SPECIALTY GUIDELINE MANAGEMENT

LUCENTIS (ranibizumab)

POLICY

I. INDICATIONS

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

FDA-Approved Indications

A. Neovascular (wet) age-related macular degeneration
B. Macular edema following retinal vein occlusion
C. Diabetic macular edema
D. Diabetic retinopathy
E. Myopic choroidal neovascularization

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

II. CRITERIA FOR INITIAL APPROVAL

A. Diabetic Macular Edema
   Authorization of 24 months may be granted for treatment of diabetic macular edema.

B. Neovascular (Wet) Age-Related Macular Degeneration
   Authorization of 24 months may be granted for treatment of neovascular (wet) age-related macular degeneration.

C. Macular Edema Following Retinal Vein Occlusion
   Authorization of 24 months may be granted for treatment of macular edema following retinal vein occlusion.

D. Diabetic Retinopathy
   Authorization of 24 months may be granted for treatment of diabetic retinopathy.

E. Myopic Choroidal Neovascularization
   Authorization of 24 months may be granted for treatment of myopic choroidal neovascularization.

III. CONTINUATION OF THERAPY

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