



Louisiana

bimatoprost Implant (Durysta™)

Policy # 00725

Original Effective Date: 01/11/2021

Current Effective Date: 01/08/2024

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 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 bimatoprost implant (Durysta™)† for the treatment of open-angle glaucoma or ocular hypertension to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for bimatoprost implant (Durysta) will be considered when all of the following criteria are met:

- Patient is using the requested drug for the reduction of elevated intraocular pressure due to open-angle glaucoma OR for the reduction of elevated intraocular pressure due to ocular hypertension; AND
- Patient is 18 years of age or older; AND
- Dosage does NOT exceed one 10 mcg implant per eye; AND
- Patient has NOT previously received the requested drug in the requested eye; AND
- Patient has tried and failed (e.g., intolerance or inadequate response) a GENERIC ophthalmic prostaglandin (e.g., latanoprost, bimatoprost, travoprost) after at least one month of therapy unless there is clinical evidence or patient history that suggests the required GENERIC products will be ineffective or cause an adverse reaction to the patient; AND
(Note: This specific patient criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).
- Patient has tried and failed (e.g., intolerance or inadequate response) a GENERIC ophthalmic beta-adrenergic blocker or combination product (e.g., betaxolol, carteolol, levobunolol, metipranolol, timolol, dorzolamide plus timolol) after at least one month of therapy unless

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there is clinical evidence or patient history that suggests the use of the required GENERIC products will be ineffective or cause an adverse reaction to the patient.

*(Note: This specific patient criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of bimatoprost implant (Durysta) when the patient has NOT tried and failed the prerequisite medications to be **not medically necessary.****

Based on review of available data, the Company considers the use of bimatoprost implant (Durysta) when the patient has NOT tried and failed the prerequisite medications for at least one month EACH to be **not medically necessary.****

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 the use of bimatoprost implant (Durysta) when the patient selection criteria are not met (with the exception of those denoted above as **not medically necessary****) to be **investigational.***

Background/Overview

Durysta is a prostaglandin analog indicated for the reduction of intraocular pressure in patients with open-angle glaucoma or ocular hypertension. The active ingredient in Durysta, bimatoprost, is a synthetic structural analog of prostaglandin with ocular hypotensive activity. It is believed to lower intraocular pressure by increasing outflow of aqueous humor through both the trabecular meshwork and uveoscleral routes. Durysta is administered via the intracameral route. One implant of Durysta contains 10 mcg of bimatoprost. The package insert states that “Durysta should not be readministered to an eye that received a prior Durysta.”

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Open-angle glaucoma is an optic neuropathy characterized by progressive peripheral visual loss. The peripheral vision loss is often followed by central field loss. Open-angle glaucoma is typically accompanied by intraocular pressure increases caused by increased aqueous production and/or decreased aqueous outflow. Elevated intraocular pressure presents a major risk factor for glaucomatous field loss. The higher the level of intraocular pressure, the greater the likelihood of optic nerve damage and visual field loss. Ocular hypertension is distinguished from glaucoma in that there are no detectable changes in vision, no evidence of visual field loss, and no damage to the optic nerve. Patients diagnosed with ocular hypertension are at an increased risk of developing glaucoma. Typical treatments for open-angle glaucoma and ocular hypertension include drug classes such as ophthalmic prostaglandins (e.g. latanoprost) and ophthalmic beta blockers (e.g. timolol), both of which have generic products available in their respective classes.

The American Academy of Ophthalmology (AAO) preferred practice guidelines for the treatment of primary open-angle glaucoma note that the initial therapy choice may be influenced by cost, adverse event profile, and dosing schedules. The guidelines note prostaglandins as the most frequently used initial eye drops for lowering intraocular pressure in patients with glaucoma. The AAO does not prefer one prostaglandin over another.

For now, it seems that Durysta is a therapeutic alternative to other ophthalmic products for the treatment of patients with open-angle glaucoma or ocular hypertension.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Durysta is a prostaglandin analog indicated for the reduction of intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

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, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

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Efficacy was evaluated in two multicenter, randomized, parallel-group, controlled 20-month (including 8-month extended follow-up) studies of Durysta compared to twice daily topical timolol 0.5% drops, in patients with open-angle glaucoma or ocular hypertension. Durysta demonstrated an intraocular pressure reduction of approximately 5-8 mmHg in patients with a mean baseline intraocular pressure of 24.5 mmHg. At all time points (hours 0 and 2, weeks 2, 6, and 12), the mean intraocular pressure reduction was greater with Durysta compared with timolol. Durysta demonstrated non-inferiority to timolol for each of the measured timepoints. It should be noted that a higher than FDA approved dose was given to some subjects in the study and Durysta may have been implanted multiple times in the study (contrary to the package insert guidance) to produce these results.

References

1. Durysta [package insert]. Allergan USA, Inc. Madison, New Jersey. November 2020.
2. Durysta Drug Evaluation. Express Scripts. April 2020.
3. Prum PE, Rosenberg LF, Gedde SJ, et al. Preferred practice pattern: primary open-angle glaucoma. The American Academy of Ophthalmology. 2015. Available at: <http://www.aao.org/guidelines-browse?filter=preferredpracticepatterns>.
4. Open-angle glaucoma treatment. UpToDate. Accessed November 2020.

Policy History

Original Effective Date: 01/11/2021

Current Effective Date: 01/08/2024

12/03/2020	Medical Policy Committee review
12/09/2020	Medical Policy Implementation Committee approval. New policy.
06/21/2021	Coding update
07/23/2021	Coding update
12/02/2021	Medical Policy Committee review
12/08/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
12/01/2022	Medical Policy Committee review
12/14/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
12/07/2023	Medical Policy Committee review

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12/13/2023 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 12/2024

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 2022 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	66030
HCPCS	J7351
ICD-10 Diagnosis	H40.051-H40.059, H40.10-H40.11

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*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 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 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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‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

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