Ascension
Personalized Care

Ascension

Verteporfin

(Visudyne®) J3396 (0.1mg)

Covered with prior authorization

Visudyne® (Verteporfin) may be authorized when the following criteria are met:

- Individual is 18 years of age or older; **AND**
- Individual has a diagnosis of predominantly classic subfoveal choroidal neovascularization due to one of the following:
  - Age-related macular degeneration (AMD); **OR**
  - Pathologic myopia; **OR**
  - Presumed ocular histoplasmosis; **OR**
  - Chronic central serous chorioretinopathy (also includes retinal pigment epithelial leakage without evident CNV).

Exclusion Criteria:
Requests may not be approved for the following:

- Product use for non-FDA approved indications or indications not supported by industry-accepted guidelines.
- Doses, durations, or dosing intervals that exceed FDA maximum limits for any FDA-approved indication or are not supported by industry-accepted practice guidelines or peer-reviewed literature for the relevant off-label use.

Initial authorization approval is up to 3 months.

Reauthorization approval is up to 3 months.

Reauthorization Criteria:
Visudyne® (Verteporfin)is considered medically necessary for continued use when initial criteria are met **AND** there is documentation that the patient has experienced a positive clinical response to therapy.

Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

U.S. Food and Drug Administration:
This section is to be used for informational purposes. FDA approval alone is not a basis for coverage.

Visudyne® (Verteporfin) therapy is a photo enhancer indicated for the treatment of patients with predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration, pathologic myopia or presumed ocular histoplasmosis.

References:

1. Brown DM, Michels M, Kaiser PK, et al; ANCHOR Study Group. Ranibizumab versus verteporfin photodynamic therapy for neovascular age-related macular degeneration: Two-year results of the ANCHOR study. Ophthalmology. 2009;116(1):57-65.
2. Visudyne® [Prescribing Information]. Charleston,SC: Alcami Carolinas Corporation; 2021.
3. Van Rijssen TJ, van Dijk EHC, Yzer S, et al. Central serous chorioretinopathy: Towards an evidence-based treatment guideline. Prog Retin Eye Res. 2019;73:100770

Criteria History/ Revision Information:

Date	Summary of Changes
August 2022	Criteria for use summary developed by the Ascension Medical Specialty Prior Authorization Team.
September 2022	Criteria for use summary approved by the Ascension Ambulatory Care Expert Review Panel.

If you have questions, call 833-980-2352 to speak to a member of the Ascension Rx prior authorization team.

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