



Drug Coverage Policy

Effective Date5/1/2025

Coverage Policy Number.....IP0619

Policy Title.....iDose TR

Ophthalmology – iDose TR

- iDose® TR (travoprost implant, for intracameral administration – Glaukos)

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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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 Healthcare Coverage Policy

OVERVIEW

iDose TR, a prostaglandin analog, is indicated for the reduction of intraocular pressure (IOP) in **open-angle glaucoma** or **ocular hypertension**.¹

Disease Overview

Glaucoma, a disease that damages the eye's optic nerve, is the leading cause of blindness in people > 60 years of age.² Reduction of IOP, regardless of the pretreatment IOP, reduces the risk of disease progression.³ In addition, IOP reduction may prevent the onset of early glaucoma in patients with ocular hypertension.

Ophthalmic prostaglandins, beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, rho kinase inhibitor (netarsudil), and fixed combination products are used to treat glaucoma.³ The choice of product is influenced by potential cost, adverse event profile, dosing schedule, and the degree of pressure lowering needed.

Dosing Considerations

iDose TR is a travoprost delivery system consisting of a travoprost releasing implant pre-loaded in a sterile, single-dose inserter.¹ Each implant contains 75 mcg travoprost. iDose TR is administered intracamerally through a small, clear corneal incision and is anchored into the sclera at the iridocorneal angle. iDose TR should not be re-administered to an eye that received a prior iDose TR.

Medical Necessity Criteria

Policy Statement

Prior Authorization is recommended for prescription benefit coverage of iDose TR. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with iDose TR as well as the monitoring required for adverse events and long-term efficacy, approval requires iDose TR to be prescribed by a physician who has consulted with or who specializes in the condition.

iDose TR is considered medically necessary when the following are met:

- 1. Ocular Hypertension.** Approve for a one-time use in each treated eye (i.e., one implant per treated eye; a total of two implants per patient) if the patient meets ALL of the following (A, B, C, D, and E):
 - A)** Patient is ≥ 18 years of age; AND
 - B)** Patient is not receiving re-treatment of eye(s) previously treated with iDose TR; AND
 - C)** Patient meets BOTH of the following criteria (i and ii):
 - i. Patient has tried at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy) for the treatment of open-angle glaucoma or ocular hypertension; AND
Note: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan (bimatoprost 0.01% ophthalmic solution), Vyzulta (latanoprostene bunod 0.024% ophthalmic solution), Xelpros (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% ophthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution).
 - ii. Patient has tried at least two other ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes for the treatment of open-angle glaucoma or ocular hypertension; AND

Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil).

- D)** For each of the ophthalmic medications that were tried, the patient meets ONE of the following criteria (i or ii):
- i. Patient has had inadequate efficacy to the previously tried ophthalmic products, according to the prescriber; OR
 - ii. Patient has experienced adverse event(s) severe enough to warrant discontinuation of the previously tried ophthalmic products, according to the prescriber; AND
- E)** The medication is administered by or under the supervision of an ophthalmologist.

Dosing. Approve up to one iDose TR implant per treated eye(s) [two implants per patient].

- 2. Open-Angle Glaucoma.** Approve for a one-time use in each treated eye (i.e., one implant per treated eye; a total of two implants per patient) if the patient meets ALL of the following (A, B, C, D, and E):

- A. Patient is ≥ 18 years of age; AND
- B. Patient is not receiving re-treatment of eye(s) previously treated with iDose TR; AND
- C. Patient meets BOTH of the following criteria (i and ii):

- i. Patient has tried at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy) for the treatment of open-angle glaucoma or ocular hypertension; AND
- ii. Patient has tried at least two other ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes for the treatment of open-angle glaucoma or ocular hypertension; AND

Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil).

- D.** For each of the ophthalmic medications that were tried, the patient meets ONE of the following criteria (i or ii):
- i. Patient has had inadequate efficacy to the previously tried ophthalmic products, according to the prescriber; OR
 - ii. Patient has experienced adverse event(s) severe enough to warrant discontinuation of the previously tried ophthalmic products, according to the prescriber; AND
- E.** The medication is administered by or under the supervision of an ophthalmologist.

Dosing. Approve up to one iDose TR implant per treated eye(s) [two implants per patient].

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 1. Re-Treatment of Previously Treated Eye(s).** iDose TR is approved for a one-time use in each treated eye. Repeat administration in previously treated eye(s) is not approvable.
- 2. Concurrent use of iDose TR with Durysta (bimatoprost intracameral implant).** Durysta is another intracameral implant and should not be used with iDose TR.

Coding Information

Note:

- 1) This list of codes may not be all-inclusive.
- 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach

HCPCS Codes	Description
J7355	Injection, travoprost, intracameral implant, 1 microgram

***Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL**

References

1. iDose® TR intracameral implant [prescribing information]. San Clemente, CA: Glaukos; December 2023.
2. Boyd K. Glaucoma. Available at: <https://www.aao.org/eye-health/diseases/what-is-glaucoma>. Last reviewed, December 4, 2023. Accessed on February 3, 2025.
3. Gedde SJ, Vinod K, Wright MW, et al. Primary open-angle glaucoma Preferred Practice Pattern® guidelines. The American Academy of Ophthalmology. 2020. Available at: <https://www.aao.org/education/preferred-practice-pattern/primary-open-angle-glaucoma-ppp>. Accessed on February 3, 2025.
4. Durysta® [prescribing information]. North Chicago, IL: AbbVie; October 2024.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	6/1/2024
Annual Revision	No criteria changes.	5/1/2025

The policy effective date is in force until updated or retired.

"Cigna Companies" refers to operating subsidiaries of The Cigna Group. 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 The Cigna Group. © 2025 The Cigna Group.