



# Louisiana

## Intravitreal Corticosteroid Implants

**Policy #** 00549

**Original Effective Date:** 04/19/2017

**Current Effective Date:** 05/10/2021

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

### When Services Are Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member’s contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider a fluocinolone acetonide intravitreal implant 0.59 mg (Retisert®)‡ for the treatment of chronic noninfectious intermediate uveitis, posterior uveitis, or panuveitis to be **eligible for coverage.\*\***

Based on review of available data, the Company may consider a fluocinolone acetonide intravitreal implant 0.19 mg (Iluvien®)‡ for the treatment of diabetic macular edema in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure to be **eligible for coverage.\*\***

Based on review of available data, the Company may consider a fluocinolone acetonide intravitreal implant 0.18 mg (Yutiq™)‡ for the treatment of chronic noninfectious intermediate uveitis, posterior uveitis, or panuveitis to be **eligible for coverage.\*\***

### When Services May Be Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member’s contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider a dexamethasone intravitreal implant 0.7 mg (Ozurdex™)‡ to be **eligible for coverage.\*\***

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# Louisiana

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### Patient Selection Criteria

Coverage eligibility for a dexamethasone intravitreal implant 0.7 mg (Ozurdex) will be met when treating any of the following conditions:

- Noninfectious ocular inflammation, or uveitis, affecting the intermediate or posterior segment of the eye, OR
- Macular edema following branch or central retinal vein occlusion, OR
- Diabetic macular edema

## **When Services Are Considered Investigational**

*Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.*

Based on review of available data, the Company considers a fluocinolone acetonide intravitreal implant 0.59 mg (Retisert) or 0.19 mg (Iluvien) or 0.18 mg (Yutiq) OR dexamethasone intravitreal implant 0.7 mg (Ozurdex) when treating the following conditions, to be **investigational\***

- Age-Related Macular Degeneration
- Birdshot retinochoroidopathy
- Cystoid macular edema related to retinitis pigmentosa
- Idiopathic macular telangiectasia type 1
- Postoperative macular edema
- Circumscribed choroidal hemangiomas
- Proliferative vitreoretinopathy
- Radiation retinopathy

Based on review of available data, the Company considers all other uses of a corticosteroid intravitreal implants to be **investigational.\***

## **Background/Overview**

### **INTRAVITREAL IMPLANTS**

Intravitreal implants deliver a continuous concentration of drug to the eye over a prolonged period. Intravitreal corticosteroid implants are being studied for a variety of eye conditions that lead to macular edema, including uveitis, diabetic retinopathy, and retinal venous occlusions. The goal of

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therapy is to reduce inflammation in the eye while minimizing the adverse effects of the therapeutic regimen.

Selection of the route of corticosteroid administration (topical, systemic, periocular, or intraocular injection) is based on the cause, location, and severity of the disease. Each therapeutic approach has drawbacks. For example, topical corticosteroids require frequent (e.g., hourly) administration and may not adequately penetrate the posterior segment of the eye due to their poor ability to penetrate ocular tissues. Systemically administered drugs penetrate poorly into the eye because of the blood-retinal barrier, and high-dose or long-term treatments may be necessary. Long-term systemic therapies can be associated with substantial adverse effects such as hypertension and osteoporosis, while repeated (every 4-6 weeks) intraocular corticosteroid injections may result in pain, intraocular infection, globe perforation, fibrosis of the extraocular muscles, reactions to the delivery vehicle, increased intraocular pressure, and cataract development.

Corticosteroid implants are biodegradable or nonbiodegradable. Nonbiodegradable systems are thought to be preferable for treating chronic, long-term disease, while biodegradable products may be preferred for conditions that require short-term therapy. Although the continuous local release of steroid with an implant may reduce or eliminate the need for intravitreal injections and/or long-term systemic therapy, insertion or surgical implantation of the device carries risks, and the device could potentially increase ocular toxicity due to increased corticosteroid concentrations in the eye over a longer duration. With any route of administration, cataracts are a frequent complication of long-term corticosteroid therapy.

Intraocular corticosteroid implants being evaluated include:

- Retisert (nonbiodegradable fluocinolone acetonide intravitreal implant; Bausch & Lomb) is a sterile implant that consists of a tablet containing fluocinolone acetonide 0.59 mg, a synthetic corticosteroid that is less soluble in aqueous solution than dexamethasone. The tablet is encased in a silicone elastomer cup with a release orifice and membrane; the entire elastomer cup assembly is attached to a suture tab. Following implantation (via pars plana incision and suturing) in the vitreous, the implant releases the active drug at a rate of 0.3 to 0.4  $\mu\text{g}/\text{d}$  over 2.5 years.
- ILUVIEN (nonbiodegradable injectable intravitreal implant with fluocinolone acetonide; Alimera Sciences) is a rod-shaped device made of polyimide and polyvinyl alcohol. It is

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small enough to be placed using an inserter with a 25-gauge needle. It is expected to provide sustained delivery of fluocinolone acetonide for up to 3 years.

- Ozurdex (previously known as Posurdex; biodegradable dexamethasone intravitreal implant; Allergan, Irvine, CA) is composed of a biodegradable copolymer of lactic acid and glycolic acid with micronized dexamethasone. This implant is placed into the vitreous cavity through the pars plana using a customized, single-use, 22-gauge applicator. The implant provides intravitreal dexamethasone for up to 6 months. The mean number of Ozurdex injections reported in the literature is 4.2 injections per year, and more than 6 consecutive injections have been reported.
- Yutiq (non-biodegradable fluocinolone acetonide intravitreal implant, EyePoint Pharmaceuticals) contains 0.18 mg fluocinolone acetonide, designed to release 0.25 µg/d consistently over 36 months.

## EYE CONDITIONS

### Uveitis

Uveitis encompasses various conditions, of infectious and noninfectious etiologies, that are characterized by inflammation of any part of the uveal tract of the eye (iris, ciliary body, choroid). Infectious etiologies include syphilis, toxoplasmosis, cytomegalovirus retinitis, and candidiasis. Noninfectious etiologies include sarcoidosis, Behçet syndrome, and “white dot” syndromes such as multifocal choroiditis or “birdshot” chorioretinopathy. Uveitis may be idiopathic, have a sudden or insidious onset, a duration that is limited (<3 months) or persistent, and a course that may be acute, recurrent, or chronic.

