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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.

**P&T Date: 10/09/2025**

### **Intravitreal Corticosteroid Implants for Posterior Non-Infectious Uveitis**

**Iluvien®** (fluocinolone acetonide)

**Ozurdex®** (dexamethasone)

**Retisert®** (fluocinolone acetonide)

**HCPCS:** Iluvien: J7313; Ozurdex: J7312; Retisert: J7311

#### **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. 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: One year at a time and align with FDA recommended duration of treatment
  - 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:

- Uveitis is one of the leading causes of vision loss with patients also at a high risk of ocular complications, including glaucoma, macular edema, and cataracts. Recurring flares may lead to cumulative eye damage and increasing risk of impaired vision or blindness.
- There are four types of uveitis, classified according to the part of the uvea that is affected. Anterior uveitis, which affects the front part of the eye, is also sometimes called iritis since the iris is part of the front of the eye. Almost 80% of cases of uveitis affect the anterior portion of the eye. Intermediate uveitis, also known as pars planitis or cyclitis, refers to inflammation of tissues in the area just behind the iris and lens of the eye. Posterior uveitis, also known as choroiditis, refers to inflammation of the choroid, the back part of the uvea. Posterior uveitis may affect the retina and/or the optic nerve and may lead to permanent loss of vision. Panuveitis refers to inflammation throughout the eye and does not refer to a specific area.
- Uveitis frequently occurs in association with other systemic medical conditions, especially infections and inflammatory diseases, but may occur as an isolated process, and can be divided into four major subsets based upon the etiology: infectious, systemic immune-mediated, syndromes usually confined to the eye, and masquerade syndromes. Approximately 40% of patients have uveitis associated with a systemic immune-mediated disease. Approximately 30% of patients with uveitis do not fit into any well-defined diagnostic category and are usually labeled as having idiopathic uveitis. Other alternative terms for idiopathic uveitis include undifferentiated and unclassifiable uveitis.
- Some people do not experience symptoms; however, symptoms may have a sudden onset and get worse quickly. Posterior uveitis is characterized by floater, reduced visual acuity, light sensitivity, blurred or lost vision, difficulty seeing in the dark, and difficulty seeing color. Of note, 50% of patients have reduced vision and 10-15% have complete vision loss. Early detection and treatment is important to reduce the risk of permanent vision loss.
- The 2018 Guidance on Non-corticosteroid Systemic Immunomodulatory Therapy in Noninfectious Uveitis and the 2019 Evidence-Based Treatment for Uveitis state there are four types of therapy that can be used to treat posterior non-infectious uveitis: topical or intravitreal corticosteroids (i.e. injectable or implantable); systemic corticosteroids (i.e. high-dose oral prednisone or intravenous methylprednisolone); systemic immunomodulators (i.e. T-cell inhibitors or antimetabolites); and biologics (i.e. adalimumab or infliximab). General consensus is to start treatment for posterior non-infectious uveitis with injectable or implantable intravitreal corticosteroids. Intravitreal corticosteroids are associated with higher rates of increased intraocular pressure (IOP) and cataracts, therefore there is a push to start patients on systemic non-steroidal therapy sooner.

## References:

1. Iluvien [prescribing information]. Alpharetta, GA: Alimera Sciences, Inc.; May 2025.
2. Ozurdex [prescribing information]. North Chicago, IL: AbbVie Inc.; May 2024.
3. Retisert [prescribing information]. Bridgewater, NJ: Bausch & Lomb Americas Inc; April 2025.
4. Yutiq [prescribing information]. Watertown, MA: EyePoint Pharmaceuticals US, Inc.; June 2023.
5. Rosenbaum JT, Bodaghi B, Couto C, et al. New observations and emerging ideas in diagnosis and management of non-infectious uveitis: a review. *Semin Arthritis Rheum*. 2019; 49 (3): 438 – 44.
6. Dick AD, Accorinti M, Rosenbaum JT, et al. Guidance on noncorticosteroid systemic immunomodulatory therapy in noninfectious uveitis. *Ophthalmology*. 2018 May; 125 (5): 757 – 73.
7. Gamalero L, Simonini G, Ferrara G, et al. Evidence-based treatment for uveitis. *Isr Med Assoc J*. 2019 Jul; 21 (7): 475 - 9.
8. National Organization for Rare Disorders. Posterior uveitis. 2021 April 21. Available at: <https://rarediseases.org/rare-diseases/posterior-uveitis/>. Accessed on July 21, 2025.

| Policy History |                               |                                                                               |
|----------------|-------------------------------|-------------------------------------------------------------------------------|
| #              | Date                          | Change Description                                                            |
| 1.1            | Effective Date:<br>01/01/2026 | UM medical management system update for BCBS and BCN for Iluvien and Retisert |
| 1.0            | Effective Date:<br>10/09/2025 | New Policy                                                                    |

*\* 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>.*

# Blue Cross Blue Shield/Blue Care Network of Michigan Medication Authorization Request Form



This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. 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                                |
|----------------------------------------------------------------------|------------------------------------------------------|
| Name                                                                 | Name                                                 |
| ID Number                                                            | Specialty                                            |
| D.O.B. <input type="checkbox"/> Male <input type="checkbox"/> Female | Address                                              |
| Diagnosis                                                            | City /State/Zip                                      |
| Drug Name                                                            | Phone/Fax: P: (       )       - F: (       )       - |
| Dose and Quantity                                                    | NPI                                                  |
| Directions                                                           | Contact Person                                       |
| Date of Service(s)                                                   | Contact Person<br>Phone / Ext.                       |

## STEP 1: DISEASE STATE INFORMATION

- Is this request for: ☐ Initiation ☐ Continuation Date patient started therapy: \_\_\_\_\_
- Administered by patient or a medical professional? ☐ patient (self) ☐ health care professional (physician, nurse, etc.)
- Site of administration? ☐ Provider office/Home infusion ☐ Other: \_\_\_\_\_  
☐ Hospital outpatient facility (go to #4) Reason for Hospital Outpatient administration: \_\_\_\_\_  
☐ Hospital inpatient facility for Car-T therapy only (for example: Kymriah, Yescarta, or Tecartus) (go to #5)
- Please specify location of administration if hospital outpatient infusion: \_\_\_\_\_
- Please specify location of administration if hospital inpatient infusion: \_\_\_\_\_
- Please provide the NPI number for the place of administration: \_\_\_\_\_
- Initiation AND Continuation of therapy:**
  - What is the patient's diagnosis? \_\_\_\_\_
  - What other medication has the patient received for their condition? Please list \_\_\_\_\_  
    - Please describe the response to previous therapies: \_\_\_\_\_
  - Will the patient be receiving any other treatment for the listed condition while on this medication? Please list: \_\_\_\_\_
  - Please list any labs values important for diagnosing or monitoring this patient's condition: \_\_\_\_\_
- Continuation of therapy:**
  - Has the patient progressed while on this medication? ☐ yes ☐ no
  - How has the patient's condition changed while on this medication?
 

☐ Improved: Please describe: \_\_\_\_\_
 ☐ Stable: please describe: \_\_\_\_\_
 ☐ Worsened; Please describe: \_\_\_\_\_
 ☐ Other; Please describe: \_\_\_\_\_

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review (required)

**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

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

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7/26/2018, 9/18/2018; 1/31/2020; 3/17/2020; 8/9/2021