Clinical Policy: Verteporfin (Visudyne)
Reference Number: CP.PHAR.187
Effective Date: 03.01.16
Last Review Date: 02.21
Line of Business: Commercial, HIM, Medicaid

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
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 health plans affiliated with Centene Corporation® 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. 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;
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:**
- **HIM/Medicaid** – 3 months (1 dose)
- **Commercial** – Length of Benefit

**B. Other diagnoses/indications**
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Choroidal Neovascularization** (must meet all):
1. Currently receiving medication via Centene 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.

**Approval duration:**
- **HIM/Medicaid** – 3 months (1 dose)
- **Commercial** – Length of Benefit

**B. Other diagnoses/indications** (must meet 1 or 2):
1. Currently receiving medication via Centene 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 for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.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 policies –
IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

<table>
<thead>
<tr>
<th>Abbreviation/Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMD</td>
<td>age-related macular degeneration</td>
</tr>
<tr>
<td>CNV</td>
<td>choroidal neovascularization</td>
</tr>
<tr>
<td>mCNV</td>
<td>myopic choroidal neovascularization</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
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</tbody>
</table>

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bevacizumab</td>
<td>Neovascular (wet) AMD: 1.25 to 2.5 mg administered by intravitreal injection every 4 weeks</td>
<td>2.5 mg/month</td>
</tr>
<tr>
<td></td>
<td>mCNV: 0.05 mL initial intravitreal injection, followed by monthly evaluation for additional injections as needed</td>
<td>0.5 mL/month</td>
</tr>
<tr>
<td>Beovu® (brolucizumab)</td>
<td>Neovascular (wet) AMD: 6 mg (1 via) administered by intravitreal injection every 4 weeks for the first 3 months, then every 8 or 12 weeks thereafter</td>
<td>6 mg (1 vial) every 2 months after loading period</td>
</tr>
<tr>
<td>Eylea® (aflibercept)</td>
<td>Neovascular (wet) AMD: 2 mg (0.05 mL) administered by intravitreal injection once a month for 3 months then 2 mg every 2 months.</td>
<td>2 mg/month</td>
</tr>
<tr>
<td>Lucentis® (ranibizumab)</td>
<td>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.</td>
<td>0.5 mg/month</td>
</tr>
<tr>
<td></td>
<td>Myopic CNV:</td>
<td>0.5 mg/month</td>
</tr>
</tbody>
</table>
### CLINICAL POLICY

**Verteporfin**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 mg (0.05 mL) administered by intravitreal injection once a month for up to 3 months. Patients may be retreated if needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macugen® (pegaptanib)</td>
<td><strong>Neovascular (wet) AMD:</strong> 0.3 mg (0.09 mL) administered by intravitreal injection every 6 weeks</td>
<td>0.3 mg/6 weeks</td>
</tr>
</tbody>
</table>

*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 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

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predominantly classic subfoveal CNV due to AMD, pathologic myopia or presumed ocular histoplasmosis</td>
<td>6 mg/m² IV diluted with 5% dextrose to a final volume of 30 mL infused over 10 minutes</td>
<td>6 mg/m² IV</td>
</tr>
</tbody>
</table>
VI. Product Availability
Vial for reconstitution: 15 mg (2 mg/mL after reconstitution)

VII. References

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.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3396</td>
<td>Injection, verteporfin, 0.1 mg</td>
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<td></td>
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</tbody>
</table>

Reviews, Revisions, and Approvals
Medicaid: Removed age restriction. Removed restriction that lesion must be ≤ 5400 microns in greatest linear diameter for predominantly classic CNV. Added definition for occult CNV. Added option for contraindication/clinically significant adverse effects to anti-VEGF trial requirement. Removed max dose criterion, and instead incorporated dosing as a quantity limit (1 dose per 3 month approval period). Removed safety criteria. For continuation: Modified “Currently receiving…” to “Previously received…” to account for as needed dosing. Added requirement for documentation of positive response to therapy. Specified that FA should be at least 3 months after the last treatment.

1Q18 annual review: Policy combined for Medicaid and commercial lines of business; For Medicaid: Added specialist requirement, Removed fluorescein angiography for diagnosis due to addition of specialist, Added age limit, Expanded VEGF requirement for AMD and pathologic myopia specifically to bevacizumab or other VEGF inhibitors, Added redirection to Lucentis for mCNV due to clinical
<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>superiority. Removed allowed indication for occult CNV per limitation of use; References reviewed and updated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1Q 2019 annual review: no significant changes; references reviewed and updated.</td>
<td>11.20.18</td>
<td>02.19</td>
</tr>
<tr>
<td>1Q 2020 annual review: no significant changes; added Avastin biosimilar to therapeutic alternatives; references reviewed and updated.</td>
<td>10.23.19</td>
<td>02.20</td>
</tr>
<tr>
<td>Ad Hoc update: clarified redirection from bevacizumab to Avastin as compounding pharmacies often break standard Avastin vials into smaller dosages specifically for ophthalmic use and there is a temporary CPT code not currently available to biosimilars.</td>
<td>10.01.20</td>
<td></td>
</tr>
<tr>
<td>1Q 2021 annual review: no significant changes; added HIM line of business; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.</td>
<td>12.01.20</td>
<td>02.21</td>
</tr>
<tr>
<td>Ad Hoc update: updated redirection to “bevacizumab intravitreal solution” given availability of generic bevacizumab intravitreal solution and considering goal was to minimize use of IV bevacizumab products, most notably biosimilars; converted redirection language to “must use”</td>
<td>03.04.21</td>
<td></td>
</tr>
</tbody>
</table>

**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. The Health Plan 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. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the
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