The classification scheme recommended by the Uveitis Study Group and the Standardization of Uveitis Nomenclature (SUN) Working Group is based on anatomic location. Patients with anterior uveitis typically develop symptoms such as light sensitivity, pain, tearing, and redness of the sclera. In posterior uveitis, which comprises approximately 5% to 38% of all uveitis cases in the United States, the primary site of inflammation is the choroid or retina (or both). Patients with intermediate or posterior uveitis typically experience minimal pain, decreased visual acuity, and the presence of floaters (bits of vitreous debris or cells that cast shadows on the retina). Chronic inflammation associated with posterior segment uveitis can lead to cataracts and glaucoma and to structural damage to the eye, resulting in severe and permanent vision loss. The primary goal of therapy for uveitis is to preserve vision. Noninfectious uveitis typically responds well to corticosteroid treatment. Immunosuppressive therapy (e.g., antimetabolites, alkylating agents, T-cell inhibitors,

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tumor necrosis factor inhibitors) may also be used to control severe uveitis. Immunosuppressive therapy is typically reserved for patients who require chronic high-dose systemic steroids to control their disease. While effective, immunosuppressants may have serious and potentially life-threatening adverse effects, including renal and hepatic failure and bone marrow suppression.

### **Macular Edema After Retinal Vein Occlusion**

Retinal vein occlusions are classified by whether the central retinal vein or one of its branches is obstructed. Central retinal vein occlusion (CRVO) and branch retinal vein occlusion (BRVO) differ in pathophysiology, clinical course, and therapy. CRVOs are categorized as ischemic or nonischemic. Ischemic CRVOs are referred to as severe, complete, or total vein obstruction, and account for 20% to 25% of all CRVOs. Macular edema and permanent macular dysfunction occur in virtually all patients with ischemic CRVO, and in many patients with nonischemic CRVO. Intravitreal injections of triamcinolone are used to treat macular edema associated with CRVO, with a modest beneficial effect on visual acuity. The treatment effect lasts about 6 months, and repeat injections may be necessary. Cataracts are a common side effect, and steroid-related pressure elevation occurs in about one-third of patients, with 1% requiring filtration surgery.

BRVO is a common retinal vascular disorder in adults between 60 and 70 years of age and occurs approximately 3 times more often than CRVO. Macular photocoagulation with grid laser improves vision in BRVO but is not recommended for CRVO. Although intravitreal injections of triamcinolone have also been used for BRVO, the serious adverse effects have stimulated the evaluation of new treatments, including intravitreal steroid implants or the intravitreal injection of anti-vascular endothelial growth factor.

### **Diabetic Macular Edema**

Diabetic retinopathy is a common microvascular complication of diabetes and a leading cause of blindness in adults. The 2 most serious complications for vision are diabetic macular edema (DME) and proliferative diabetic retinopathy. At its earliest stage (nonproliferative retinopathy), microaneurysms occur. As the disease progresses, blood vessels that provide nourishment to the retina are blocked, triggering the growth of new and fragile blood vessels (proliferative retinopathy). Severe vision loss with proliferative retinopathy arises from leakage of blood into the vitreous. DME is characterized by swelling of the macula due to gradual leakage of fluids from blood vessels and breakdown of the blood-retinal barrier. Moderate vision loss can arise from the fluid accumulating in the center of the macula (macular edema) during the proliferative or nonproliferative stages of the

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# Louisiana

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Policy # 00549

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disease. Although proliferative disease is the main blinding complication of diabetic retinopathy, macular edema is more frequent and is the leading cause of moderate vision loss in people with diabetes.

Tight glycemic and blood pressure control is the first line of treatment to control diabetic retinopathy, followed by laser photocoagulation for patients whose retinopathy is approaching the high-risk stage. Although laser photocoagulation is effective at slowing the progression of retinopathy and reducing visual loss, it does not restore lost vision. Alternatives to intravitreal implants include intravitreal injection of triamcinolone acetonide, which is used as an off-label adjunctive therapy for DME. Angiostatic agents such as injectable vascular endothelial growth factor inhibitors, which block stages in the pathway leading to new blood vessel formation (angiogenesis), have demonstrated efficacy in DME.

### **Age-Related Macular Degeneration**

Age-related macular degeneration (AMD) is a degenerative disease of retina that results in loss of central vision with increasing age. Two distinctively different forms of degeneration, known as dry and wet, may be observed. The dry form (also known as atrophic or areolar) is more common and is often a precursor to the wet form (also known as exudative neovascular or disciform). The wet form is more devastating and characterized by serous or hemorrhagic detachment of the retinal pigment epithelium and development of choroidal neovascularization (CNV), which greatly increases the risk of developing severe irreversible loss of vision. CNV is categorized as classic or occult. Effective specific therapies for exudative or wet AMD are intravitreal injection of a vascular endothelial growth factor inhibitor, possibly thermal laser photocoagulation (in selected patients), and photodynamic therapy.

## **FDA or Other Governmental Regulatory Approval**

### **U.S. Food and Drug Administration (FDA)**

In June 2009, Ozurdex (dexamethasone 0.7 mg intravitreal implant; Allergan) was approved by the U.S. FDA for the treatment of macular edema following branch retinal vein occlusion or central retinal vein occlusion. Subsequently, in September 2010, the indication was expanded to include treatment of noninfectious uveitis affecting the posterior segment of the eye. In June 2014, the indication was again expanded to include treatment of diabetic macular edema.

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# Louisiana

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In September 2014, Iluvien (fluocinolone acetonide 0.19 mg intravitreal implant; Alimera Sciences) was approved by FDA for the treatment of diabetic macular edema in patients previously treated with a course of corticosteroids and without a clinically significant rise in intraocular pressure.

In November 2014, Retisert (fluocinolone acetonide 0.59 mg intravitreal implant; Bausch & Lomb) was approved by FDA for the treatment of chronic noninfectious uveitis affecting the posterior segment of the eye.

In October 2018, Yutiq (fluocinolone acetonide 0.18 mg intravitreal implant; EyePoint Pharmaceuticals) was approved by FDA for the treatment of chronic noninfectious uveitis affecting the posterior segment (intermediate, posterior, and panuveitis) of the eye.

## **Rationale/Source**

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, Blue Cross and Blue Shield Association technology assessment program (TEC) and other non-affiliated technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

## **NONINFECTIOUS UVEITIS**

### **Intravitreal Fluocinolone Acetonide Implant (0.59 mg)-Retisert**

#### **Pivotal Trials**

Two double-blind, randomized trials were conducted in patients with chronic ( $\geq 1$ -year history) noninfectious uveitis affecting the posterior segment of 1 or both eyes. The primary efficacy end point in both trials was the rate of recurrence of uveitis. These trials randomized patients to a fluocinolone acetonide 0.59-mg or to 2.1-mg implant. In 2004, the FDA approved only the 0.59-mg dose and its approval was based on comparison of rates of recurrence of uveitis affecting the posterior segment of the study eye in the 34-week period postimplantation compared to the rates of recurrence in the 34-week period preimplantation. Data from 224 patients were included. Subsequently, FDA reported recurrence rates 1, 2, and 3 years postimplantation. Results are summarized in Table 1.

