MEMORIAL HERMANN HEALTH SYSTEM
MEMORIAL HERMANN HEALTH PLAN HOLDINGS, LLC
POLICY

POLICY TITLE:	MHHP MEDM-MA VEG-001 VEGF Inhibitors Step Therapy Criteria
PUBLICATION DATE:	05/28/2025
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VERSION:	2

POLICY PURPOSE:

The Memorial Hermann Health VEGF inhibitors – Intravitreal Indications (non-oncology) policy aims to advise providers of preferred drug products and outline the exceptions to preferred drug products during the prior authorization process. Step therapy criteria is applied in conjunction with any relevant National Coverage Determinations (NCD), Local Coverage Determination (LCD), InterQual and other MHHP internal medical necessity and or Part B drug criteria.

DEFINITIONS:

None

SCOPE:

This policy applies to Memorial Hermann Medicare plans.

POLICY STATEMENT:

The step therapy program applies to vascular endothelial growth factor (VEGF) inhibitors used for intravitreal indications for non-oncology conditions as described in this policy. Requested Part B drug coverage must comply with step criteria in this policy. If approved, authorizations will be approved for 6 months. If a provider administers a non-preferred drug without obtaining prior authorization, the request for coverage may be denied. Preferred may still require prior authorization. This policy applies to all Medicare members who are new to treatment with a non-preferred product. A member will not be required to change the current drug treatment. For the purposes of this policy, "current drug treatment" is defined as either a paid claim for the drug or clinical documentation confirming that the member has been using the non-preferred drug

within the past 365 days. In addition, there must be evidence of regular follow-up visits with the prescribing physician within the last 6 months. The member must also demonstrate clinical improvement as a result of the ongoing treatment. If a new plan member is currently using a particular drug, MHHP will not require the member to switch to the preferred drug upon enrollment. An existing member currently using a particular drug will not be required to change drug/products if this policy is updated. Not all indications for the non-preferred drug are listed in this policy. Indications and medications listed in this policy may change upon varying factors and should be evaluated by guidelines, the FDA and manufacturer package insert to verify appropriate use at the time of review.

VEGF Inhibitors for Neovascular (wet) age related macular degeneration (AMD)

Initial (New Starts) Authorization Criteria
1st preferred drug - covered Avastin ® (bevacizumab) MVASI ™ (bevacizumab-awwb) Zirabev ™ (bevacizumab-bvzr) Vegzelma ® (bevacizumab-adcd) Alymsys ® (bevacizumab-maly) Pavblu (aflibercept-ayyh)
2nd preferred drug (s) – requires step therapy Eylea ® (aflibercept) Eylea ® HD (aflibercept) Byooviz ™ (ranibizumab-nuna) Cimerli ™ (ranibizumab-eqrn) Vabysmo ™ (faricimab)
Non-preferred drug(s): Lucentis ® (ranibizumab) Susvimo ™ (ranibizumab) *(Note: Any drugs not listed as preferred will be considered non-preferred until the next policy update)*
Criteria: Coverage for the non-preferred product (s) is provided when there is clinical documentation to support one or more of the following criteria: **1.** The member has received the requested non-preferred drugs in the past 365 days and there is objective evidence of clinical benefit via imaging, lab results, or clinical assessment **OR**

2. Theres has been an inadequate response to a trial of both bevacizumab and a secondary preferred drug.

OR

3. There has been an adverse event to both bevacizumab and a secondary preferred drug (Byooviz, Eylea or Eylea HD)

OR

4. There is a contraindication to the preferred drugs

OR

5. The member has tried and failed the biosimilar for the non-preferred drugs (ranibizumab)

AND

6. Dosing must be in accordance with FDA approved labeling or otherwise supported by approved compendia and disease specific treatment guidelines.

