

**Clinical Policy: Verteporfin (Visudyne)**

Reference Number: IL.PHAR.187

Effective Date: 1.1.20

Last Review Date: 2.20.24

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Verteporfin (Visudyne<sup>®</sup>) is a light activated drug used in photodynamic therapy.

**FDA Approved Indication(s)**

Visudyne 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

Limitation(s) of use: There is insufficient evidence to indicate Visudyne for the treatment of predominantly occult subfoveal choroidal neovascularization.

**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Visudyne is **medically necessary** when the following criteria are met:

**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  $\geq$  18 years;
4. For AMD, member meets one of the following (a or b):
  - a. Failure of intravitreal bevacizumab solution, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for bevacizumab intravitreal solution. Requests for IV formulations of Avastin, Mvasi, and Zirabev will not be approved*
  - b. Disease has progressed after use of a vascular endothelial growth factor (VEGF) as first-line treatment;
5. For CNV due to pathologic myopia, failure of intravitreal bevacizumab (Avastin) unless contraindicated or clinically significant adverse effects are experienced;

*\*Prior authorization may be required for bevacizumab and Lucentis*

6. Dose does not exceed 6 mg/m<sup>2</sup> body surface area.

**Approval duration:**

**Medicaid** – 3 months (1 dose)

**B. Central Serous Chorioretinopathy (off-label) (must meet all):**

1. Diagnosis of central serous chorioretinopathy confirmed by retinal scan;
2. Prescribed by or in consultation with an ophthalmologist;
3. Disease is characterized as chronic or recurrent as evidenced by one of the following (a or b):
  - a. Persistent subretinal fluid for  $\geq 3$  months;
  - b. Persistent subretinal fluid for  $< 3$  months and prescriber attestation that member is symptomatic (e.g., blurry central vision);
4. Member meets one of the following (a or b):
  - a. Member is not taking medications from any of the following classes: corticosteroids, stimulants, decongestants, or erectile dysfunction medications;
  - b. Documentation that prescriber has evaluated medications as risk factors if they are from any of the following classes: corticosteroids, stimulants, decongestants, or erectile dysfunction medications;
5. Dose does not exceed 6 mg/m<sup>2</sup> body surface area.

**Approval duration:**

**HIM/Medicaid** – 3 months (1 dose)

**Commercial** – 12 months or duration of request, whichever is less

**C. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Choroidal Neovascularization (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
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<sup>2</sup> body surface area.

**Approval duration:**

**Medicaid** – 3 months (1 dose)

**B. Central Serous Chorioretinopathy (off-label):**

- 1. Re-authorization is not permitted. Members must meet the initial approval criteria.

**Approval duration: Not applicable**

**C. Other diagnoses/indications (must meet 1 or 2):**

- 1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: and CP.PMN.16 for Medicaid; or
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage document.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

AMD: age-related macular degeneration

CNV: choroidal neovascularization

FDA: Food and Drug Administration

mCNV: myopic choroidal neovascularization

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
bevacizumab (Avastin®)	<b>Neovascular (wet) AMD:</b> 1.25 to 2.5 mg administered by intravitreal injection every 4 weeks	2.5 mg/month
	<b>mCNV:</b> 0.05 mL initial intravitreal injection, followed by monthly evaluation for additional injections as needed	0.5 mL/month
Beovu® (brolucizumab)	<b>Neovascular (wet) AMD:</b> 6 mg (1 via) administered by intravitreal injection every 4 weeks for the first 3 months, then every 8 or 12 weeks thereafter	6 mg (1 vial) every 2 months after loading period
Eylea® (afibercept)	<b>Neovascular (wet) AMD:</b> 2 mg (0.05 mL) administered by intravitreal injection once a month for 3 months then 2mg every 2 months.	Eylea: 2 mg/month  Eylea HD: 0.8 mg/dose
Lucentis® (ranibizumab)	<b>Neovascular (wet) AMD:</b> 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
	<b>Myopic CNV:</b> 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
Macugen® (pegaptanib)	<b>Neovascular (wet) AMD:</b> 0.3 mg (0.09 mL) administered by intravitreal injection every 6 weeks	0.3 mg/6 weeks

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

*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.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration, pathologic myopia or presumed ocular histoplasmosis	6 mg/m <sup>2</sup> Body Surface Area IV diluted with 5% dextrose to a final volume of 30 mL infused over 10 minutes	6 mg/m <sup>2</sup> IV

**VI. Product Availability**

Vial for reconstitution: 15 mg (2 mg/mL after reconstitution)

**VII. References**

1. Visudyne Prescribing Information. Bridgewater, NJ: Valeant Ophthalmics; February 2023. Available at: [www.visudyne.com](http://www.visudyne.com). Accessed November 2, 2023.
2. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; October 2019. Available at: [www.aao.org/ppp](http://www.aao.org/ppp). Accessed November 2, 2023.
3. Diaz RI, Sigler EJ, Rafieetary MR, Calzada JI. Ocular histoplasmosis syndrome. *Surv Ophthalmol*. 2015; 60(4): 279-295.

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*. 2014; 121(3):682-92.e2. doi: 10.1016/j.ophtha.2013.10.023. Epub 2013 Dec 8.
5. Salehi M, Wenick S, Law HA, Evans JR, Gehlbach P. Interventions for central serous chorioretinopathy: a network meta-analysis. *Cochrane Database Syst Rev*. 2016; 12. doi: 10.1002/14651858.CD011841.pub2.
6. Hanumunthadu D, Tan ACS, Singh SR, et al. Management of chronic central serous chorioretinopathy. *Indian J Ophthalmol*. 2018; 66(12): 1704-1714.
7. Van Rijssen TJ, van Dijk EHC, Yzer S, et al. Central serous chorioretinopathy: towards an evidence-based treatment guideline. *Progress in Retinal and Eye Research*. 2019; 73. doi: 10.1016/j.preteyeres.2019.07.003.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3396	Injection, verteporfin, 0.1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PHAR.187 Verteporfin (Visudyne) policy.	12.11.19	
1Q 2020 annual review: no significant changes; added Avastin biosimilar to therapeutic alternatives; references reviewed and updated.	12.31.19	1.7.20
2Q2021 annual review: redirection to “bevacizumab intravitreal solution” given availability of generic	4.15.2021	
2Q 2022 annual review: no significant changes; references reviewed and updated	4.26.22	
1Q 2024 Annual review: Template changes applied to other diagnoses/indications and continued therapy section. In Appendix B, added Eylea HD dosing information; references reviewed and updated.	2.20.24	

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.



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