Molina Clinical Policy
Visudyne (verteporfin) Ocular Photodynamic Therapy: Policy No. 308

Last Approval: 08/14/2024
Next Review Due By: August 2025

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Age-Related Macular Degeneration (AMD) is a degenerative disease of the retina that leads to the loss of central vision. Two main types of AMD exist: dry (atrophic) and wet (exudative). Dry AMD is more common and progresses more slowly than wet AMD. Dry AMD is distinguished by small yellow lipid debris deposits beneath the retina. It is frequently a precursor of wet AMD. The wet form is less common and progresses faster and is also distinguished by the development of choroidal neovascularization (CNV), which greatly increases the risk of developing severe irreversible vision loss. Although non-neovascular or dry AMD accounts for approximately 80% of AMD patients, the neovascular form is responsible for most of the severe central visual acuity loss associated with AMD. The three types of lesions associated with wet AMD are classic, occult, and minimally classic. Choroidal neovascular lesions are classified as classic or occult based on fluorescein angiographic assessments. CNV disrupts the anatomy of the retinal pigment epithelium-photoreceptor complex, leaks serum and sometimes blood, and is frequently accompanied by irreversible scar formation, which is associated with photoreceptor loss. AMD management options include observation and early detection, antioxidant vitamin and mineral supplements, intravitreal injection of anti-vascular endothelial growth factor (VEGF) agents, photodynamic therapy, laser photocoagulation surgery, and smoking cessation counseling for patients who currently smoke. Photodynamic therapy and thermal laser photocoagulation remain approved treatment options for subfoveal lesions, but “current practice patterns support use of anti-VEGF monotherapy for patients with newly diagnosed neovascular AMD and suggest that these other therapies are rarely needed” (AAO 2019). The safety and effectiveness of each treatment are determined by the type and location of the neovascularization (Boyd 2024; DynaMed 2024; AAO 2019).

Central serous chorioretinopathy (CSC) is a chorioretinal disease where there is a buildup of fluid under the retina. The fluid comes from the choroid, which is a layer of tissue under the retina. There is a layer of cells between the retina and the choroid called the retinal pigment epithelium (RPE). Subretinal fluid (SRF) builds up under the retina, which causes detachment and subsequent loss of visual acuity, blurred central vision and other visual disturbances. Risk factors include male gender, ages 20-60s, stress, steroid use, autoimmune disease, hypertension, Type A personality and genetics. CSC may be classified as acute or chronic. Acute CSC is generally a self-limited condition that resolves in 2 to 3 months, with minimal atrophic changes to the retinal pigment epithelium, Chronic CSC patients continue to have persistent subretinal fluid and atrophy of the retinal pigment epithelium, which could cause permanent damage to the photoreceptors. Treatment is recommended for patients with chronic CSC. (Feenstra et al. 2022; AAO 2024).

Photodynamic therapy (PDT) is a technique that involves the use of a photosensitizing agent that causes localized and selective tissue damage when activated by light of a specific wavelength (DynaMed 2024). In patients with predominantly classic choroidal neovascular lesions, PDT with verteporfin slows retinal damage associated with AMD. Verteporfin, in combination with nonthermal light, is used to treat primarily classic subfoveal CNV caused by AMD. PDT with verteporfin is not recommended for use in less severe, dry macular degeneration without neovascularization (DynaMed 2024). With the increased use of anti-VEGF therapy, the role of PDT has been reduced. Patients who do not respond to initial anti-VEGF therapies should consider PDT (with or without intravitreal bevacizumab, aflibercept, or ranibizumab).

