

Clinical Policy: Verteporfin (Visudyne)

Reference Number: LA.PHAR.187

Effective Date: 09.21

Last Review Date: 07.5.22

Line of Business: Medicaid

[Coding Implications](#)
[Revision Log](#)

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Verteporfin (Visudyne®) is a light activated drug used in photodynamic therapy.

FDA Approved Indication(s)

Visudyne is indicated for the treatment of patients with predominantly classic subfoveal choroidal neovascularization (CNV) due to:

- Age-related macular degeneration (AMD)
- Pathologic myopia
- Presumed ocular histoplasmosis

Limitation(s) of use: There is insufficient evidence to indicate Visudyne for the treatment of predominantly occult subfoveal CNV.

Policy/Criteria

Prior authorization is required. Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections that Visudyne is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Choroidal Neovascularization (must meet all):

1. Diagnosis of subfoveal CNV due to one of the following (a, b, or c):
 - a. AMD;
 - b. Pathologic myopia;
 - c. Presumed ocular histoplasmosis;
2. Prescribed by or in consultation with an ophthalmologist;
3. Age ≥ 18 years;
4. For AMD, member meets one of the following (a or b):
 - a. ~~Failure of~~ ~~Member must use~~ bevacizumab intravitreal solution, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for bevacizumab intravitreal solution. Requests for IV formulations of Avastin, Mvasi, and Zirabev will not be approved*
 - b. Disease has progressed after use of a vascular endothelial growth factor (VEGF) as first-line treatment;

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5. For CNV due to pathologic myopia, failure of intravitreal Avastin or Lucentis®, unless clinically significant adverse effects are experienced or both are contraindicated;

**Prior authorization may be required for Avastin and Lucentis*

6. Dose does not exceed 6 mg/m² body surface area.

Approval duration:

Medicaid – 3 months (1 dose)

B. Central Serous Chorioretinopathy (off-label) (must meet all):

1. Diagnosis of central serous chorioretinopathy confirmed by retinal scan;
2. Prescribed by or in consultation with an ophthalmologist;
3. Disease is characterized as chronic or recurrent as evidenced by one of the following (a or b):
 - a. Persistent subretinal fluid for ≥ 3 months;
 - b. Persistent subretinal fluid for < 3 months and prescriber attestation that member is symptomatic (e.g., blurry central vision);
4. Member meets one of the following (a or b):
 - a. Member is not taking medications from any of the following classes: corticosteroids, stimulants, decongestants, or erectile dysfunction medications;
 - b. Documentation that prescriber has evaluated medications as risk factors if they are from any of the following classes: corticosteroids, stimulants, decongestants, or erectile dysfunction medications;
5. Dose does not exceed 6 mg/m² body surface area.

Approval duration:

Medicaid – 3 months (1 dose)

B-C. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.

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II. Continued Therapy

A. Choroidal Neovascularization (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by one of the following (a, b, c, or d):
 - a. Detained neovascularization;
 - b. Improvement in visual acuity;
 - c. Maintenance of corrected visual acuity from prior treatment;
 - d. Supportive findings from optical coherence tomography or fluorescein angiography;
3. Recent fluorescein angiography, conducted at least 3 months after the last treatment, shows recurrent or persistent choroidal neovascular leakage;
4. If request is for a dose increase, new dose does not exceed 6 mg/m² body surface area.

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Approval duration:

Medicaid – 3 months (1 dose)

B. Central Serous Chorioretinopathy (off-label):

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

B.C. Other diagnoses/indications (must meet 1 or 2);

1. Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.

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III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AMD: age-related macular degeneration

CNV: choroidal neovascularization

mCNV: myopic choroidal neovascularization

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Bevacizumab (Avastin®)	Neovascular (wet) AMD: 1.25 to 2.5 mg administered by intravitreal injection every 4 weeks	2.5 mg/month
	mCNV: 0.05 mL initial intravitreal injection, followed by monthly evaluation for additional injections as needed	0.5 mL/month
Beovu® (brolucizumab)	Neovascular (wet) AMD: 6 mg (1 vial) administered by intravitreal injection every 4 weeks for the first 3 months, then every 8 or 12 weeks thereafter	6 mg (1 vial) every 2 months after loading period
Eylea® (aflibercept)	Neovascular (wet) AMD: 2 mg (0.05 mL) administered by intravitreal injection once a month for 3 months then 2mg every 2 months.	2 mg/month

