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Policy Number: C10417-A

Ranibizumab (Lucentis, Byooviz, Cimerli)

PRODUCTS AFFECTED

Lucentis (ranibizumab), Byooviz (ranibizumab-nuna), Cimerli (ranibizumab-eqrn)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Diabetic macular edema, Neovascular (wet or exudative) age-related macular degeneration, Macular edema following retinal vein occlusion, Diabetic retinopathy or Myopic choroidal neovascularization

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review.

A. FOR ALL INDICATIONS:

1. Documented diagnosis of ANY of the following: Neovascular (Wet) age-related macular degeneration, Macular edema following retinal vein occlusion, Diabetic macular edema (Lucentis, Cimerli Only), Diabetic retinopathy (Lucentis, Cimerli Only), or Myopic choroidal

neovascularization
AND

2. Documentation of an inadequate response (defined as 1-2 injections with minimal to no improvement), clinically significant adverse effects, or contraindication to bevacizumab.
AND
3. Documentation of baseline visual status with notation of eye(s) being treated [DOCUMENTATION REQUIRED]
AND
4. Prescriber attests that requested medication will not be used with other ophthalmic VEGF inhibitors (i.e., aflibercept, pegaptanib, bevacizumab, brolucizumab, etc.)
AND
5. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to Ranibizumab include: ocular or periocular infections, known hypersensitivity to ranibizumab or any of the product excipients.]
AND
6. (a) IF THIS IS A PHARMACY BENEFIT REQUEST FOR A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or intolerance to a majority (not more than 3) of the preferred formulary alternatives for the given diagnosis. Documentation of medication(s) tried, dates of trial(s) and reason for treatment failure(s) is required.
AND
(b) If request is for reference product with a biosimilar available for initial or continuation of therapy requests: Documentation of a trial and failure, intolerance or contraindication to a majority (not more than 3) biosimilar product(s) is required (unless otherwise specified per applicable state regulations and/or there is data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs).
[DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was tried and the length of the trial period, Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache)]
OR
7. FOR INITIAL OR CONTINUATION OF THERAPY REQUESTS OF A PHYSICIAN ADMINISTERED MEDICATION: BIOSIMILAR DRUGS are preferred when requested as a physician administered drug per applicable state regulations and/or there is a lack of data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs. A reference medication is approved under the following conditions:
   a. Treatment with at least two (2) associated biosimilar drug(s) has been ineffective, not tolerated, or is contraindicated (i.e. an allergic reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR an adverse reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR therapeutic success while taking a non-preferred biologic product or biosimilar and therapeutic failure while taking the preferred biologic product or biosimilar documented by patient diary or medical charted notes)

   [DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was tried and the length of the trial period, Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache)]

CONTINUATION OF THERAPY:

A. FOR ALL INDICATIONS:

1. Reauthorization request is for the same eye(s) as initial authorization
   NOTE: The continuation of therapy criteria is only for the same previously treated eye(s). If member has

developed condition in an untreated eye, Prescriber must submit new request with Initial Coverage criteria.
AND

2. Documentation of improvement or stabilization of disease state and visual status [DOCUMENTATION REQUIRED]
   AND
3. Documentation of administration records showing dates and eye(s) administered, along with documentation of member compliance with treatment plan
   AND
4. Prescriber attests to or clinical reviewer has found no evidence of unacceptable toxicity from the drug (i.e., endophthalmitis and retinal detachments, increase in intraocular pressure or arterial thromboembolic events)
   AND
5. Prescriber attests that requested medication will not be used with other ophthalmic VEGF inhibitors (i.e., aflibercept, pegaptanib, bevacizumab, brolucizumab, etc.)

DURATION OF APPROVAL:
Initial: 6 months, Continuation: 12 months

PRESCRIBER REQUIREMENTS:
Prescribed by or in consultation with a board-certified ophthalmologist, ophthalmic surgeon or retinal specialist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:
18 years of age and older

QUANTITY:
Age-related macular degeneration (AMD), neovascular (wet): One eye: ONE injection per month; Up to TWELVE vials per year, Both eyes: TWO injections per month; Up to TWENTY-FOUR vials per year J2778/ Q5124 – 5 units/eye (0.5 mg) every 30 days
Diabetic macular edema (DME) [Lucentis, Cimerli Only]: Intravitreal: 0.3 mg once a month (approximately every 28 days); J2778 – 3 units/eye (0.3 mg) every 30 days
Diabetic retinopathy [Lucentis, Cimerli Only]: Intravitreal: 0.3 mg once a month (approximately every 28 days); J2778 – 3 units/eye (0.3 mg) every 30 days
Myopic choroidal neovascularization: One eye: ONE injection per month; Up to TWELVE vials per year, Both eyes: TWO injections per month; Up to TWENTY-FOUR vials per year
J2778/ Q5124 – 5 units/eye (0.5 mg) every 30 days
Macular edema following retinal vein occlusion: One eye: ONE injection per month; Up to TWELVE vials per year, Both eyes: TWO injections per month; Up to TWENTY-FOUR vials per year J2778 – 5 units/eye (0.5mg) every 30 days