Visudyne (verteporfin injection), a light-activated drug used in PDT, was approved by the FDA in April 2000 for the treatment of predominantly classic subfoveal CNV caused by AMD, pathologic myopia, or suspected ocular histoplasmosis. Once verteporfin has been activated by light in the presence of oxygen, highly reactive, short-lived reactive oxygen radicals are produced. Light activation of verteporfin causes local damage to neovascular endothelium, which leads to vessel blockage. A course of verteporfin therapy requires the administration of both verteporfin for injection and non-thermal red light. The first stage is a 10-minute intravenous infusion of verteporfin, followed by 83 seconds of nonthermal low-intensity light five minutes later. PDT has advantages over traditional laser therapies due to its capacity for causing targeted tissue injury. PDT has advantages over conventional laser treatments due to its ability to cause selective tissue injury. The ability to affect CNV selectively is due to preferential localization of the photosensitizer dye to the CNV complex and irradiation of the complex with light levels far lower than required for thermal injury. The most frequently reported adverse events in verteporfin clinical trials include injection site reactions, pain, inflammation, extravasation, rashes, hemorrhage, and visual disturbances, which occurred in clinical trials at a rate ranging from 10% to 30% of patients. Verteporfin is contraindicated in patients with porphyria or hypersensitivity to any component of the verteporfin preparation. Re-treatment may be indicated as frequently as every 3 months based on the appearance of leakage on fluorescein angiography. However, the appropriate frequency of repeat treatments and the number of total treatments a patient may require during clinical management of their neovascular AMD are not defined. There is also no clear definition of treatment failure and, as a result, no method for determining when treatment should be discontinued. The current data suggest that PDT with verteporfin is beneficial for up to 2 years; however, there are no data for longer time periods. Verteporfin was granted orphan drug status by the FDA on March 9, 2012 (FDA 2024).

COVERAGE POLICY

Ocular PDT utilizing Visudyne in the treatment of adult patients **may be considered medically necessary** when **ALL** the following clinical criteria are met:

1. Diagnosis of **ONE** of the following:
    a. Wet age-related macular degeneration:
        i. Fluorescein angiography confirms presence of choroidal neovascularization
        ii. Use of anti-vascular endothelial growth factor is contraindicated; patient has failed the therapy or therapy is refused by patient. Documentation with date(s) of failed therapy or clinical event required
    b. Myopic choroidal neovascularization, and use of anti-vascular endothelial growth factor is contraindicated
    c. Presumed ocular histoplasmosis
    d. Chronic central serous chorioretinopathy when **ALL** the following criteria are met:
        i. Duration 3 months or longer
        ii. Fluorescein angiography confirms the diagnosis of chronic central serous chorioretinopathy
        iii. Patient use of glucocorticoids has been discontinued

2. Disease progression after use of an anti-VEGF as first-line treatment for AMD. Documentation with date(s) of failed therapy or clinical event required

    EXCEPTIONS: Clinically significant adverse effects, labeled contraindication, or clinical rationale supporting the inappropriateness to VEGF Inhibitor therapies. Documentation required.

3. Requested Visudyne therapy will be used in combination with PDT. NOTE: Ocular PDT is only authorized when used in conjunction with verteporfin

CONTINUATION OF THERAPY

Continuation of therapy may be authorized when **ALL** the following clinical criteria are met:

1. Reauthorization request is for the same eye as initial authorization AND 3 months since the previous Ocular PDT with Visudyne
    NOTE: The continuation of therapy criteria applies only to the same previously treated eye. If member has developed condition in an untreated eye, a new request should be submitted and meet all initial coverage criteria.

2. Member continues to meet coverage criteria AND continued need for treatment has been formally assessed and documentation submitted for review

3. Required documentation for continuation of therapy:
   a. Positive clinical response to Visudyne as evidenced by at least **ONE** of the following:
      1. Detained neovascularization
      2. Improvement or stabilization in visual acuity from baseline/prior treatment
      3. Reduction in the number of episodes of severe visual acuity loss
      4. Supportive findings from OCT or fluorescein angiography (FA).
   b. Clinical evidence of deterioration as demonstrated by persistent fluorescein leakage from CNV: Recurrent or persistent choroidal neovascular leakage indicated by a recent fluorescein angiography *conducted at least 3 months after the last treatment.*
      NOTE: Re-treatment is necessary if FA or OCT show any signs of recurrence or persistence of leakage.
   c. Member is likely to benefit from re-treatment without being exposed to significant risk according to Prescriber.

LIMITATIONS AND EXCLUSIONS

The following are considered **contraindications/exclusions** based on insufficient evidence:

1. Concurrent or in combination with ANY of the following treatments or conditions
   a. Bilateral treatment UNLESS member had previous verteporfin therapy, with an acceptable safety profile, then treatment of both eyes concurrently (approximately 3 months after the initial treatment) may be considered. Documentation required.
   b. Concurrent or combination therapy with VEGF Inhibitors [Avastin (bevacizumab); Lucentis (ranibizumab); Eylea (aflibercept); Macugen (pegaptanib); Beovu (brolucizumab), etc.]