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Lucentis® (ranibizumab)	Neovascular (wet) AMD: 0.5 mg (0.05 mL) administered by intravitreal injection once a month. Alternative dosing: Once monthly injections for three months followed by 4-5 doses dispersed among the following 9 months Or Treatment may be reduced to one injection every 3 months after the first four injections if monthly injections are not feasible.	0.5 mg/month
	Myopic CNV: 0.5 mg (0.05 mL) administered by intravitreal injection once a month for up to 3 months. Patients may be retreated if needed.	0.5 mg/month
Macugen® (pegaptanib)	Neovascular (wet) AMD: 0.3 mg (0.09 mL) administered by intravitreal injection every 6 weeks	0.3 mg/6 weeks

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Porphyria
 - Hypersensitivity
- Boxed warning(s): none reported

Appendix D: General Information

- In the ANti-VEGF Antibody for the Treatment of Predominantly Classic CHORoidal Neovascularisation in AMD (ANCHOR) trial, the number of patients that lost fewer than 15 letters at 12 months was achieved by 96.4% of patients treated with Lucentis 0.5 mg compared to 64.3% of patients treated with Visudyne ($p < 0.001$). Rate of intraocular inflammation was higher for patients treated with Lucentis 0.5 mg at 15% compared to Visudyne at 2.8%.
- In the RADIANCE, a Phase III, 12-month, multicenter, randomized, double-masked, active-controlled trial, Lucentis was compared to vPDT (Visudyne and photodynamic therapy) for the treatment of mCNV. Lucentis treatment in groups I and II was superior to vPDT based on mean average BCVA change from baseline to month 1 through month 3 (group I: +10.5, group II: +10.6 vs. group III: +2.2 Early Treatment Diabetic Retinopathy

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Study [ETDRS] letters; both $p < 0.0001$). Lucentis treatment guided by disease activity was noninferior to VA stabilization-guided retreatment based on mean average BCVA change from baseline to month 1 through month 6 (group II: +11.7 vs. group I: +11.9 ETDRS letters; $p < 0.00001$). Mean BCVA change from baseline to month 12 was +13.8 (group I), +14.4 (group II), and +9.3 ETDRS letters (group III). At month 12, 63.8% to 65.7% of patients showed resolution of myopic CNV leakage. Patients received a median of 4.0 (group I) and 2.0 (groups II and III) ranibizumab injections over 12 months. No deaths or cases of endophthalmitis and myocardial infarction occurred.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Predominantly classic subfoveal CNV due to AMD, pathologic myopia or presumed ocular histoplasmosis	6 mg/m ² IV diluted with 5% dextrose to a final volume of 30 mL infused over 10 minutes	6 mg/m ² IV

VI. Product Availability

Vial for reconstitution: 15 mg (2 mg/mL after reconstitution)

VII. References

1. Visudyne Prescribing Information. Bridgewater, NJ: Valeant Ophthalmics; February 2017. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/021119s0291bl.pdf www.visudyne.com. Accessed ~~November~~^{September} 9~~17~~¹⁰, 2021~~10~~.
2. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; October 2019. Available at: www.aao.org/ppp. Accessed ~~November~~^{September} 9~~17~~¹⁰, 2021~~10~~.
3. Diaz RI, Sigler EJ, Rafieetary MR, Calzada JI. Ocular histoplasmosis syndrome. *Surv Ophthalmol*. 2015; 60(4): 279-295.
4. Wolf S, Valciuniene VJ, Laganovska G, et al. RADIANCE: a randomized controlled study of ranibizumab in patients with choroidal neovascularization secondary to pathologic myopia. *Ophthalmology*. 2014; 121(3):682-92.e2. doi: 10.1016/j.ophtha.2013.10.023. Epub 2013 Dec 8.
5. Salehi M, Wenick S, Law HA, Evans JR, Gehlbach P. Interventions for central serous chorioretinopathy: a network meta-analysis. *Cochrane Database Syst Rev*. 2016; 12. doi: 10.1002/14651858.CD011841.pub2.
6. Hanumunthadu D, Tan ACS, Singh SR, et al. Management of chronic central serous chorioretinopathy. *Indian J Ophthalmol*. 2018; 66(12): 1704-1714.
- 4-7. Van Rijnssen TJ, van Dijk EHC, Yzer S, et al. Central serous chorioretinopathy: towards an evidence-based treatment guideline. *Progress in Retinal and Eye Research*. 2019; 73. doi: 10.1016/j.preteyeres.2019.07.003.

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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPSC Codes	Description
J3396	Injection, verteporfin, 0.1 mg

Reviews, Revisions, and Approvals	Date
Converted corporate to local policy	05.2021
<u>Added off-label criteria for central serous chorioretinopathy; converted redirection language from “must use” to “Failure of” bevacizumab intravitreal solution; References reviewed and updated.</u>	07.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the



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requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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