



Nonprofit corporations and independent licensees  
of the Blue Cross and Blue Shield Association

Medical benefit drug policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and therefore subject to change.

**Effective Date: 06/06/2024**

### **Vabysmo™ (faricimab-svoa)**

**HCPCS: J2777**

#### **Policy:**

*Requests must be supported by submission of chart notes and patient specific documentation.*

- A. Coverage of the requested drug is provided when all the following are met:
  - a. FDA approved indication
  - b. FDA approved age
  - c. Treatment with bevacizumab or a bevacizumab biosimilar has been ineffective, not tolerated or contraindicated
    - i. Trial and failure of bevacizumab is NOT required for those with a diagnosis of diabetic macular edema when visual acuity in the affected eye(s) is less than or equal to 20/50
  - d. Trial and failure, contraindication, OR intolerance to the preferred drugs as listed in BCBSM/BCN's utilization management medical drug list
- B. Quantity Limitations, Authorization Period and Renewal Criteria
  - a. Quantity Limits: Align with FDA recommended dosing
  - b. Authorization Period: For at least 60 days and up to one year at a time
  - c. Renewal Criteria: Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit

\*\*\*Note: Coverage and approval duration may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at <http://www.cms.hhs.gov/>. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

#### **Background Information:**

- Intravitreal injections of anti-vascular endothelial growth factor (VEGF) have been widely used by ophthalmologists to treat a variety of ocular diseases. They are injected directly into the eye to prevent the formation of new blood vessels and reduce blood vessel leakage and inflammation. Vabysmo is an anti-VEGF therapy indicated for neovascular (wet) age related macular degeneration (AMD) and diabetic macular edema (DME).

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- Age-related Macular Degeneration
  - Age-related macular degeneration is a degenerative disease of the macula that results primarily in loss of central vision. Wet AMD is characterized by growth of abnormal vessels into the subretinal space. These abnormal blood vessels leak leading to collections of subretinal fluid and/or blood beneath the retina. The 2022 American Academy of Ophthalmologists (AAO) Age-Related Macular Degeneration Preferred Practice Pattern Guidelines recommend observation and early detection, antioxidant vitamin and mineral supplements, and intravitreal injections of anti-VEGF agents for the management of wet AMD. Guidelines recommend Eylea™, Avastin®, Vabysmo, or Lucentis® for treatment. The guidelines have not been updated with Beovu®, Byooviz™, and Susvimo™.
- Diabetic Macular Edema
  - Diabetic retinopathy and DME are common complications and the ocular manifestations of end-organ damage in diabetes mellitus. The 2022 AAO Diabetic Retinopathy Preferred Practice Pattern Guidelines state the goals of therapy for DR and DME include improvement or stabilization of visual function, improvement in vision-related quality of life, and optimal control of blood glucose, blood pressure, and other metabolic risk factors. Patients should always be treated with anti-VEGF therapy if they have severe non-proliferative DR or proliferative DR with center-involved macular edema. In cases of mild to moderate non-proliferative DR with center-involved macular edema, patients should also receive intravitreal injections. The guidelines support the use of Lucentis, Eylea, Vabysmo, and Avastin. AAO recommendations were based on trials comparing Eylea, Avastin, and Lucentis to focal laser treatment. All trials showed that treatment with VEGF inhibitors resulted in statistically and clinically significant improvements in visual acuity in patients with DME after one to two years compared to laser treatment.
- There are very few randomized control trials that assess the efficacy of one anti-VEGF therapy over another. Of the two that are available, Avastin, Eylea, and Lucentis were all shown to be non-inferior to each other, and because of this, choice of therapy should be based on patient characteristics, side effect profiles, cost, and availability. However, a 2015 study conducted by Wells, et al. did show Eylea was superior to Avastin therapy when patients had a visual acuity of less than or equal to 20/50. In addition, a subcohort analysis of the YOSEMITE AND RHINE trials showed Vabysmo demonstrated BCVA gains similar to aflibercept, while demonstrating numerically greater improvements in anatomic outcomes at years 1 and 2. Therefore, in these scenarios Avastin should not be used prior to Eylea or Vabysmo.

## References:

1. Avastin [prescribing information]. South San Francisco, CA: Genentech, Inc.; January 2021.
2. Vabysmo [prescribing information]. South San Francisco, CA: Genentech, Inc.; October 2023.
3. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-related macular degeneration preferred practice pattern. *Ophthalmology*. 2020 Jan (updated March 2022); 127 (1): P1 - P65.
4. Tufail A, Patel PJ, Egan C, et al. Bevacizumab for neovascular age related macular degeneration (ABC Trial): multicentre randomized double masked study. *BMJ*. 2010; 340: c2459.
5. Michaelides M, Kaines A, Hamilton R, et al. A prospective randomized trial of intravitreal bevacizumab or laser therapy in the management of diabetic macular edema (BOLT Study). *Amer Acad Ophth*. 2010 Mar; 117 (6): 1078 – 86.
6. Wells JA, Glassman AR, Ayala AR, et al. Aflibercept, bevacizumab, or ranibizumab for diabetic macular edema. *NEJM*. 2015 March 26; 372 (13): 1193 – 203.
7. Vedula SS & Krzystolik MG. Antiangiogenic therapy with anti-vascular endothelial growth factor modalities for neovascular age-related macular degeneration. *The Cochrane database of systematic reviews*. 2008(2):CD005139. PMID: 18425911 6.