2. Hypersensitivity to verteporfin or any component of the formulation

3. Porphyria or other porphyrin-related hypersensitivity

4. Atrophic or “dry” AMD

5. Inability to obtain an adequate, legible fluorescein angiogram or OCT to document CNV (including difficulty with venous access). Exception: Member has a documented history of fluorescein allergy

6. No evidence of CNV leakage (as determined by fluorescein angiography or OCT)

7. Unacceptable toxicity from the agent, including extravasation, decrease in visual acuity, etc.

The following are considered **experimental, investigational, and unproven** based on insufficient evidence:

1. Any indications other than those listed above

2. Simultaneous use of Visudyne in *combination with anti-angiogenic agents* for the treatment of CNV due to AMD

DURATION OF APPROVAL: Initial authorization: 6 months; Continuation of therapy: 1 year

PRESCRIBER REQUIREMENTS: Prescribed by board-certified ophthalmologists or retinal specialist experienced in the treatment of retinal diseases. Treatment and monitoring must be retained by the Prescriber/Specialist.

AGE RESTRICTIONS: 18 years of age or older

DOSING CONSIDERATIONS: A course of verteporfin therapy is a 2-step process requiring administration of both drug and light. The first step is the intravenous (IV) infusion of verteporfin. The second step is the activation of verteporfin with light from a nonthermal diode laser. Detailed instructions can be found in the manufacturer's labeling. Subfoveal choroidal neovascularization (in adults):

- IV infusion: 6 mg/m^2 body surface area (BSA) administered IV over 10 minutes at a rate of 3 mL/min.
- Light: 50 J/cm^2 of neovascular lesion administered at an intensity of 600 mW/cm^2. This dose is administered over 83 seconds.

- Duration of therapy: The health care provider should reevaluate the patient every 3 months and if choroidal neovascular leakage is detected on fluorescein angiography, therapy should be repeated.

QUANTITY LIMITATIONS

1. Total calculated dose (mg) of the PDT drug to be administered and the member's BSA on which the dose of the drug is based does not exceed **6 mg/m^2 BSA administered every 3 months PER EYE**
2. Up to 4 treatments per eye (every 3 months) per year
3. Not to exceed two (2) years

ADMINISTRATION

1. Visudyne PDT is considered a provider-administered procedure to be performed in a provider office, outpatient setting by a qualified ophthalmologist experienced in intravitreal injections
2. Documentation of the following information required for review and submission of requests for subsequent treatment(s): Dose and frequency; AND Treated eye(s) (right/ left/both)
3. Refer to MHI Policy & Procedure: Specialty Medication Administration Site of Care Policy: MHI Pharm 11

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DRUG INFORMATION

ROUTE OF ADMINISTRATION: Intravenous (IV) infusion

DRUG CLASS: Ophthalmic Agent; Photosensitizing Agents

FDA-APPROVED USES: Subfoveal choroidal neovascularization

Treatment of predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration, pathologic myopia, or presumed ocular histoplasmosis.

Limitations of use: There is insufficient evidence to indicate verteporfin for the treatment of predominately occult subfoveal choroidal neovascularization.

