Clinical Policy Title:	verteporfin
Policy Number:	RxA.554
Drug(s) Applied:	Visudyne®
Original Policy Date:	03/06/2020
Last Review Date:	12/07/2021
Line of Business Policy Applies to:	All lines of business

Background

Verteporfin (Visudyne®) is a light activated drug used in photodynamic therapy.
It 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

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
verteporfin (Visudyne®)	Predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration, pathologic myopia or presumed ocular histoplasmosis	6 mg/m^2 Body Surface Area intravenously diluted with 5% dextrose to a final volume of 30 mL infused over 10 minutes	6 mg/m^2 intravenously

Dosage Forms

- Vial for reconstitution: 15 mg of verteporfin as a dark green lyophilized cake in a single-dose vial for reconstitution (2 mg/mL after reconstitution)

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

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. Member has failed an intravitreal anti-vascular endothelial growth factor (VEGF), unless contraindicated or clinically significant adverse effects are experienced;
   *Prior authorization may be required
5. Dose does not exceed 6 mg/m^2 body surface area.

Approval Duration
Commercial: 3 months (1 dose)
Medicaid: 3 months (1 dose)

II. Continued Therapy Approval

A. Choroidal Neovascularization (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
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/m^2 body surface area.

Approval Duration
Commercial: 3 months (1 dose)
Medicaid: 3 months (1 dose)

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
AMD: age-related macular degeneration
CNV: choroidal neovascularization
FDA: Food and Drug Administration
mCNV: myopic choroidal neovascularization
VEGF: vascular endothelial growth factor
BCVA: Best Corrected Visual Acuity

APPENDIX B: Therapeutic Alternatives
Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Maximum Dose
bevacizumab (Avastin®), bevacizumab-(Mvasi®), bevacizumab	Neovascular (wet) AMD: 1.25 to 2.5 mg administered by intravitreal injection every 4 weeks.	2.5 mg/month
	mCNV: 0.05 mL initial intravitreal injection, followed by monthly evaluation for additional injections as needed.	0.5 mL/month

Eylea®	Neovascular (wet) AMD: 2 mg (0.05 mL) administered by intravitreal injection once a month for 3 months then 2mg every 2 months.	2 mg/month
Lucentis®	Neovascular (wet) AMD: 0.5 mg (0.05 mL) administered by intravitreal injection once a month. <u>Alternative dosing:</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.	0.5 mg/month
	Myopic CNV: 0.5 mg (0.05 mL) administered by intravitreal injection once a month for up to 3 months. Patients may be retreated if needed.	0.5 mg/month

Therapeutic alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand, Brand name® when the drug is available by brand only and generic name when the drug is available by generic only.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Patients with porphyria or a known hypersensitivity to any component of the Visudyne® preparation.

- 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.

References

1. Visudyne® Prescribing Information. Bridgewater, NJ: Bausch Health US, LLC; July 2021. Available at: www.visudyne.com. Accessed October 2, 2021.
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3. Diaz RI, Sigler EJ, Rafieetary MR, Calzada JI. Ocular histoplasmosis syndrome. Surv Ophthalm. 2015; 60(4): 279-295. Available at: https://www.aaopt.org/detail/knowledge-base-article/choroidal-neovascularization-with-progressive-peripapillary-atrophy-in-a-patient-with-presumed-ocular-histoplasmosis. Accessed October 2, 2021.
4. Wolf S, Valciuniene VJ, Laganovska G, et al. RADIANCE: a randomized controlled study of ranibizumab in patients with choroidal neovascularization secondary to pathologic myopia. Ophthalmology March 2014; 121(3):682-92.e2. doi: 10.1016/j.ophtha.2013.10.023. Epub 2013 Dec 8. Available at: https://pubmed.ncbi.nlm.nih.gov/24326106/. Accessed October 2, 2021.
5. Ohno-Matsui K, Ikuno Y, Lai TY, et al. Diagnosis and treatment guideline for myopic choroidal neovascularization due to pathologic myopia. Progress in Retinal and Eye Research. 2018; 63: 92-106. Available at: https://pubmed.ncbi.nlm.nih.gov/29111299/. Accessed October 2, 2021.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated. Line of business policy applies was updated to all lines of business. 2. Initial approval criteria I.A.4 updated to include anti-VEGF drug as first-line. 3. Continued therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance…". 4. Commercial approval duration was updated from "length of benefit" to 3 months for initial and continued approval criteria. 5. Appendix A was updated to include VEGF. 6. Appendix B for therapeutic alternatives standard	10/05/2020	12/07/2020

verbiage has been updated. Section also updated to include more specific alternatives and remove discontinued products. 7. References were updated.		
Policy was reviewed: 1. Statement about provider sample "The provision of provider samples does not guarantee coverage…" was added to Clinical Policy. 2. Limitations of use removed from background. 3. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 4. Statement about drug listing format in Appendix B is updated to "Therapeutic alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand, Brand name® when the drug is available by brand only and generic name when the drug is available by generic only. 5. Appendix A was updated to include abbreviations for BCVA. 6. References were reviewed and updated.	10/02/2021	12/07/2021