BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Anti-Allergy Ophthalmic Agents

Policy Number: 9.914
Version Number: 2.0
Version Effective Date: 3/1/2022

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☐ MassHealth - MCO ☐ MassHealth - ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- Alocril 2% solution (nedocromil sodium)
- Alomide 0.1 % Solution (lodoxamide tromethamine)

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	None
Required Medical Information	Alocril: Diagnosis of allergic conjunctivitis. AND

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

	1. An inadequate response, intolerance or contraindication to daily use of ketotifen AND one of the following in the last 130 days: azelastine, epinastine, olopatadine or cromolyn sodium. AND 2. The use of Alocril is NOT for acute symptoms. Alomide: Diagnosis of Ocular disorders vernal keratoconjunctivitis, vernal conjunctivitis, or vernal keratitis. **AND** 1. An inadequate response, intolerance or contraindication to daily use of ketotifen AND one of the following in the last 130 days: azelastine, epinastine, olopatadine or cromolyn sodium. **AND** 2. The use of Alomide is NOT for acute symptoms. **AND** 3. For vernal keratoconjunctivitis or vernal conjunctivitis only, concurrent use of a second or third generation oral antihistamines at maximum tolerated dose while on Alomide.
Age Restriction	Alocril: ≥ 3 years of age Alomide: ≥ 2 years of age
Prescriber Restriction	None
Coverage Duration	1 year
Quantity Limit	Alocril: 10ml per 30 days Alomide: 20ml per 30 days
Other criteria	Reauthorization: Attestation that use of Alocril or Alomide decreased severity of condition and symptoms in the most recent past allergy season.

Clinical Background Information and References

1. Alocril®. Prescribing information. Allergan Inc. Ervine, CA. Revised 6/2018. Accessed Sept 2021
2. Alomide®. Prescribing information. Alcon Laboratories (Novartis). Fort Woth, TX. Revised May 2018. Accessed Sept 2021.
3. Bonini, S., Coassin, M., Aronni, S. et al. Vernal keratoconjunctivitis. Eye 18, 345–351 (2004).
4. Komi, E A et al. Clinical implications of mast cell involvement in allergic conjunctivitis. Allergy, 73(3), 528-539 (2018).

5. Pedram, H et al. Allergic conjunctivitis: Management. UpToDate. Jul 2020. Accessed Aug 2020.
6. Pedram, H et al. Vernal keratoconjunctivitis. UpToDate. Jul 2020. Accessed Aug 2020.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	New Policy created for QHP	1/1/2021	P&T Committee
11/11/2021	No recommended changes.	3/1/2022	P&T Committee

Next Review Date

2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over

these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.