



**Ophthalmic NSAID**  
**Effective 10/1/2022**

<b>Plan</b>	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input type="checkbox"/> Prior Authorization
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		<input type="checkbox"/> Quantity Limit <input checked="" type="checkbox"/> Step Therapy
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

**Overview**

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:

**First-Line:** Medications listed on first-line are covered without prior-authorization.

**Second-Line:** Second-line medications will pay if the member has filled at least two different first-line medications or a second-line medication within the past 180 days.

**Coverage Guidelines**

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member has had a documented inadequate response or side effect to at least two different 1st-line topical corticosteroids.

FIRST-LINE	SECOND-LINE
diclofenac 0.1% (Voltaren®)	bromfenac (compare to Xibrom®) 0.09%
flurbiprofen 0.03% (Ocufen®)	Acuvail® (ketorolac) 0.45%
ketorolac 0.4% (Acular® LS)	Ilevro® (nepafenac) 0.3%
ketorolac 0.5% (Acular®)	Nevanac® (nepafenac) 0.1%
	Prolensa® (bromfenac) 0.07%

**Limitations**

- Approvals will be granted for 12 months within the quantity limit.



2. The following quantity limits apply:

diclofenac 0.1% (Voltaren <sup>®</sup> )	5 mL
flurbiprofen 0.03% (Ocufer <sup>®</sup> )	5 mL
ketorolac 0.4% (Acular <sup>®</sup> LS)	5 mL
ketorolac 0.5% (Acular <sup>®</sup> )	10 mL <u>per 25 days</u>
bromfenac 0.09% (Compare to Xibrom <sup>®</sup> )	5 mL
Acuvail <sup>®</sup> (ketorolac) 0.45%	60 single-use vials (2 boxes)
Ilevro <sup>®</sup> (nepafenac) 0.3%	1.7 mL
Nevanac <sup>®</sup> (nepafenac) 0.1%	3 mL
Prolensa <sup>®</sup> (bromfenac) 0.07%	3.2 mL

### References

N/A

### Review History

Implementation Date: 04/04/11

Reviewed: 02/28/11; 02/27/12; 02/25/13; 02/23/15 P&T Mtg

Reviewed & updated: 02/24/14 P&T Mtg

Updated: 06/20/11 (gen Xibrom 6/6/11 file); 01/13/14 (Prolensa added; 05/06/13 file)

06/22/2022: Reviewed and Updated for Jun P&T; no clinical changes. Effective 10/1/2022

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