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8. Solomon SD, Lindsley K, Vedula SS, et al. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. The Cochrane database of systematic reviews. 2019 Mar 4; 3: CD005139. PMID: 30834517.
9. Zarbin M, Ding A, Tabano D, et al. Clinical outcomes of diabetic macular edema patients treated with faricimab and aflibercept: a subcohort analysis of 20/50 or worse visual acuity across faricimab phase 3 clinical trials. Presented at: The Professional Society for Health Economics and Outcomes Research Europe Conference in Vienna, Austria. 2022 Nov 6 – 9.
10. Jhaveri CD, Glassman AR, Ferris FL, et al. Aflibercept monotherapy or bevacizumab first for diabetic macular edema. NEJM. 2022 Aug 25; 387: 692 – 703.

Policy History												
#	Date	Change Description										
1.5	Effective Date: 06/06/2024	Annual review of criteria was performed, no changes were made										
1.4	Effective Date: 06/08/2023	Annual review of criteria was performed, no changes were made										
1.3	Effective Date: 04/06/2023	New policy. This policy replaces previously approved criteria that was embedded in the Intravitreal Injections for Retinal Conditions Policy which is being split into individual drug policies and retired. The authorization period was updated from up to 1 year to at least 60 days and up to 1 year										
1.2	Effective Date: 03/07/2022	UM medical management system update for MAPPO and BCNA <table border="1" style="margin: 10px auto; width: 80%;"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>Yes</td> </tr> <tr> <td>BCN</td> <td>Yes</td> </tr> <tr> <td>MAPPO</td> <td>Yes</td> </tr> <tr> <td>BCNA</td> <td>Yes</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	Yes	BCNA	Yes
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1.1	Effective Date: 02/24/2022	UM medical management system update for BCBSM and BCN <table border="1" style="margin: 10px auto; width: 80%;"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>Yes</td> </tr> <tr> <td>BCN</td> <td>Yes</td> </tr> <tr> <td>MAPPO</td> <td>No</td> </tr> <tr> <td>BCNA</td> <td>No</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	No	BCNA	No
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1.0	Effective Date: 12/09/2021	Preliminary Drug Review <table border="1" style="margin: 10px auto; width: 80%;"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>No</td> </tr> <tr> <td>BCN</td> <td>No</td> </tr> <tr> <td>MAPPO</td> <td>No</td> </tr> <tr> <td>BCNA</td> <td>No</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	No	BCN	No	MAPPO	No	BCNA	No
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\* The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or <http://dailymed.nlm.nih.gov/dailymed/index.cfm>.

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# Blue Cross Blue Shield/Blue Care Network of Michigan

## Medication Authorization Request Form

Vabysmo™ (faricimab-svoa): J2777



This form is to be used by participating physicians to obtain coverage for Vabysmo. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

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PATIENT INFORMATION	PHYSICIAN INFORMATION
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Address</b>
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b>	<b>Phone/Fax: P: (     ) -     F: (     ) -</b>
<b>Dose and Quantity</b>	<b>NPI</b>
<b>Directions</b>	<b>Contact Person</b>
<b>Date of Service(s)</b>	<b>Contact Person Phone / Ext.</b>

**STEP 1: DISEASE STATE INFORMATION**

1. Is this request for:  Initiation  Continuation *Date patient started therapy:* \_\_\_\_\_
2. Please provide the NPI number for the place of administration: \_\_\_\_\_
3. **Initiation AND Continuation of therapy:**
  - a. What eye(s) will be treated?  Left eye  Right eye
  - b. What is the patient's dose and frequency of requested medication?  
 Initiation - Dose: \_\_\_\_\_mg Frequency:  4 weeks  6 weeks  8 weeks  Other: \_\_\_\_\_  
 Maintenance - Dose: \_\_\_\_\_mg Frequency every:  4 weeks  6 weeks  8 weeks  Other: \_\_\_\_\_
  - c. What is the patient's diagnosis?  
 Neovascular (wet) age-related macular degeneration (AMD)  Other, Please specify: \_\_\_\_\_  
 Diabetic macular edema (DME) \_\_\_\_\_  **Macular edema due retinal vein occlusion (ME due to RVO)**
  - a. What is the visual acuity in the right eye? \_\_\_\_\_  
 b. What is the visual acuity in the left eye? \_\_\_\_\_
  - d. Has the patient tried Avastin or bevacizumab biosimilar intravitreal treatment?  
 No  
 Yes
    - i. Which eye was treated?  Left eye  Right eye
    - ii. Please enter number of Avastin or a bevacizumab biosimilar injections patient has received and in which eye? \_\_\_\_\_
    - iii. What was the patient's frequency of Avastin or bevacizumab biosimilar?  4 weeks  6 weeks  8 weeks  Other: \_\_\_\_\_
    - iv. Dates of the last **three** Avastin or a bevacizumab biosimilar injection: \_\_\_\_\_
    - v. What was the patient's outcome while on Avastin or bevacizumab biosimilar therapy?  
 Visual acuity improvement  Reduction in edema  Decrease in retinal thickness  Condition remained the same  
 Worsening in visual acuity  Increased edema  Increase in retinal thickness  
 Intolerance to the medication: \_\_\_\_\_  
 Other, Please list: \_\_\_\_\_
  - e. Has the patient failed treatment with other anti-VEGF therapy?  Yes  No
    - i. If yes, List what treatment(s) patient failed: \_\_\_\_\_
4. **Continuation of therapy:**
  - a. How has the patient's condition changed while on therapy?  
 Improved; Please describe: \_\_\_\_\_  
 Stable; Please describe: \_\_\_\_\_  
 Worsened; Please describe: \_\_\_\_\_  
 Other; Please describe: \_\_\_\_\_

**Please add any other supporting medical information necessary for our review**

**Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.**

Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

<b>Physician's Name</b>	<b>Physician Signature</b>	<b>Date</b>
<b>Step 2: Checklist</b>	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached chart notes	
<b>Step 3: Submit</b>	By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979	By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320