benefit details. This policy is subject to revision at the discretion of the Plan and is therefore subject to change. Refer to the disclaimer section below for more information.

POLICY

This policy addresses the coverage of intravitreal ranibizumab for ophthalmic use.

APPLICABLE HCPCS

J2778: Injection, ranibizumab, 0.1 mg; 1 billable unit = 0.1 mg (Lucentis Only)
Q5124 – Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg; 1 billable unit = 0.1 mg (Byooviz Only)
Q5128 – Injection, ranibizumab-eqrn, biosimilar (cimerli), 0.1 mg; 1 billable unit = 0.1 mg (Cimerli Only)
J2779: Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg; 1 billable unit = 0.1 mg
C1889: Implantable/insertable device, not otherwise classified (Used for Susvimo Ocular Implant Device)

Available as:
Lucentis 0.3 mg/0.05 mL single-use vial/prefilled syringe for injection.
Lucentis 0.5 mg/0.05 mL single-use vial/prefilled syringe for injection.
Byooviz 0.5 mg/0.05 mL single-use vial for injection.
Cimerli 0.3 mg/0.05 mL single-use vial for injection.
Cimerli 0.5 mg/0.05 mL single-use vial for injection.
Susvimo 100 mg/mL single-dose glass vial.

CLINICAL CRITERIA

I. INITIAL CRITERIA

Ranibizumab may be authorized when **ALL** of the following are met and submitted with clinical documentation:

1. Request for ranibizumab treatment, as indicated by **ONE** of the following **(1 OR 2):**

    a. **For Lucentis and ranibizumab biosimilars requests:** Member must meet **ONE** of the following diagnosis
        a. Diabetic macular edema
        b. Diabetic retinopathy
        c. Macular edema following retinal vein occlusion
        d. Myopic choroidal neovascularization
        e. Neovascular (wet, or exudative) age-related macular degeneration

    OR

    b. **For Susvimo requests:** Member has previously responded to at least two intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication (e.g., aflibercept, pegaptanib, brolucizumab, bevacizumab, ranibizumab).

AND

2. No concurrent ocular or periocular infection; **AND**

3. Ranibizumab is being prescribed as monotherapy: Member is not on additional ophthalmic vascular endothelial growth factor (VEGF) inhibitors (i.e., aflibercept, ranibizumab, pegaptanib, bevacizumab); **AND**

4. Member has not required removal of a Susvimo implant in the past; **AND**

5. Baseline best corrected visual acuity (BCVA) is assessed prior to treatment and will be assessed periodically during treatment.

II. REAUTHORIZATION / CONTINUATION OF THERAPY CRITERIA

Ranibizumab may be authorized for continuation of therapy when **ALL** of the following are met:

1. Member continues to meet the initial therapy criteria (as stated above); **AND**

2. Absence of adverse events from intravitreal injections of Ranibizumab (e.g., endophthalmitis and retinal detachments, increase in intraocular pressure, arterial thromboembolic events); **AND**

3. Positive response to therapy (e.g., improvement or maintenance in BCVA or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss) and continued administration is necessary for the maintenance treatment of the condition.
    OR
    For supplemental treatment with Susvimo ONLY: Member has had an insufficient response during initial or maintenance therapy with Susvimo administered every 24 weeks and requires supplemental treatment with intravitreal ranibizumab *(refer to 'Appendix' for Suvimo dosing and administration);*

AND

4. Documentation of administration records showing dates and eye(s) administered, along with documentation of member compliance with treatment plan.

STEP THERAPY

Step therapy criteria do not apply for members who are currently being treated with the requested medications. Step therapy is only applied for members that are new to therapy (have not received the requested drug in the last 365 days.

