

Clinical Policy: Ranibizumab (Lucentis)

Reference Number: LA.PHAR.186

Effective Date:

Last Review Date: 06.21

Line of Business: Medicaid

Coding Implications

Revision Log

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Ranibizumab (Lucentis®) is a vascular endothelial growth factor (VEGF) inhibitor.

FDA Approved Indication(s)

Lucentis is indicated for the treatment of:

- Neovascular (wet) age-related macular degeneration (AMD)
- Macular edema following retinal vein occlusion (RVO)
- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)
- Myopic choroidal neovascularization (mCNV)

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 Lucentis is medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Ophthalmic Disease (must meet all):

1. Diagnosis of one of the following (a, b, c, d, or e):
 - a. Neovascular (wet) AMD;
 - b. Macular edema following RVO;
 - c. DME;
 - d. DR;
 - e. mCNV;
2. Prescribed by or in consultation with an ophthalmologist;
3. Age ≥ 18 years;
4. 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*
5. Dose does not exceed:
 - a. DME and DR: 0.3 mg per month;
 - b. AMD, RVO, and mCNV: 0.5 mg per month.

Approval duration:

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mCNV: 3 months

All other indications: 6 months

B. 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.

II. Continued Therapy

A. Ophthalmic Disease (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. If request is for a dose increase, new dose does not exceed:
 - a. DME and DR: 0.3 mg per month;
 - a. AMD, RVO, and mCNV: 0.5 mg per month.

Approval duration:

mCNV: 3 months

All other indications: 6 months

B. 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.

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

DME: diabetic macular edema

DR: diabetic retinopathy

FDA: Food and Drug Administration
mCNV: myopic choroidal
neovascularization
RVO: retinal vein occlusion

VEGF: vascular endothelial growth factor

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.

<u>Drug Name</u>	<u>Dosing Regimen</u>	<u>Dose Limit/ Maximum Dose</u>
<u>Bevacizumab (Avastin®)</u>	<u>Neovascular (wet) AMD: 1.25 to 2.5 mg administered by intravitreal injection every 4 weeks</u>	<u>2.5 mg/month</u>
	<u>Neovascular glaucoma: 1.25 mg administered by intravitreal injection every 4 weeks</u>	<u>1.25 mg/month</u>
	<u>Macular edema secondary to RVO: 1 mg to 2.5 mg administered by intravitreal injection every 4 weeks</u>	<u>2.5 mg/month</u>
	<u>DR: 1.25 mg administered by intravitreal injection every 6 weeks</u>	<u>1.25 mg/6 weeks</u>
	<u>DME: 1.25 mg administered by intravitreal injection every 6 weeks</u>	<u>1.25 mg/6 weeks</u>
	<u>mCNV: 0.05 mL initial intravitreal injection, followed by monthly evaluation for additional injections as needed</u>	<u>0.5 mL/month</u>

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):**
 - **Ocular or periocular infections**
 - **Hypersensitivity**
- **Boxed warning(s): none reported**

Appendix D: General Information

- **In the Comparison of AMD Treatments Trials study, the difference in mean visual acuity improvement for patients treated with Avastin compared to Lucentis was -1.4 letters (95% [CI], - 3.7 to 0.8) at two years. The proportion of patients with arteriothrombotic events was similar in the Lucentis-treated patients (4.7%) compared to the Avastin-treated patients (5.0%; p=0.89). The proportion of patients with one or more systemic serious adverse events was higher with Avastin (39.9%) than Lucentis (31.7%; adjusted risk ratio, 1.30; 95% CI, 1.07-1.57; p = 0.009).**

Serious systemic adverse events included all-cause mortality, non-fatal stroke, non-fatal myocardial infarction, vascular death, venous thrombotic events and hypertension.

- 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 VEGF Trap-Eye: Investigation of Efficacy and Safety in Wet Age-Related Macular Degeneration (VIEW)-1 trial, the difference in the number of patients who lost fewer than 15 letters at 52 weeks between Eylea every 8 weeks compared to Lucentis was 0.6% (95.1% CI -0.32, 4.4). In terms of the number of patients who gained at least 15 letters, the mean difference between Eylea every 8 weeks was 6.6% (95.1% CI -1.0, 14.1). There were no adverse events that were found to be significant from the Lucentis arm.
- In a trial comparing Eylea, Avastin and Lucentis, the Diabetic Retinopathy Clinical Research Network found in patients with diabetic macular edema that when the initial visual-acuity letter score was 78 to 69 (equivalent to approximately 20/32 to 20/40) (51% of participants), the mean improvement was 8.0 with Eylea, 7.5 with Avastin, and 8.3 with Lucentis ($p > 0.50$ for each pair wise comparison). When the initial letter score was less than 69 (approximately 20/50 or worse), the mean improvement was 18.9 with Eylea, 11.8 with Avastin, and 14.2 with Lucentis ($p < 0.001$ for Eylea vs. Avastin, $p = 0.003$ for Eylea vs. Lucentis, and $p = 0.21$ for Lucentis vs. Avastin).

V. Dosage and Administration

<u>Indication</u>	<u>Dosing Regimen</u>	<u>Maximum Dose</u>
<u>Neovascular (wet) AMD</u>	<u>0.5 mg (0.05 mL) administered by intravitreal injection once a month.</u> <u>Alternative dosing:</u> <u>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.</u>	<u>0.5 mg/month</u>
<u>Macular edema following RVO</u>	<u>0.5 mg (0.05 mL) administered by intravitreal injection once a month.</u>	<u>0.5 mg/month</u>
<u>DME and DR with or without DME</u>	<u>0.3 mg (0.05 mL) administered by intravitreal injection once a month</u>	<u>0.3 mg/month</u>
<u>mCNV</u>	<u>0.5 mg (0.05 mL) administered by intravitreal injection once a month for up to</u>	<u>0.5 mg/month</u>

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Indication	Dosing Regimen	Maximum Dose
	<u>3 months. Patients may be retreated if needed.</u>	

VI. Product Availability

- Single-use prefilled syringes: 0.3 mg/0.05 mL, 0.5 mg/0.05 mL
- Single-use glass vials: 0.3 mg/0.05 mL, 0.5 mg/0.05 mL

VII. References

1. Lucentis Prescribing Information. South San Francisco, CA: Genentech, Inc.; March 2018. Available at: www.lucents.com. Accessed October 14, 2020.
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6. El Matri L, Chebil A, and Kort F. Current and emerging treatment options for myopic choroidal neovascularization. *Clinical Ophthalmology*. 2015;9 733–744.
7. Wells JA, Glassman AR, Ayala AR, et al. Aflibercept, bevacizumab, or ranibizumab for diabetic macular edema. *N Engl J Med*. 2015;372(13):1193-203. doi: 10.1056/NEJMoa1414264.
8. Cheung C, Arnold JJ, Holz FG, et al. American Academy of Ophthalmology: Myopic choroidal neovascularization: review, guidance, and consensus statement on management. *Ophthalmology*. 2017; 124:1690:1711. <http://dx.doi.org/10.1016/j.ophtha.2017.04.028>

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.

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<u>HCPCS Codes</u>	<u>Description</u>
J2778	<u>Injection, ranibizumab, 0.1 mg</u>

<u>Reviews, Revisions, and Approvals</u>	<u>Date</u>
<u>Converted corporate to local policy</u>	<u>06.2021</u>

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 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.

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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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