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# Louisiana

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Original Effective Date: 04/19/2017

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**Table 1. Summary of Results From the FDA Pivotal Trial in Noninfectious Posterior Uveitis**

Time Point	Uveitis Recurrence Rates, n (%) <sup>a,b</sup>	
	Study 1 (n=108)	Study 2 (n=116)
34 weeks preimplant	58 (53.7%)	46 (39.7%)
34 weeks postimplant	2 (1.8%)	15 (12.9%)
1 year postimplant	4 (3.7%)	15 (12.9%)
2 year postimplant	11 (10.2%)	16 (13.8%)
3 year postimplant	22 (20.4%)	20 (17.2%)
3 year postimplant <sup>c</sup>	33 (30.6%)	28 (24.1%)

FDA: Food and Drug Administration.

<sup>a</sup> Recurrence of uveitis for all postimplantation time points was compared to the 34-week preimplantation time point.

<sup>b</sup> P<0.01.

<sup>c</sup> Results presented include imputed recurrences. Recurrences were imputed when a subject was not seen within 10 wk of his or her final scheduled visit.

Results of 1 of the 2 pivotal trials were reported by Jaffe et al (2006). These trials are not discussed in detailed because the comparator was a nonapproved dose of fluocinolone acetonide. Briefly, the 2 trials randomized 278 patients and 239 patients to a fluocinolone acetonide 0.59-mg or 2.1-mg implant, respectively. Pooled data from both doses in the first trial showed a reduction in recurrence rates in implanted eyes compared with an increase in recurrence in nonimplanted eyes. An increase (≈6 mm Hg) in intraocular pressure (IOP) and cataracts were observed in implanted eyes compared to nonimplanted eyes. The second trial was not published and results reported in FDA documents are similar to the first trial.

### Additional Randomized Controlled Trials (RCTs)

Pavesio et al (2010) reported results of an industry-sponsored, open-label trial in which 140 patients with chronic noninfectious posterior uveitis were randomized to the fluocinolone acetonide 0.59-mg implant (n=66) or systemic corticosteroid therapy (and immunosuppression when indicated; n=74). To be included in the trial, subjects had to have at least a 1-year history of recurrent uveitis. The primary efficacy outcome was time to first recurrence of uveitis. Patients in whom tapering of adjunctive anti-inflammatory therapy was insufficient despite receiving the implant were referred to as imputed or inferred failures. Results were therefore presented as both true recurrences and true plus inferred recurrences. When inferred recurrences were censored (11 subjects removed from the

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

at-risk population), Kaplan-Meier analysis showed a significant decrease in the time to uveitis recurrence (6.3 months for 12 failures vs 7.0 months for 44 failures). When all subjects were included in the analysis, time to uveitis recurrence did not differ statistically ( $p=0.07$ ). The relative risk (RR) of recurrence of uveitis was reduced by 71% with implants compared to standard therapy (RR=0.29; 95% confidence interval [CI], 0.14 to 0.59; 132 eyes). Secondary efficacy outcomes included visual acuity improvement. Visual acuity in the implant group decreased after the surgery and again in the 15- to 18-month interval as a result of cataracts, then returned to baseline levels at 24 months, following extraction of the cataracts. Visual acuity in the systemic corticosteroid group remained consistent over the 2-year study.

The MUST Trial, sponsored by the National Eye Institute, is a partially blind RCT (N=255) designed to compare visual acuity at 2 years with fluocinolone acetonide implants to systemic corticosteroid therapy (and immunosuppression when indicated) in patients with intermediate, posterior, or panuveitis.<sup>8</sup> Assessment of the primary outcome measure of best-corrected visual acuity (BCVA) using the Early Treatment Diabetic Retinopathy Study (ETDRS) chart was blinded. After 24 and 54 months of follow-up, the vision improvement from baseline in the implant groups compared to systematic therapy group was not statistically significant (+6.0 and +3.2 letters,  $p=0.16$ ; +2.4 and 3.1 letters;  $p=0.073$ , respectively). Notably, approximately 21% of patients in the systemic group had received an implant by 54 months. At 24 and 54 months, the proportion of patients with a minimally important improvement did not differ significantly for any of the quality of life metrics (results not shown). Patients receiving systemic therapy (in which corticosteroid-sparing immunosuppressive therapy was used to minimize ongoing use of prednisone to <10 mg/d for the large majority of patients) was associated with relatively little additional systemic morbidity compared with implant therapy. Systemic adverse events were infrequent in both groups. At 2 years, the proportion of patients with systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg at any visit was lower in the implant group than in the systemic group (13% vs 27%; hazard ratio [HR], 0.44;  $p=0.030$ ), but the rate of antihypertensive treatment initiation did not differ substantially between the 2 groups (5% vs 11%; hazard ratio [HR], 0.40;  $p=0.13$ ), respectively. The incidences of other adverse systemic outcomes, including hyperlipidemia, diabetes, osteoporosis, fractures, and blood count/chemistry abnormalities, were not statistically distinguishable between groups (data not shown). Weight was stable over time in both groups.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

### Systematic Reviews

Brady et al (2016) reported results of a Cochrane review of RCTs comparing fluocinolone acetonide or dexamethasone intravitreal implants with standard therapy with at least 6 months of follow-up posttreatment. The primary outcome was recurrence of uveitis. Included trials enrolled patients of all ages who had chronic noninfectious posterior uveitis, intermediate uveitis, or panuveitis with vision that was “better than hand motion.” Two trials, Pavesio et al (2010) and Kempen et al (2011), were included and judged to be of moderate quality (both are discussed above). Because the 2 studies were designed to answer different questions (1 measured recurrence, 1 visual acuity), reviewers did not combine efficacy data. However, they did perform a meta-analysis of common side effects, which showed increased risks of needing cataract surgery (RR=2.98; 95% CI, 2.33 to 3.79; 371 eyes) and surgery to lower IOP (RR=7.48; 95% CI, 3.94 to 14.19; 599 eyes) in the implant group compared with the standard therapy group through 2 years of follow-up. Reviewers were unable to conclude that the implants were superior to traditional systemic therapy for the treatment of noninfectious uveitis.

### Subsection Summary: Intravitreal Fluocinolone Acetonide Implant (0.59 mg) for Noninfectious Uveitis

Four RCTs have established the efficacy of fluocinolone acetonide implants (0.59 mg) for patients with noninfectious intermediate or posterior uveitis. Two of the 4 RCTs compared 2 doses of implants and 2 trials compared implants with systemic steroids (and immunosuppression when indicated). All trials supported the efficacy of fluocinolone acetonide intravitreal implants in preventing recurrence and improving vision over a 4-year follow-up. The head-to-head trial comparing implants with systemic corticosteroids did not show substantial superiority in the overall effectiveness of either approach. The major limitation of these implants is nearly all phakic patients will develop cataracts and will require cataract surgery. Further, most will also develop glaucoma, with 75% patients requiring IOP-lowering medications and 35% requiring filtering surgeries.

