



## STEP THERAPY POLICY

- POLICY:** Ophthalmic Nonsteroidal Anti-Inflammatory Drugs Step Therapy Policy
- Acular® (ketorolac tromethamine 0.5% ophthalmic solution – Allergan, generic)
  - Acular LS® (ketorolac tromethamine 0.4% ophthalmic solution – Allergan, generic)
  - Acuvail® (ketorolac tromethamine 0.45% ophthalmic solution – Allergan)
  - Bromfenac 0.09% ophthalmic solution (generic only)
  - BromSite® (bromfenac 0.075% ophthalmic solution – Sun)
  - Diclofenac 0.1% ophthalmic solution (generic only)
  - Flurbiprofen 0.03% ophthalmic solution (generic only)
  - Nevanac® (nepafenac 0.1% ophthalmic suspension – Novartis)

**REVIEW DATE:** 11/01/2023

### INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

### CIGNA NATIONAL FORMULARY COVERAGE:

#### OVERVIEW

In general, the ophthalmic nonsteroidal anti-inflammatory drugs (NSAIDS) are indicated for the management of **ocular pain and inflammation in the postoperative setting**.<sup>1-7</sup> Note that the specific labeled indications may differ among the products. Ketorolac 0.5% ophthalmic solution is also indicated for the treatment of seasonal allergic conjunctivitis.<sup>1</sup> Flurbiprofen 0.03% ophthalmic solution is not indicated for use in the postoperative setting; flurbiprofen is indicated for the inhibition of intraoperative miosis.<sup>8</sup> All of the ophthalmic products included in this Step Therapy are preserved with benzalkonium chloride, except Acuvail, diclofenac 0.1% ophthalmic solution, and flurbiprofen 0.03% ophthalmic solution.<sup>1-8</sup>

## POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration. Note: Ilevro and Prolensa are not included in this policy.

**Ophthalmic Nonsteroidal Anti-Inflammatory Drugs product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.**

**Step 1:** generic bromfenac 0.09% ophthalmic solution, generic diclofenac 0.1% ophthalmic solution, generic flurbiprofen 0.03% ophthalmic solution, generic ketorolac 0.4% ophthalmic solution generic ketorolac 0.5% ophthalmic solution

**Step 2:** Acular, Acular LS, Acuvail, BromSite, Nevanac

## CRITERIA

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.

## REFERENCES

1. Acular® ophthalmic solution [prescribing information]. Irvine, CA: Allergan; May 2012.
2. Acular LS® ophthalmic solution [prescribing information]. Irvine, CA: Allergan; June 2016.
3. Acuvail® ophthalmic solution [prescribing information]. Irvine, CA: Allergan; February 2019.
4. Nevanac® ophthalmic suspension [prescribing information]. East Hanover, NJ: Novartis; November 2020.
5. Bromfenac 0.09% ophthalmic solution [prescribing information]. Bedminister, NJ: Alembic; November 2022.
6. Diclofenac 0.1% ophthalmic solution [prescribing information]. Tampa, FL: Bausch & Lomb; June 2022.
7. BromSite® ophthalmic solution [prescribing information]. Cranbury, NJ: Sun; March 2023.
8. Flurbiprofen 0.03% ophthalmic solution [prescribing information]. Tampa, FL: Bausch & Lomb; September 2022.

## HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	10/26/2022
Annual Revision	No criteria changes.	11/01/2023

"Cigna Companies" refers to operating subsidiaries of Cigna Corporation. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2023 Cigna