A. **PREFERRED PRODUCT(S): AVASTIN (no step therapy required)**

B. NON-PREFERRED PRODUCTS: Ranibizumab may be authorized when all of the clinical criteria above are met **AND** the member meets the following criteria for a non-preferred intravitreal VEGF antagonist:

1. Inadequate response to a trial of the *preferred agent, bevacizumab (Avastin); **or**
2. History of contraindication or adverse event(s) to Avastin (bevacizumab); **or**
3. Member has been on the requested agent within the past 365 days; **or**
4. Member currently has a Susvimo ocular implant and requests supplemental injections with ranibizumab;

DOSAGE AND AUTHORIZATION TIMEFRAMES

1. Recommended / Maximum Dose

Indications	Initial / Maintenance Dosing (per eye)	Maximum Dosing
Diabetic Macular Edema; Diabetic Retinopathy	**Lucentis and Cimerli only** Initial: 0.3 mg once a month Maintenance: After 3 consecutive monthly doses (if using the 0.5 mg dose), dosing interval may be extended	**Lucentis and Cimerli only** *0.3 mg per eye every month
Macular Edema, following retinal vein occlusion; Myopic Choroidal Neovascularization	**Lucentis and ranibizumab biosimilars** Initial: 0.5 mg once a month for up to 3 months Maintenance: May be retreated if needed.	**Lucentis and ranibizumab biosimilars** +0.5 mg per eye every month
Neovascular (wet, or exudative) AMD	**Lucentis and ranibizumab biosimilars** Initial: 0.5 mg per eye once a month for 3-4 months Maintenance: 0.5 mg per eye once every 3-4 months	**Lucentis and ranibizumab biosimilars** +0.5 mg per eye every month

Neovascular (wet, or exudative) AMD	**Susvimo** Initial: 2 mg per eye via ocular implant every 24 weeks. Maintenance: 0.5 mg per eye every 24 weeks while implant is in place if needed NOTE: Supplemental intravitreal injections (Lucentis) of 0.5 mg may be administered to the affected eye while implant is in place if needed.	**Susvimo** 2 mg per eye via ocular implant every 24 weeks

*0.3 mg vial / prefilled syringe for injection: 1 vial / syringe per eye every 28 days
+0.5 mg vial / prefilled syringe for injection: 1 vial / syringe per eye every 28 days

2. Authorization Period

   a. May be authorized for 12 months and reauthorized with continuation of therapy criteria; and

   b. Frequency is regarded as excessive when services are performed more frequently than indicated on the FDA-approved labeling or generally accepted by guidelines or consensus, and a rationale for the additional services is not documented. Dosage and frequency should be in accordance with the FDA label or CMS-recognized compendia (for off-label use). Services rendered in excess of the established standard of care may be subjected to review.

3. Limitations

   a. It is not reasonable and necessary to inject more than one anti-VEGF medication (e.g., aflibercept, pegaptanib, brolucizumab, bevacizumab, ranibizumab, faricimab-svoa, etc.) in the same eye during the same treatment session. It is not typical to inject one anti-VEGF medication in one eye and another in the other eye. If different medications are injected into each eye during the same date of service date of service, the rationale for this therapy must be documented in the medical record and the billing modifier [right (RT) and left (LT) modifiers] must be appended to the correct drug. Intravitreal injection for the treatment of macular edema more frequently than every 4 weeks regardless of which drug is used for any given injection i.e. alternating drugs every 2 weeks will not be covered.

   b. Concurrent use of more than one VEGF inhibitor in the same eye: The safety and effectiveness of combinational use of VEGF inhibitors for ocular indications has not been established and is currently not the standard of care according to clinical evidence and guidelines.

DRUG INFORMATION

PHARMACOLOGIC CATEGORY: Ophthalmic Agent; Vascular Endothelial Growth Factor (VEGF) Inhibitor

ROUTE OF ADMINISTRATION: Intravitreal Injection

FDA-APPROVED INDICATIONS

1. Age-related Macular Degeneration, neovascular (wet) (Lucentis and ranibizumab biosimilars; Susvimo)
2. Diabetic Macular Edema (Lucentis and Cimerli only)
3. Diabetic Retinopathy (Lucentis and Cimerli only)
4. Macular edema following retinal vein occlusion (Lucentis and ranibizumab biosimilars)
5. Myopic Choroidal Neovascularization (Lucentis and ranibizumab biosimilars)

COMPENDIAL APPROVED (OFF-LABELED) USES:

1. Retinopathy of prematurity, Type 1

CONTRAINDICATIONS:

Hypersensitivity to ranibizumab or any component of the formulation; ocular or periocular infections; active intraocular inflammation (implant only).

BOXED WARNING:

Susvimo: Endophthalmitis (implant): The implant has been associated with a 3-fold higher rate of endophthalmitis than monthly intravitreal injections of ranibizumab. Many of these events were associated with conjunctival retractions or erosions. Appropriate conjunctiva management and early detection with surgical repair of conjunctival retractions or erosion may reduce the risk of endophthalmitis.