### Intravitreal Dexamethasone Implant (0.7 mg)-Ozurdex

The evidence for dexamethasone intravitreal implants consists of 1 pivotal, double-blind RCT (HURON). In this 8-week, manufacturer-sponsored, multicenter trial (46 study sites in 18 countries), 229 patients with noninfectious intermediate or posterior uveitis were randomized to 0.7-mg implants (n=77), 0.35-mg implants (n=76), or sham procedure (n=76). The primary outcome measure was the proportion of eyes with a vitreous haze score of 0 (0 = no inflammation) at week 8. At baseline, the mean vitreous haze score was approximately +2 (moderate blurring of the optic

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Policy # 00549

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Current Effective Date: 05/10/2021

nerve head). At 8 weeks posttreatment, the proportion of eyes with a vitreous haze score of 0 was 47% with the 0.7-mg implant and 12% with the sham procedure. At 8 weeks, visual acuity, as assessed by gain of 15 or more letters in BCVA from baseline, was achieved by 40% of patients who received implants compared to 10% who received sham control. The incidences of elevated IOP ( $\geq 25$  mm Hg) and cataracts in phakic eyes were higher in 0.7-mg implant-treated eyes versus sham control eyes (7.1% vs 4.2% and 15% vs 7%, respectively). Unlike the fluocinolone acetonide 0.59-mg implant, the long-term efficacy and safety data for the dexamethasone 0.7-mg implant is not available. Lightman et al (2013) reported 26-week data for vision-related functioning using National Eye Institute-Visual Function Questionnaire (NEI-VFQ) from HURON trial. Using the distribution- and anchor-based methods, the authors reported that a clinically meaningful change for the NEI VFQ-25 composite score was 3.86 and 10 points, respectively. Others have reported that range changes of 2.3 to 3.8 units in the composite score are meaningful. In the HURON trial, the proportion of patients with a 5 or more point improvement in composite score at week 26 was 58% (42/73) in the 0.7-mg implant group versus 32% (24/74) in the sham-controlled arm ( $p < 0.05$ ).

### **Subsection Summary: Intravitreal Dexamethasone Implant (0.7 mg) for Noninfectious Uveitis**

One RCT comparing 2 doses of implants with sham-control has supported the efficacy of dexamethasone implants (0.7 mg) for patients with noninfectious intermediate or posterior uveitis. Results of this trial have demonstrated the efficacy of the dexamethasone 0.7-mg implant in reducing inflammation and resulted in clinically meaningful improvements in vision at week 8 compared to sham controls. Further, at week 26, patients treated with implants reported meaningful improvements in vision-related functioning. The major limitation of this trial was its lack of long-term follow-up. Further, as a class effect, use of dexamethasone implants resulted in higher incidences of cataracts and elevated IOP.

### **Intravitreal Fluocinolone Implant (0.18) mg- Yutiq**

The efficacy of intravitreal fluocinolone acetonide implant 0.18 mg was assessed in two randomized (2:1, intravitreal fluocinolone acetonide implant 0.18 mg: sham-injection), multi-center, double-masked, parallel-groups studies that enrolled patients with noninfectious uveitis affecting the posterior segment of the eye. The primary efficacy endpoint in both trials was the proportion of patients who experienced a recurrence of uveitis in the study eye within 6 months of follow-up; recurrence was also assessed at 12 months. Recurrence of uveitis was defined as either deterioration in visual acuity, vitreous haze attributable to non-infectious uveitis or the need for rescue medications. In study 1, 16/87 subjects (18%) treated with intravitreal fluocinolone acetonide

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

implant 0.18 mg had a recurrence of uveitis within 6 months vs. 33/42 (79%) of subjects in the sham group. In study 2, 22/101 subjects (22%) treated with intravitreal fluocinolone acetonide implant 0.18 mg had a recurrence of uveitis within 6 months of follow-up vs. 28/52 (54%) in the sham group. In study 1, 24/87 subjects (28%) treated with intravitreal fluocinolone acetonide implant 0.18 mg had a recurrence of uveitis within 12 months vs. 36/42 (86%) of subjects in the sham group. In study 2, 33/101 subjects (33%) treated with intravitreal fluocinolone acetonide implant 0.18 mg had a recurrence of uveitis within 12 months of follow-up vs. 31/52 (60%) in the sham group.

### **Subsection Summary: Intravitreal Fluocinolone Implant (0.18 mg) for Noninfectious Uveitis**

Two clinical trials demonstrated efficacy for the use of fluocinolone acetonide 0.18 mg intravitreal implants for the treatment of non-infectious uveitis in the posterior segment of the eye.

### **MACULAR EDEMA AFTER RETINAL VEIN OCCLUSION**

In 2015, the American Academy of Ophthalmology (AAO) published a technology assessment on therapies for macular edema associated with CRVO. AAO identified 4 clinical trials that provided level I evidence supporting the use of anti-vascular endothelial growth factor (anti-VEGF) pharmacotherapies and 2 clinical trials providing level I evidence for intravitreal corticosteroid injection with the dexamethasone intravitreal implants or triamcinolone. Evidence on the safety and efficacy of other reported interventions was of lesser strength. The assessment noted that evidence on long-term efficacy of corticosteroid treatments is limited and that intravitreal corticosteroids led to a higher frequency of adverse events, including cataracts and IOP elevation compared with anti-VEGF treatments. There was limited information on combination therapy with anti-VEGF and corticosteroid injections compared with monotherapy.

A Bayesian network meta-analysis of the efficacy and safety of treatments for macular edema secondary to BRVO was published in 2015. A total of 8 RCTs (total N=1743 patients) were included; patients were treated with ranibizumab given as needed, aflibercept monthly, dexamethasone implant, laser photocoagulation, ranibizumab plus laser, or sham intervention. The probability of being the most efficacious treatment, based on letters gained, or for a gain 15 letters or more, was highest for monotherapy of anti-VEGF treatments (30%-54% probability), followed by ranibizumab plus laser, and lowest (0%-2% probability) for the dexamethasone implant, laser, or sham treatment. Treatment with ranibizumab resulted in an average increase of 8 letters compared with the dexamethasone implant. Patients treated with the dexamethasone implant had statistically significant higher rates of ocular hypertension than patients given anti-VEGF monotherapy (odds ratio, 13.1).

