Aflibercept

Included Products: Eylea (aflibercept), Eylea HD (aflibercept)

Nonformulary for outpatient benefit. PA required on medical benefit.

Created: 03/13/2012 *Revised:* 11/09/2023 *Reviewed:* 11/09/2023 *Updated:* 12/01/2023

Diabetic Macular Edema (DME) Or Diabetic Retinopathy (DR)

Initial Criteria		If yes	If no
1.	Does the member have diabetic macular edema or diabetic retinopathy in diabetic macular edema?	Continue to #2.	Do not approve.
2.	Has the member tried and failed Avastin?	Continue to #3.	Do not approve.
3.	Is the request for Eylea HD?	Continue to #4.	Continue to #5.
4.	Is the intent to inject Eylea HD at an interval of every 9 weeks or greater?	Continue to #5.	Do not approve.
5.	Approve for 6 months, with the following renewal language: “Renewal after the initial 6 months requires either documentation that you will reduce the dosing frequency OR evidence of the medical necessity for more frequent treatments.”		
Renewal Criteria		**If yes**	**If no**
1.	Is the request for a dosing interval greater than 4 weeks?	Continue to #3.	Continue to #2.
2.	Is there documentation that extended interval dosing has been tried and failed?	Continue to #3.	Do not approve.
3.	Has the member demonstrated disease stabilization or clinical response?	Continue to #4.	Do not approve.
4.	Approve the requested quantity for 12 months.		

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Macular Edema Following Retinal Vein Occlusion (RVO)

Initial Criteria		If yes	If no
1.	Does the member have macular edema following retinal or branch retinal vein occlusion (RVO or BRVO)?	Continue to #2.	Do not approve.
2.	Has the member tried and failed Avastin?	Continue to #3.	Do not approve.
3.	Approve for 12 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member demonstrated disease stabilization or clinical response?	Continue to #2	Do not approve.
2.	Approve the requested quantity for 12 months.		

Neovascular (Wet) Age-Related Macular Degeneration (AMD)

Initial Criteria		If yes	If no
1.	Does the member have exudative (wet) age-related macular degeneration (AMD)?	Continue to #2.	Do not approve.
2.	Has the member tried and failed Avastin?	Continue to #3.	Do not approve.
3.	Is the request for Eylea HD?	Continue to #4.	Continue to #5.
4.	Is the intent to inject Eylea HD at an interval of every 9 weeks or greater?	Continue to #5.	Do not approve.
5.	Approve for 3 months with the following approval language: “Renewal after the initial 3 months requires either documentation that you will reduce the dosing frequency OR evidence of the medical necessity for more frequent treatments.”		
Renewal Criteria		**If yes**	**If no**
1.	Is the request for a dosing interval greater than 4 weeks?	Continue to #3.	Continue to #2.

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2.	Is there documentation that extended interval dosing has been tried and failed?	Continue to #3.	Do not approve.
3.	Has the member demonstrated disease stabilization or clinical response?	Continue to #4.	Do not approve.
4.	Approve the requested quantity for 12 months.		

Retinopathy of Prematurity

Initial Criteria		If yes	If no
1.	Has the member tried and failed Avastin?	Continue to #2.	Do not approve.
2.	Approve for 6 months.		