Pharmacy Policy

Rho Kinase Inhibitors

Policy Number: 9.912
Revision Number: R0
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☒ New Hampshire Medicaid	☐ MassHealth- MCO ☐ MassHealth- ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Rhopressa Ophthalmic Solution 0.02%**
- **Rocklatan Ophthalmic Solution 0.02%/0.005%**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All medically excepted indications unless otherwise excluded
Exclusion Criteria	Previous glaucoma intraocular surgery or glaucoma laser procedure in the affected eye. Ocular surgery or laser treatment within three months prior to initiation and member does not currently have any of the following: ocular infection or disease, inflammation, blepharitis or conjunctivitis.
Required Medical Information	1. Diagnosis of open-angle glaucoma or ocular hypertension; AND 2. An inadequate response or intolerance to a Preferred prostaglandin agonist

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

	ophthalmic solution and a Preferred beta blocker ophthalmic solution (See Appendix A).
Age Restrictions	18 years of age and older
Prescriber Restriction	None
Coverage Duration	12 months
Quantity Limit	5mL per 30 days
Other criteria	Reauthorization 1. Patient must continue to meet above initial criteria; AND 2. Provider attestation of demonstrated efficacy (e.g., reduction in IOP).

Appendix A

Beta Blocker Agents	**Prostaglandin Agonist Agents**
betaxolol (generic for Betoptic®)	bimatoprost (generic for Lumigan®)
carteolol (generic for Ocupress®)	latanoprost/PF (generic for Xalatan®)
Combigan®	Travatan Z®
dorzolamide/timolol/PF (generic for Cosopt®*/PF®)	timolol/brimonidine/dorzolamide/latanoprost
levobunolol (generic for Betagan®)	timolol/dorzolamide/latanoprost/PF
metipranolol (generic for OptiPranolol®)	timolol/latanoprost/PF
timolol (generic for Timoptic®)	travoprost (generic for Travatan®)
timolol XE (generic for Timoptic XE®)	
timolol/brimonidine/dorzolamide/latanoprost	
timolol/brimonidine/dorzolamide/PF	
timolol/dorzolamide/latanoprost/PF	

*If a combination agent appears in 2 classes, it will only count as 1 agent for trial/failure purposes

Clinical Background Information and References

1. Rhopressa (netasurdil) Prescribing Information. Aerie Pharmaceuticals, Inc. Irvine, CA 92614. March 2019.
2. Jacobs, DS. Open-angle Glaucoma: Treatment. UptoDate. Last updated April 23, 2019. Accessed July 2019.
3. Rocklatan (netarsudil/latanoprost) [prescribing information]. Aerie Pharmaceuticals, Inc. Irvine, CA 92614. June 2020.

Original Approval Date	Original Effective Date	Policy Owner	Approved by

9/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
9/10/2020	9.700 Rhopressa Policy retired, new policy created. Replaced documentation language with attestation, added Appendix to list PDL preferred agents	1/1/2021	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.