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

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### **Intravitreal Dexamethasone Implant (0.7 mg)-Ozurdex**

Data presented to FDA for the dexamethasone intravitreal implant (Ozurdex) were from two, 6-month, double-masked RCTs called GENEVA (167 clinical sites in 24 countries). A 6-month open-label extension of these 2 pivotal trials was reported in 2011. A total of 1267 patients who had clinically detectable macular edema associated with either CRVO or BRVO were randomized to a single treatment with a dexamethasone 0.7-mg implant (n=427), dexamethasone 0.35-mg implant (n=414), or sham control (n=426). The primary outcome measure was time to achieve a 15-or-more letter improvement in BCVA. A secondary outcome was the proportion of eyes achieving a 15-or-more letter improvement from baseline at 180 days. In individual studies as well as pooled analysis, time to achieve a 15-or-more letter (3-line) improvement in BCVA was significantly faster with implants than with sham (p<0.01) (data not shown). As evident from Table 2, the proportion of patients with a 15-or-more letter improvement from baseline in BCVA was higher in the implant with the FDA-approved dose (0.7 mg) compared to sham for the first 3 months. There was no significant difference in the proportion of patients who improved by 15 letters or more at 6-month follow-up. Note that the implant lasts for 6 months.

**Table 2. Summary of Results From the FDA Pivotal Trial in Retinal Vein Occlusion**

Time Point	N (%) of Patients With ≥15 Letters Improvement From Baseline in BCVA					
	Study 1			Study 2		
	Implant (0.7 mg)	Sham	p	Implant (0.7 mg)	Sham	p
Day 30	40 (20%)	15 (7%)	<0.01	51 (23%)	17 (8%)	<0.01
Day 60	58 (29%)	21 (10%)	<0.01	67 (30%)	27 (12%)	<0.01
Day 90	45 (22%)	25 (12%)	<0.01	48 (21%)	31 (14%)	0.039
Day 180	39 (19%)	37 (18%)	0.780	53 (24%)	38 (17%)	0.087

BCVA: best-corrected visual acuity; FDA: Food and Drug Administration.

### **Intravitreal Fluocinolone Acetonide Implant (0.59 mg)-Retisert**

No RCTs were identified with fluocinolone acetonide implants for the treatment of macular edema following retinal vein occlusion.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

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### **Additional RCTs**

Kuppermann (2007) reported results for an RCT in which 315 patients with persistent macular edema of different etiology (diabetic retinopathy [n=172], BRVO [n=60], CRVO [n=42], uveitis [n=14], or post-cataract surgery macular edema [n=27]) were assigned to the dexamethasone 0.35-mg implant, the dexamethasone 0.7-mg implant, or observation. At 6 months, the proportion of patients meeting the primary outcome of an improvement in visual acuity of 10 letters was 24%, 35% and 13% in 0.35-mg implants, 0.7-mg implants, and observation-only groups, respectively. In a small trial in 50 patients, Pichi et al (2014) found that the combination of dexamethasone 0.7-mg intravitreal implants plus macular grid laser increased both visual acuity and the interval between repeated implants. Gado and Macky (2014; n=60) reported no significant differences in visual acuity outcomes between dexamethasone implants and bevacizumab. Maturi et al (2014) reported results for 30 patients randomized to dexamethasone implants plus bevacizumab or to bevacizumab monotherapy and found no additional benefit for visual acuity with the combination treatment at 6 months.

### **Subsection Summary: Intravitreal Dexamethasone Implant (0.7 mg) for Macular Edema After Retinal Vein Occlusion**

Two identical RCTs have established the efficacy of dexamethasone intravitreal implants (0.7 mg) for patients with macular edema following retinal vein occlusion. The 2 RCTs compared 2 doses of implants with a sham control. Compared to sham, both doses of the dexamethasone implant resulted in clinically meaningful improvements in visual acuity within 1 to 3 months postimplantation. Further, implant-treated patients achieved improvement in vision faster than the sham controls. However, the vision gain was similar at 6 months. Other small RCTs with shorter follow-up have demonstrated that the combination of implants with macular grid laser may increase the interval between repeated implants. Further, as a class effect, use of dexamethasone implants resulted in higher incidences of cataracts and elevated IOP.

### **DIABETIC MACULAR EDEMA**

A 2008 Cochrane review evaluated the efficacy of intravitreal steroids for macular edema in diabetes. Seven studies, involving 632 eyes with DME, were included. Four trials examined the effectiveness of intravitreal triamcinolone acetate injection, and 3 examined intravitreal steroid implantation with fluocinolone acetonide (Retisert) or the dexamethasone drug delivery system (the 2007 trial by Kuppermann previously described). Cochrane reviewers concluded that steroids placed inside the eye by intravitreal injection or surgical implantation may improve visual outcomes in eyes

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

with persistent or refractory DME. However, questions remained whether intravitreal steroids could be of value in other (earlier) stages of DME or in combination with other therapies, such as laser photocoagulation.

### **Intravitreal Fluocinolone Acetonide Implant (0.59 mg)-Retisert**

In 2011, Pearson et al reported on the 3-year efficacy and safety results of an industry-sponsored, single-blind (evaluator) RCT in which 196 patients with persistent or recurrent unilateral or bilateral DME (referred to as refractory DME) were randomized to implants (n=127) or standard of care, defined as additional laser as needed after 6 months or observation (n=69). All patients had received focal/grid laser photocoagulation prior to randomization. At 6 months, the proportions of patients who received laser retreatment in implant and standard of care groups were 4% and 13%, respectively; the percentages after 3 years of follow-up were 15% and 41%, respectively. The primary efficacy outcome ( $\geq 15$ -letter improvement in BCVA at 6 months before any additional laser treatment) was achieved in 16.8% of implanted eyes versus 1.4% of standard of care eyes ( $p < 0.05$ ). Between 6 and 24 months, visual acuity was statistically significant in favor of the implant group but not beyond 30 months. At 3 years, there was no significant differences between the groups (eg, 31.1% of implanted eyes vs 20.0% of standard of care eyes improved  $\geq 15$  letters at 3 years). As expected, there were higher incidences of elevated IOP ( $\geq 30$  mm Hg; 61.4% vs 5.8%), need for surgery to treat glaucoma (33.8% vs 2.4%), and cataracts extraction in phakic eyes (91% vs 20%), respectively, for eyes treated with implants compared to standard of care. The incidence of vitreous hemorrhage (40.2% vs 18.8%), pruritus (38.6% vs 21.7%), and abnormal sensation in the eye (37.0% vs 11.6%), respectively, were also higher in the eyes treated with implants versus standard of care.