PLACE OF ADMINISTRATION:
The recommendation is that injectable medications in this policy will be for pharmacy or medical benefit coverage and the intravitreal injectable products be administered in a place of service that is a non- hospital facility-based location.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Intravitreal injection

DRUG CLASS:
Vascular endothelial growth factor (VEGF) antagonists

FDA-APPROVED USES:
Lucentis (ranibizumab injection), Cimerli (ranibizumab-eqrn)
is indicated for the treatment of members with:
Neovascular (Wet) age-related macular degeneration, Macular edema following retinal vein occlusion, Diabetic macular edema, Diabetic retinopathy and Myopic choroidal neovascularization

Byooviz (ranibizumab-nuna)
Is indicated for the treatment of patients with:
Neovascular (Wet) Age-Related Macular Degeneration, Macular Edema Following Retinal Vein Occlusion, Myopic Choroidal Neovascularization

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
None

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Lucentis (ranibizumab), Byooviz (ranibizumab-nuna), and Cimerli (ranibizumab-eqrn) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy.
Contraindications to Lucentis (ranibizumab) and Byooviz (ranibizumab-nuna) and Cimerli (ranibizumab-eqrn) include: ocular or periocular infection, hypersensitivity

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

Note: 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

HCPCS CODE	DESCRIPTION
J2778	Injection, ranibizumab, 0.1 mg
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg

AVAILABLE DOSAGE FORMS:
Byooviz SOLN 0.5MG/0.05ML
Lucentis SOLN 0.5MG/0.05ML
Lucentis Prefilled Syringe0.3MG/0.05ML
Lucentis Prefilled Syringe 0.5MG/0.05ML
Cimerli INJ 0.3MG
Cimerli INJ 0.5MG

REFERENCES

1. Lucentis [package insert]. South San Francisco, CA: Genentech, Inc.; March 2018
2. Byooviz (ranibizumab-nuna) [package insert]. Cambridge, MA; Biogen, Inc. June 2022
3. Cimerli (ranibizumab-eqrn) [package insert]. Redwood City, CA; Coherus BioSciences. August 2022.
4. American Academy of Ophthalmology Retinal/Vitreous Panel. Preferred Practice Pattern Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; 2015. Available at: www.aao.org/ppp.
5. American Academy of Ophthalmology Retinal/Vitreous Panel. Preferred Practice Pattern Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology; 2015. Available at: www.aao.org/ppp.
6. Zhang G, Yang M, Zeng J, et al: Comparison of intravitreal injection of ranibizumab versus laser therapy for zone II treatment-requiring retinopathy of prematurity. Retina 2017; 37(4):710- 717.
7. Gunay M, Sukgen EA, Celik G, et al: Comparison of bevacizumab, ranibizumab, and laser photocoagulation in the treatment of retinopathy of prematurity in Turkey. Curr Eye Res 2017; 42(3):462-469.
8. Kabatas EU, Kurtul BE, Altiaylik Ozer P, et al: Comparison of intravitreal bevacizumab, intravitreal ranibizumab and laser photocoagulation for treatment of type 1 retinopathy of prematurity in Turkish preterm children. Curr Eye Res 2017; 42(7):1054-1058.
9. Rich RM, Rosenfeld PJ, Puliafito CA, et al. Short-term safety and efficacy of intravitreal bevacizumab (Avastin) for neovascular age-related macular degeneration. Retina 2006; 26:495- 511.
10. Avery RL, Pieramici DJ, Rabena MD, et al. Intravitreal bevacizumab (Avastin) for neovascular age-related macular degeneration. Ophthalmol 2006; 113:363-72
11. Solomon SD, Chew E, Duh EJ, et al. Diabetic retinopathy: a position statement by the American Diabetes Association. Diabetic Care 2017; 40:412-418.
12. Lushchyk T, Amarakoon S, Martinez-Ciriano JP, et al: Bevacizumab in age-related macular degeneration: a randomized controlled trial on the effect of injections every 4 weeks, 6 weeks and 8 weeks. Acta Ophthalmol 2013; 91(6):e456-e461.
13. Rajendram R, Fraser-Bell S, Kaines A, et al: A 2-year prospective randomized controlled trial of intravitreal bevacizumab or laser therapy (BOLT) in the management of diabetic macular edema: 24-month data: report 3. Arch Ophthalmol 2012; 130(8):972-979.
14. Gharbiya M, Giustolisi R, Allievi F, et al: Choroidal neovascularization in pathologic myopia: intravitreal ranibizumab versus bevacizumab--a randomized controlled trial. Am J Ophthalmol2010; 149(3):458-464.
15. Iacono P, Parodi MB, Papayannis A, et al: Intravitreal ranibizumab versus bevacizumab for treatment of myopic choroidal neovascularization. Retina 2012; 32(8):1539-1546.

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Title Required Medical Information Continuation of Therapy Quantity Other Special Considerations Available Dosage Forms References	Q4 2022
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Quantity FDA Approved Uses Coding/Billing Information Available Dosage Forms References	Q3 2022
Q2 2022 Established tracking in new format	Historical changes on file