SPECIALTY GUIDELINE MANAGEMENT

VISUDYNE (verteporfin)

POLICY

A. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Visudyne is indicated for the treatment of patients with predominantly classic subfoveal choroidal neovascularization due to age related macular degeneration, pathologic myopia, or presumed ocular histoplasmosis.

Compendial Uses

- Occult choroidal neovascularization
- Central serious chorioretinopathy
- Juxtafoveal retinal telangiectasia
- Choroidal hemangioma
- Polypoidal choroidal vasculopathy

All other indications are considered experimental/investigational and are not covered benefits.

B. PRESCRIBER RESTRICTION

Visudyne must be prescribed by, or in conjunction with, an ophthalmologist.

C. CRITERIA FOR APPROVAL

1. Ocular Indications
   a. Authorization of 12 months may be granted for members prescribed Visudyne for any of the following indications:
      i. Classic subfoveal choroidal neovascularization due to age-related macular degeneration
      ii. Pathologic myopia
      iii. Presumed ocular histoplasmosis
      iv. Occult subfoveal choroidal neovascularization
      v. Central serious chorioretinopathy
      vi. Juxtafoveal retinal telangiectasia
      vii. Choroidal hemangioma
      viii. Polypoidal choroidal vasculopathy

D. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

E. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

REFERENCES


Visudyne SGM P2015