### **Subsection Summary: Intravitreal Fluocinolone Acetonide Implant (0.59 mg) for Diabetic Macular Edema**

One RCT comparing fluocinolone acetonide implants (0.59 mg) with standard of care (as needed laser or observation) has supported the efficacy of implants for patients with DME. The primary efficacy outcome, at least a 15-letter improvement in BCVA was significantly improved in a greater proportion of patients given implants versus laser at all time points assessed, except at or beyond 30 months. Note that this implant is active for 30 months. As a class effect, in patients with phakic eyes, use of implants resulted in 90% requiring cataract surgery and 60% developing elevated IOP. Due to the substantial increase in adverse events and availability of agents with safer tolerability profiles (eg, VEGF inhibitors), this implant is not indicated for DME.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

### **Intravitreal Fluocinolone Acetonide Implant (0.19 mg)-ILUVIEN**

Two double-blind, randomized trials (FAME) has assessed patients with DME previously treated with laser photocoagulation. The primary efficacy end point of both trials was the proportion of subjects in whom vision had improved by 15 letters or more at 2 years from baseline. These trials randomized patients to fluocinolone acetonide 0.19-mg or 0.5-mg implants or to sham. Results of these trials were published by Campochiaro et al (2011). In 2014, FDA approved the 0.19-mg dose only based on similar efficacy at 2 years between the low and high dose in improving vision by 15 letters or more from baseline (data not shown). Relevant results with FDA-approved dosing are summarized in Table 3. Subsequently, 3-year results were reported in 2012. The percentage of patients who gained 15 letters or more using the last observation carried forward was 28.7% in the implant group and 18.9% in the sham group. Results of sensitivity analysis without imputation for missing data ( $\approx 70\%$  follow-up) showed similar results; the percentages of patients who gained 15 letters or more in the 2 groups were 33.0% and 21.4%, respectively. Subgroup analysis showed greater improvement in visual acuity in patients who were pseudophakic compared to those who were phakic (difference in mean change in number of letters at 2 years from baseline was 5.6 in pseudophakic patients vs 1 letter in phakic patients). This was due to loss of vision as a result of cataracts in phakic eyes that was observed more frequently in eyes with implants versus sham controls. Subgroup analysis also showed greater efficacy in patients with chronic ( $\geq 3$  years) compared with nonchronic ( $< 3$  years) DME. The difference in the proportion of patients who gained 15 or more letters in the implant group versus the sham control group with chronic DME patients was 21% and -5.5 % among nonchronic DME patients.

**Table 3. Summary of Results (2 Years) From the FDA Pivotal Trials in Diabetic Macular Edema**

Outcome	Study 1 (N=285)			Study 2 (N=276)		
	Implant (n=190)	Sham (n=95)	Difference (95% CI)	Implant (n=186)	Sham (n=90)	Difference (95% CI)
↑ 15 letters	51 (27%)	14 (15%)	12.1% (2.6% to 21.6%)	57 (31%)	16 (18%)	13.0% (2.7% to 23.4%)
↓ 15 letters	26 (14%)	5 (5%)	8.4% (1.8% to 15.1%)	22 (12%)	9 (10%)	1.8% (-5.9% to 9.6%)

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

CI: confidence interval; FDA: Food and Drug Administration.

Massin et al (2016) reported the results of a small prospective noncomparative study in 16 patients with DME insufficiently responsive to laser and anti-VEGF who received fluocinolone acetonide 0.19-mg implants. Two groups of patients were evaluated—group 1 (n=6) included patients ineligible anti-VEGF therapy who received previous treatment with laser photocoagulation while group 2 (n=10) included patients previously treated with laser photocoagulation and at least 3 monthly anti-VEGF treatments. Central subfield thickness was reduced by -299  $\mu\text{m}$  in group 1 and -251  $\mu\text{m}$  in group 2 at 12 months. Mean change in area under the curve from baseline to last value for all eyes was +4.2 letters in group 1 and +3.9 letters in group 2. The benefit in BCVA letter score was more limited and heterogeneous (the effect was more pronounced in pseudophakic eyes) with some patients achieving high improvements of visual acuity, whereas others did not improve. Small number of patients and lack of a control arm limit the interpretation of these findings.

### **Subsection Summary: Intravitreal Fluocinolone Acetonide Implant (0.19 mg) for Diabetic Macular Edema**

Two RCTs have established the efficacy of fluocinolone acetonide implants (0.19 mg) for patients with DME. Both trials demonstrated the superiority of implants over sham controls. Implant-treated eyes showed clinically meaningful improvement in vision at 2 and 3 years postimplant. Subgroup analysis showed greater improvements in visual acuity in patients who were pseudophakic compared to those who were phakic. The major limitation of these implants is that nearly 80% all phakic patients will develop cataracts and will require cataract surgery. Further, IOP was elevated in 34% of patients who received this implant compared with 10% of controls, leading to the restricted indication for patients previously treated with corticosteroids who do not have a clinically significant rise in IOP.

### **Intravitreal Dexamethasone Implant (0.7 mg)-Ozurdex**

Two double-blind, randomized trials have assessed patients with DME. These trials randomized patients to a 0.7-mg or to a 0.35-mg implant or to a sham procedure. Retreatment was allowed if it was at least 6 months since the prior treatment and there was evidence of residual edema. The primary efficacy end point in both trials was the proportion of subjects in whom visual acuity had improved by 15 or more letters at 39 months from baseline or at the final visit for patients who exited the study at or prior to month 36. The month 39 extension was included to accommodate the evaluation of safety and efficacy outcomes for patients who received retreatment at month 36.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

Results of these trials were published by Boyer et al (2014). In 2014, FDA approved the 0.7-mg dose. Relevant results with FDA-approved dosing are summarized in Table 4. Only 14% of study patients completed the month 39 visit (16.8% from implant, 12.2% from sham). The visual acuity improvement from baseline increased during a treatment cycle, peaked at 3 months posttreatment and diminished thereafter (data not shown). This was due to loss of vision related to development of cataracts. Subgroup analysis showed greater improvements in visual acuity in patients who were pseudophakic than in those who were phakic (difference in mean change in number of letters at 39 months from baseline was 4.2 letters in pseudophakic patients vs 0.3 letters in phakic patients).

**Table 4. Summary of 39-Month Results From the FDA Pivotal Trials in Diabetic Macular Edema**

Outcome	Study 1 (N=328)			Study 2 (N=328)		
	Implant (n=163)	Sham (n=165)	Difference (95% CI)	Implant (n=165)	Sham (n=163)	Difference (95% CI)
↑ 15 letters	34 (21%)	19 (12%)	9.3% (1.4% to 17.3%)	30 (18%)	16 (10%)	13.0% (2.7% to 23.4%)
↓ 15 letters	15 (9%)	17 (10%)	-1.1% (-7.5% to 5.3%)	30 (18%)	18 (11%)	7.1% (-0.5% to 14.7%)

CI: confidence interval ; FDA: Food and Drug Administration.

