

## **Clinical Policy: Pegaptanib (Macugen)**

Reference Number: CP.PHAR.185

Effective Date: 03.16

Last Review Date: 02.19

Line of Business: Commercial, Medicaid

[Coding Implications](#)

[Revision Log](#)

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

### **Description**

Pegaptanib (Macugen<sup>®</sup>) is a selective vascular endothelial growth factor (VEGF) antagonist.

### **FDA Approved Indication(s)**

Macugen is indicated for the treatment of neovascular (wet) age-related macular degeneration (AMD).]

### **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 Macugen is **medically necessary** when the following criteria are met:

## **I. Initial Approval Criteria**

### **A. Neovascular Age-Related Macular Degeneration** (must meet all):

1. Diagnosis of neovascular (wet) AMD;
2. Prescribed by or in consultation with an ophthalmologist;
3. Age  $\geq$  18 years;
4. Failure of intravitreal bevacizumab, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for bevacizumab*
5. Dose does not exceed 0.3 mg (1 syringe) every 6 weeks.

**Approval duration: 6 months**

### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

## **II. Continued Therapy**

### **A. Neovascular Age-Related Macular Degeneration** (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. If request is for a dose increase, new dose does not exceed 0.3 mg (1 syringe) every 6 weeks.

**Approval duration: 6 months**

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less);** or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and 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.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage document.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

AMD: age-related macular degeneration

FDA: Food and Drug Administration

VEGF: vascular endothelial growth factor

*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.*

| Drug Name  | Dosing Regimen   | Dose Limit/<br>Maximum Dose |
|--|--|-----------------------------|
| Avastin <sup>®</sup><br>(bevacizumab),<br>Mvasi <sup>™</sup><br>(bevacizumab-<br>awwb) | <b>Neovascular (wet) AMD:</b><br>1.25 to 2.5 mg administered by intravitreal injection every 4 weeks | 2.5 mg/month                |

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

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s):
  - In patients with ocular or periocular infections

- In patients with known hypersensitivity to pegaptanib sodium or any other excipient in this product
- Boxed warning(s): none reported

*Appendix D: General Information*

- In the VEGF Inhibition Study in Ocular Neovascularization (VISION) trial, the proportion of patients who lost fewer than 15 letters at week 54 for patients treated with Macugen 0.3 mg was 70%, compared to 55% for placebo (p < 0.001). There was a significant difference in adverse events between patients treated with Macugen compared to placebo for vitreous floaters (33% vs. 8%, p < 0.001), vitreous opacities (18% vs. 10%, p < 0.001), and anterior chamber inflammation (14% vs. 6%, p = 0.001).

**V. Dosage and Administration**

| Indication            | Dosing Regimen  | Maximum Dose         |
|-----------------------|---|----------------------|
| Neovascular (wet) AMD | 0.3 mg (0.09 mL) administered by intravitreal injection every 6 weeks | 0.3 mg every 6 weeks |

**VI. Product Availability**

Single-use syringe: 0.3 mg/90 µL solution for intravitreal injection

**VII. References**

1. Macugen Prescribing Information. Bridgewater, NJ: Bausch + Lomb; July 2016. Available at: [www.macugen.com](http://www.macugen.com). Accessed October 26, 2018.
2. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern<sup>®</sup> Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; January 2015. Available at: [www.aao.org/ppp](http://www.aao.org/ppp). Accessed October 26, 2018.

**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                          |
|-------------|--------------------------------------|
| J2503       | Injection, pegaptanib sodium, 0.3 mg |

| Reviews, Revisions, and Approvals   | Date  | P&T Approval Date |
|---|-------|-------------------|
| Medicaid: Policy converted to new template and split from CP.PHAR.39 AMD Retinal Disorder Treatments.<br>Criteria: added age and max dose; monotherapy defined as “other anti-VEGF drugs” since Visudyne is sometimes used with anti-VEGF drugs in nonresponsive cases; removed requests for documentation. | 03.16 | 03.16             |

| Reviews, Revisions, and Approvals   | Date     | P&T Approval Date |
|---|----------|-------------------|
| Medicaid: Removed age restriction. Removed hypersensitivity safety criteria.<br>For re-auth: modified “Currently receiving...” to “Previously received...”;<br>modified documentation of positive response criterion to be open-ended; added criterion to verify that Macugen is not being used with other anti-VEGF therapies.   | 03.17    | 03.17             |
| 1Q18 annual review: Policies combined for Medicaid and commercial; For Medicaid: Added bevacizumab redirection, Added specific documentation of positive response to therapy required for continued approval, Added “not used concomitantly with other VEGF therapies” to section III. Diagnoses/indications NOT authorized, Added specialist requirement, Removed criteria checking for contraindications (ocular infections) due to its ophthalmic nature and addition of specialist requirement, Added age limit following safety guidance, References reviewed and updated. | 11.28.17 | 02.18             |
| 1Q 2019 annual review: reduced commercial approval durations from length of benefit to 6 months; removed section III requirement against concomitant use with other VEGF medications; references reviewed and updated.  | 11.20.18 | 02.19             |

**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.

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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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