OTHER CONSIDERATIONS:

Monitoring Parameters

Intraocular pressure (prior to and 30 minutes following injection via tonometry); consider checking for perfusion of the optic nerve head immediately following injection; signs of infection/inflammation (for first week following injection); retinal perfusion, endophthalmitis; visual acuity. Perform a dilated slit lamp exam and/or dilated indirect ophthalmoscopy to inspect the implant for dislodgement prior to and after the refill-exchange procedure. Monitor implant and tissue overlying the implant routinely for signs and symptoms of conjunctival blebs, conjunctival erosion, conjunctival retraction, endophthalmitis, implant dislocation, rhegmatogenous retinal detachment, and vitreous hemorrhage.

CLINICAL SUMMARY / APPENDIX

None

REFERENCES

Government Agency

Centers for Medicare and Medicaid Services (CMS). Medicare coverage database (no National Coverage Determination identified; no applicable LCD identified). Available from CMS.

Prescribing Information

1. Lucentis [package insert]. South San Francisco, CA; Genentech, Inc; March 2018.
2. Byooviz [package insert]. Cambridge, MA; Biogen, Inc; June 2022.
3. Cimerli [package insert]. Redwood City, CA; Coherus BioSciences, Inc; August 2022.
4. Susvimo (ranibizumab) [prescribing information]. South San Francisco, CA: Genentech Inc; April 2022.

Peer-reviewed Literature, Guidelines, and Consensus

1. Milliman Care Guidelines (MCG). Ambulatory Care 27th Edition. ACG: A-0450 (AC). 2023.
2. Flaxel CJ, et al. Age-Related Macular Degeneration. Preferred Practice Pattern [Internet] American Academy of Ophthalmology. 2019 Accessed at: http://www.aao.org/.
3. Solomon SD, Lindsley K, Vedula SS, Krzystolik MG, Hawkins BS. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. Cochrane Database of Systematic Reviews 2019, Issue 3. Art. No.: CD005139. DOI: 10.1002/14651858.CD005139.pub4.

IMPORTANT REMINDER

This Medicare Part B Step Therapy Medical Necessity Guideline is provided for informational purposes only and neither constitutes nor replaces professional medical advice. Physicians, hospitals, and other providers are expected to administer or use drugs/biologicals in the most effective and clinically appropriate manner. Treating physicians and other health care providers are solely responsible for all medical care decisions. In accordance with the member's Evidence of Coverage (EOC), every benefit plan has its own coverage provisions, limitations, and exclusions. In the event of a conflict between this policy and the member's EOC,

the member's EOC provisions will take precedence.

Aspire Health Plan (AHP) adheres to Medicare guidelines, including National Coverage Determination (NCD), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other relevant Medicare manuals established by CMS. Compliance with these guidelines is required when applicable. Refer to the CMS website at http://www.cms.hhs.gov. For the most up-to-date Medicare policies and coverage, please search the Medicare Coverage Database. All LCDS are the same for each state within a Jurisdiction. Medicare Part B Administrative Contractor (MAC) for CA [Jurisdiction E (1)]: Active LCDs - JE Part B – Noridian (noridianmedicare.com). In the event of a discrepancy between this policy and the Medicare NCD or LCD, the Medicare NCD/LCD will govern.

This policy is utilized by AHP to determine coverage in the absence of applicable CMS Medicare guidelines. Please refer to the links provided in the References section to access the Medicare source materials that were used for developing this resource document. This document does not serve as a substitute for the official Medicare source materials that provide detailed information on Medicare coverage requirements. In the event of a conflict between this document and Medicare source materials, the Medicare source materials will take precedence.

The procedure and/or diagnosis codes listed in this policy are provided for reference only and may not be all-inclusive.The inclusion of a code in this guideline does not indicate whether the health service described by the code is covered or not covered. Benefit coverage for health services is governed by the member-specific benefit plan document and applicable laws that may mandate coverage for a particular service. Inclusion of a code does not confer a right to reimbursement or guarantee payment of a claim. Other Policies and Guidelines may also apply.

POLICY HISTORY

Version	Date	Revision Author/Title	Summary of Changes
1	9/27/2023		New Policy