The BEVORDEX trial compared bevacizumab with dexamethasone implants in a randomized trial of 86 patients with DME. Forty-six received bevacizumab every 4 weeks and 46 eyes received a dexamethasone implant every 16 weeks as needed. Results after 12 months of follow-up were reported. Although the primary end point of improvement in BCVA of 10 or more letters was similar for both groups (40% of the bevacizumab-treated eyes vs 41% of the dexamethasone-treated eyes), the proportion of patients with vision loss of more than 10 letters was higher in the eyes dexamethasone-treated eyes (10.9%) than in bevacizumab-treated eyes 0%). The dexamethasone implant reduced mean central macular thickness more than bevacizumab (187 μm vs 122 μm; p=0.015), but led to a greater number of adverse events, including IOP elevation of 10 mm Hg or more (19.6% vs 0%) and cataracts (13% vs 4.8%), respectively. Other studies have shown an increase in cataracts predominantly in the second year of treatment with the dexamethasone implant.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

### **Subsection Summary: Intravitreal Dexamethasone Implant (0.7 mg) for Diabetic Macular Edema**

Two identical RCTs have established the efficacy of dexamethasone intravitreal implants (0.7 mg) for patients with DME. The 2 RCTs compared 2 doses of implants with a sham control. Compared to sham, both doses of the dexamethasone implant resulted in clinically meaningful improvements in visual acuity at 39 months postimplantation. The visual acuity improvement peaked at 3 months posttreatment but diminished thereafter, possibly due to development of cataracts. Subgroup analysis showed greater improvements in visual acuity in patients who were pseudophakic than in those who were phakic. One small RCT with 1-year follow-up has demonstrated similar rates of success on the primary end point; however, more implant-treated patients experienced vision loss of at least 10 letters and greater frequency of side effects (eg, cataracts, elevated IOP) compared to bevacizumab.

### **AGE-RELATED MACULAR DEGENERATION**

#### **Intravitreal Dexamethasone Implant (0.7 mg) Plus Anti-VEGF Therapy- Ozurdex**

Kuppermann et al (2015) reported the results of industry-sponsored, single-masked, sham-controlled, randomized trial in which 243 patients with choroidal neovascularization secondary to AMD were allocated to dexamethasone implants (n=123) or a sham procedure (n=120). All patients received 2 protocol-mandated intravitreal ranibizumab injections with the next injection given as needed based on established study criteria. The primary efficacy end point was the ranibizumab injection-free interval at 6 months. The median injection-free survival was 34 days in the implant group and 29 days in the sham control group. Though this difference was statistically significant (p=0.016), the effect size was small and clinically insignificant. The proportions of patients who did not require rescue ranibizumab over the 6-month study period were 8.3% the implant group and 2.5% in the sham group (p=0.048). There were no significant differences between groups in mean change from baseline BCVA. More patients in the dexamethasone implant group had increased IOP (13.2% vs 4.2%; p=0.014), but there were no differences between groups in cataracts-related events. Notably, the trial had a short follow-up (6 months).

### **Section Summary: Intravitreal Dexamethasone Implant (0.7 mg) Plus Anti-VEGF Therapy for Age-Related Macular Degeneration**

One RCT evaluated the impact of adding implants to a standard VEGF inhibitor for patients with AMD. Results of this trial failed to demonstrate clinically meaningful reductions in the ranibizumab injection-free interval. Further, there was an IOP elevation in greater proportion of patients receiving implants without any additional clinical benefit.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

### **OTHER CONDITIONS**

#### **Birdshot Retinochoroidopathy**

Birdshot retinochoroidopathy, also known as birdshot chorioretinopathy or vitiliginous chorioretinitis, is a chronic, bilateral rare form of posterior uveitis with characteristic hypopigmented lesions. No RCTs were identified for the treatment of this indication for any corticosteroids intravitreal implants. Bajwa et al (2014) published a retrospective case series involving 11 patients (11 eyes) refractory or intolerant to conventional immunomodulatory therapy who received fluocinolone acetonide implants (0.59 mg). Reported outcomes were disease activity markers. The proportion of patients with intraocular inflammation was 55% at baseline, which decreased to 10%, 11%, and 0% at year 1, 2, and 3, respectively. Active vasculitis was noted in 36.3% patients at baseline and 0% at 3-year follow-up. More than 20% reduction in central retinal thickness was noted in all patients with cystoid macular edema at 6 months, 1 year, 2 years, and 3 years postimplant. Another retrospective cohort study (2015) that included 11 eyes with birdshot chorioretinitis reported improved control of inflammation and decreased reliance on adjunctive therapy with fluocinolone acetonide implants (0.59 mg). Authors observed a more robust increase in IOP compared to the observed elevation in patients with other types of posterior uveitis and panuveitis. Results of another retrospective study by Rush et al (2011), which included 32 eyes with birdshot chorioretinopathy who received fluocinolone acetonide implant (0.59 mg) with 12-month follow-up, also reported decrease in vitreous haze from 26% at baseline to 100% at 12 months. In 2 small retrospective studies with 6 eyes in 3 patients and 6 eyes in 4 patients, respectively, reported the favorable effects of dexamethasone implants on ocular inflammation and macular edema during treatment. All eyes exhibited control of ocular inflammation and macular edema. In the first study, all 3 patients achieved BCVA of at least 20/25 during treatment. In the second, there was a mean improvement of 70 letters on BCVA using the EDTRS chart.

#### **Section Summary: Birdshot Retinochoroidopathy**

No RCTs were identified on the treatment of birdshot retinochoroidopathy with any corticosteroids intravitreal implants. Available evidence includes multiple observational studies that noted improvements in anatomic and visual acuity outcomes in patients refractory or intolerant to current standard of treatment. Long-term follow-up for efficacy and safety is limited. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in refractory or intolerant patients with birdshot retinopathy.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

### **Cystoid Macular Edema Related to Retinitis Pigmentosa**

Retinitis pigmentosa is a degenerative process of the retina affecting primarily the rod photoreceptors and retinal pigment epithelium. Many studies have shown a prevalence of cystoid macular edema in 10% to 15% of patients with retinitis pigmentosa. No RCTs were identified on the treatment of this indication for any corticosteroids intravitreal implants. Multiple case reports describing the use of dexamethasone implants in 8 patients with macular edema as a consequence of retinitis pigmentosa have been published. All case reports have short follow-up (<1 year) and a few lacked complete description of benefit. Overall, these reports found mixed improvements on various anatomic and functional outcomes with transient benefits to complete recovery of cystoid macular edema.

#### **Section Summary: Cystoid Macular Edema Related to Retinitis Pigmentosa**

No RCTs were identified on the treatment of cystoid macular edema with any corticosteroids intravitreal implants. Available evidence includes multiple case reports that have noted mixed results for anatomic and visual acuity outcomes. Long-term follow-up for efficacy and safety is limited. Larger RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with cystoid macular edema related to retinitis pigmentosa.

### **Idiopathic Macular Telangiectasia Type 1**

Type 1 macular telangiectasia is a rare congenital and unilateral condition of the eye in which a focal expansion or outpouching and dilation of capillaries in the parafoveal region leads to vascular incompetence, atrophy, and central loss of vision. It is also considered a variant of Coats disease. No RCTs were identified on the treatment of macular telangiectasia with any corticosteroids intravitreal implants. Three case reports with a total 9 patients with type 1 idiopathic macular telangiectasia treated with dexamethasone implants have described mixed results on improvements in visual acuity and reduction in inflammation.