VEGF Inhibitors for Macular edema following retinal vein occlusion (RVO)

Initial (New Starts) Authorization Criteria
1st preferred drug - covered Avastin ® (bevacizumab) MVASI ™ (bevacizumab-awwb) Zirabev ™ (bevacizumab-bvzr) Vegzelma ® (bevacizumab-adcd) Alymsys ® (bevacizumab-maly) Pavblu (aflibercept-ayyh)
2nd preferred drug (s) – requires step therapy Eylea ® (aflibercept) Eylea ® HD (aflibercept) Byooviz ™ (ranibizumab nuna) Cimerli ™ (ranibizumab eqrn) Vabysmo ™ (faricimab)
Non-preferred drug(s): Lucentis ® (ranibizumab) Susvimo ™ (ranibizumab) *(Note: Any drugs not listed as preferred will be considered non-preferred until the next policy update)*

Criteria: Coverage for the non-preferred product (s) is provided when there is clinical documentation to support one or more of the following criteria:

1. The member has received the requested non-preferred drugs in the past 365 days and there is objective evidence of clinical benefit via imaging, lab results, or clinical assessment.

OR

2. Theres has been an inadequate response to a trial of both bevacizumab and a secondary preferred drug.

OR

3. There has been an adverse event to both bevacizumab and a secondary preferred drug.

OR

4. There is a contraindication to the preferred drugs.

OR

5. The member has tried and failed the biosimilar for the non-preferred drugs,

AND

6. Dosing must be in accordance with FDA approved labeling or otherwise supported by approved compendia and disease specific treatment guidelines.

VEGF Inhibitors for Myopic choroidal neovascularization (mCNV)

Initial (New Starts) Authorization Criteria
1st preferred drug - covered Avastin ® (bevacizumab) MVASI ™ (bevacizumab-awwb) Zirabev ™ (bevacizumab-bvzr) Vegzelma ® (bevacizumab-adcd) Alymsys ® (bevacizumab-maly) Pavblu (aflibercept-ayyh)
2nd preferred drug (s) – requires step therapy Eylea ® (aflibercept) Eylea ® HD (aflibercept) Byooviz ™ (ranibizumab-nuna) Cimerli ™ (ranibizumab-eqrn) Vabysmo ™ (faricimab-sova)

Non-preferred drug(s):
Lucentis ® (ranibizumab)
Susvimo ™ (ranibizumab)

(Note: Any drugs not listed as preferred will be considered non-preferred until the next policy update)

Criteria: Coverage for the non-preferred product (s) is provided when there is clinical documentation to support one or more of the following criteria:

1. The member has received the requested non-preferred drugs in the past 365 days and there is objective evidence of clinical benefit via imaging, lab results, or clinical assessment.

OR

2. Theres has been an inadequate response to a trial of both bevacizumab and a secondary preferred drug.

OR

3. There has been an adverse event to both bevacizumab and a secondary preferred drug.

OR

4. There is a contraindication to the preferred drugs.

OR

5. The member has tried and failed the biosimilar for the non-preferred drugs.

OR

6. Dosing must be in accordance with FDA approved labeling or otherwise supported by approved compendia and disease specific treatment guidelines.

VEGF Inhibitors for Diabetic macular edema and Diabetic Retinopathy

Initial (New Starts) Authorization Criteria
1st preferred drug - covered Avastin ® (bevacizumab) MVASI ™ (bevacizumab-awwb) Zirabev ™ (bevacizumab-bvzr) Vegzelma ® (bevacizumab-adcd) Alymsys ® (bevacizumab-maly)

Pavblu (aflibercept-ayyh)

2nd preferred drug (s) – requires step therapy

Eylea ® (aflibercept)
Eylea ® HD (aflibercept)
Byooviz ™ (ranibizumab-nuna)
Cimerli ™ (ranibizumab-eqrn)
Vabysmo ™ (faricimab-sova)

Non-preferred drug(s):
Lucentis ® (ranibizumab)
Susvimo ™ (ranibizumab)

Criteria: Coverage for the non-preferred product (s) is provided when there is clinical documentation to support one or more of the following criteria:

1. The member has received the requested non-preferred drugs in the past 365 days and there is objective evidence of clinical benefit via imaging, lab results, or clinical assessment

OR

2. Theres has been an inadequate response to a trial of both bevacizumab and a secondary preferred drug.

OR

3. There has been an adverse event to both bevacizumab and a secondary preferred drug.

OR

4. There is a contraindication to the preferred drugs

OR

5. The member has tried and failed the biosimilar for the non-preferred drugs.

AND

6. Dosing must be in accordance with FDA approved labeling or otherwise supported by approved compendia and disease specific treatment guidelines.

Related documents

MHHP MEDM-MA 303 Medical Necessity Determinations

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