#### **Section Summary: Idiopathic Macular Telangiectasia Type 1**

No RCTs were identified on the treatment of idiopathic macular telangiectasia type 1 with any corticosteroids intravitreal implants. Available evidence includes multiple case reports, which have noted mixed results for visual acuity and inflammation-related outcomes. Long-term follow-up on efficacy and safety is limited. Better quality studies with long-term follow-up are needed to permit conclusions on the efficacy of corticosteroid implants in patients with this indication.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

### **Postoperative Chronic Macular Edema**

Postoperative chronic macular edema, also called as pseudophakic cystoid macular edema or Irvine-Gass syndrome, is one of the most common causes of visual loss after cataract surgery. It is thought to occur as a consequence of inflammatory mediators that are upregulated in the aqueous and vitreous humors after surgical manipulation; it can lead to permanent visual loss. No RCTs were identified on the treatment of this indication with any corticosteroids intravitreal implants. Multiple case series have assessed improvements in visual acuity and anatomic changes. However, these studies have included only small numbers of patients and reported mean pre-post changes in visual acuity and eye anatomy that lack responder analysis using clinically meaningful changes in outcomes. EPISODIC, a 2016 observational retrospective study conducted in France, included 100 patients with postsurgical macular edema who received dexamethasone implants between April 2011 and June 2014 and who had a minimum of 1-year follow-up. Mean improvement in BCVA was 9.6 EDTRS letters at month 6 and 10.3 at month 12. The proportion of eyes with gains in BCVA of 15 or more letters was 32.5% and 37.5% at months 6 and 12, respectively. Average reduction in central subfield macular thickness was 135.2 and 160.9  $\mu\text{m}$  at months 6 and 12.

### **Section Summary: Postoperative Chronic Macular Edema**

No RCTs were identified on the treatment of postoperative chronic macular edema with any corticosteroids intravitreal implants. Available evidence includes multiple observational studies. Of these, 1 large retrospective analysis of 100 patients showed that 2 of every 5 patients experienced clinically meaningful improvements in visual acuity after 1 year of follow-up. An RCT is needed to confirm the efficacy of corticosteroid implants in patients with this indication.

### **Circumscribed Choroidal Hemangioma**

Circumscribed choroidal hemangiomas are benign vascular hamartomas without systemic associations. No RCTs were identified on the treatment of circumscribed choroidal hemangiomas with any corticosteroids intravitreal implants. A single case report has described the use of photodynamic therapy combined with dexamethasone implants. Authors concluded that implants potentiated the effect of photodynamic therapy with less risk of local side effects than triamcinolone acetate.

### **Section Summary: Circumscribed Choroidal Hemangiomas**

No RCTs were identified on the treatment of circumscribed choroidal hemangiomas with any corticosteroids intravitreal implants. Available evidence includes a single case report that does not

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

permit conclusion on the efficacy and safety of adding dexamethasone implants to photodynamic therapy for treatment of circumscribed choroidal hemangiomas. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with this indication.

### **Proliferative Vitreoretinopathy**

Proliferative vitreoretinopathy develops as a complication of rhegmatogenous retinal detachment. Proliferative vitreoretinopathy occurs in 8% to 10% of patients undergoing primary retinal detachment surgery and prevents the successful surgical repair of rhegmatogenous retinal detachment. No RCTs were identified on the treatment of proliferative vitreoretinopathy with any corticosteroids intravitreal implants. A case series (2017) of 5 patients with proliferative vitreoretinopathy has described combined use of surgery, endolaser, and dexamethasone implants. A case report (2013) found a benefit of dexamethasone implants in preventing proliferative vitreoretinopathy in a patient with a rhegmatogenous retinal detachment, who experienced improvements in visual acuity and retinal attachment 9 months postsurgery.

### **Section Summary: Proliferative Vitreoretinopathy**

No RCTs were identified on the treatment of proliferative vitreoretinopathy with any corticosteroids intravitreal implants. Available evidence includes 1 case series and 1 case report. These studies reported multiple interventions, including dexamethasone implants in conjunction with surgery and laser, for preventing proliferative retinopathy after retinal detachment surgery. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with proliferative retinopathy.

### **Radiation Retinopathy**

Radiation retinopathy is delayed-onset damage to the retina due to exposure to ionizing radiation, typically after months and is slowly progressive. No RCTs were identified on the treatment of radiation retinopathy with any corticosteroids intravitreal implants. In a retrospective study (2015), 12 eyes diagnosed with radiation maculopathy secondary to plaque brachytherapy were treated with dexamethasone implants. Anatomic improvements in foveal thickness were reported, with nonsignificant improvements in visual acuity. In a 2014 retrospective case series, 2 patients who developed radiation maculopathy after radiotherapy for uveal melanoma were treated with dexamethasone implants. They had limited responses to bevacizumab and intravitreal triamcinolone. Dexamethasone implants provided a prolonged period of anatomic stabilization. In another retrospective chart review (2013) of 5 patients with choroidal melanoma treated with dexamethasone

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

implants for radiation macular edema, mix improvements in visual acuity were reported. The mean improvement in EDTRS letters was 5. Visual acuity improved for 3 patients (+4, +9, and +15 letters) and remained unchanged for 2.

### **Section Summary: Radiation Retinopathy**

No RCTs were identified on the treatment of radiation retinopathy with any corticosteroids intravitreal implants. Available evidence includes multiple observational studies that noted improvements in anatomic stability and visual acuity. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with radiation retinopathy.

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Policy # 00549

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Policy # 00549

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# Louisiana

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Policy # 00549

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### **Policy History**

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Current Effective Date: 05/10/2021

- 04/06/2017 Medical Policy Committee review
  - 04/19/2017 Medical Policy Implementation Committee approval. New Policy.
  - 04/05/2018 Medical Policy Committee review
  - 04/18/2018 Medical Policy Implementation Committee approval. No change to coverage.
  - 04/04/2019 Medical Policy Committee review
  - 04/24/2019 Medical Policy Implementation Committee approval. Added a new drug, Yutiq, to the policy. Updated background and rationale information. Removed summary section at the end of the policy.
  - 04/02/2020 Medical Policy Committee review
  - 04/08/2020 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
  - 04/01/2021 Medical Policy Committee review
  - 04/14/2021 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
  - 07/16/2021 Coding update
- Next Scheduled Review Date: 04/2022

### **Coding**

*The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of*

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

*descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.*

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Code Type	Code
CPT	67027, 67028
HCPCS	J7311, J7312, J7313, J7314
ICD-10 Diagnosis	H30.90-H30.93, H34.8110-H34.8192, H34.8310-H34.8392, H35.81, H44.111-H44.119, H44.131-H44.139

\*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
  2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
  3. Reference to federal regulations.

**\*\*Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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# Louisiana

## Intravitreal Corticosteroid Implants

Policy # 00549

Original Effective Date: 04/19/2017

Current Effective Date: 05/10/2021

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