COMPENDIAL APPROVED OFF-LABELED USES: None

SUMMARY OF MEDICAL EVIDENCE

Van Dijk et al. (2023) completed a systematic review with network meta-analysis of the short-term efficacy of multiple treatment modalities for chronic central serous chorioretinopathy (cCSC) that were tested in randomized controlled trials (RCT). Short term treatment efficacies were evaluated and ranked using the network meta-analysis. To be considered chronic, the patient had to have a diagnosis of central serous chorioretinopathy (CSC) for at least 3 months or have symptoms that were attributable to CSC for at least 3 months. Only studies that used optical coherence tomography (OCT) to evaluate their patients were included. (OCT allows the provider to examine the retina's layers, and map and measure the thickness). All interventions were considered if they were randomized for comparison to another group. The comparison was another intervention, a non-treatment control or a placebo treatment. The primary outcome was complete resolution of subretinal fluid (SRF) based on OCT. Outcomes at 2 months post treatment were, or as close to 2 months were evaluated, but at least within 1 to 3 months post treatment. Risk of bias within the selected studies was evaluated independently by 2 authors, and risk of bias was then compared and discussed with a third author. A total of 17 RCTs were included that totaled 1172 eyes. "Treatments included conventional laser (44 eyes), half-dose or half-fluence photodynamic therapy (PDT) (298 eyes), ranibizumab (16 eyes), antioxidants (50 eyes), mineralocorticoid receptor antagonists (187 eyes), rifampicin (91 eyes), selective retina therapy (SRT) (67 eyes) and subthreshold micropulse laser (192 eyes)". Short term resolution

of subretinal fluid was most significantly impacted by half-dose or half- fluence PDT (OR: 20.6; 95% CI: 6.3–66.7; p < 0.0001) and threshold conventional laser therapy (OR: 36.4; 95% CI: 2.0–655.7; p = 0.015) and less significantly by selective retinal therapy (OR: 3.4; 95% CI: 1.7–6.8; p = 0.00075). Conventional laser therapy closes the defect to the retinal pigment epithelium, but photocoagulation carries the risk vision loss, central scotoma, and risk of foveal neovascularization. Selective retinal therapy is based on microlaser technology and is thought to cause retinal pigment epithelium damage without impacting the photoreceptors. Currently selective retinal therapy remains experimental. The authors concluded that half-dose or half-fluence PDT "is the only viable treatment option for patients with cCSC" and is "widely considered the first line and preferred therapy for cCSC".

Lim et al. (2020) completed the EVEREST II trial, a 24-month phase IV randomized clinical trial with the goal to compare treatment outcomes of a combination therapy of ranibizumab 0.5mg with verteporfin PDT to monotherapy with ranibizumab 0.5mg alone in participants with polypoidal choroidal vasculopathy. A total of 322 participants were included in the study and were randomized on a 1:1 ratio to the combination group (n=168) or the monotherapy group (n=154). Participants in both groups received ranibizumab injections for 3 consecutive months before being placed on a pro re nata regimen. Those in the combination therapy group received verteporfin PDT while those in the monotherapy group received sham PDT. Verteporfin treatments were guided by indocyanine green angiography findings. Participants in the monotherapy group were allowed to switch to the combination therapy group in year 2 if necessary for therapeutic benefit. A total of 41 participants switched to combination therapy. Approximately 113 participants in the monotherapy group had already completed the trial prior to the decision to allow participants to switch. The mean baseline best-corrected visual acuity (BCVA) for both groups was 61.1 letters, and the mean central subfield thickness (CSFT) was 413.3 µm. The mean improvement in BCVA at 24 months was +9.6 letters for those receiving combination therapy and +5.5 letters for those receiving monotherapy. The mean reduction in CSFT at 24 months was -152.9 µm in the combination therapy group and -109.3 µm in the monotherapy group. Combination therapy was found to be superior to monotherapy for improvements in complete polypoidal lesion regression. Researchers also noted "a higher proportion of participants in the combination group showed absence of leakage on fluorescein angiography compared with the monotherapy group" and the combination therapy group had lower disease activity at month 23. The combination therapy group received a lower median number of ranibizumab injections over 24 months compared to the monotherapy group (6.0 vs 12.0). A higher number of participants in the monotherapy group required 20-24 injections for 24 months compared to the combination therapy group (30 out of 154 vs 7 out of 168). The number of ocular adverse events was 64 in the combination group, 49 in the monotherapy group, and 8 in the switched group. The number of ocular serious adverse events was 23 in the combination group, 18 in the monotherapy group, and 2 in the switched group. Serious ocular adverse events consisted of vitreous hemorrhage, cataract, macular hole, unilateral blindness, endophthalmitis, ocular hypertension, and retinal hemorrhage. Limitations of the study included assessment of disease activity for retreatment consideration being a subjective decision by investigators and indocyanine green angiography not being mandated during year 2 except for the final indocyanine green angiography completed at the end of the study. Findings from this study indicate that combination treatment is more effective for improving BCVA and complete polypoidal lesion regression.

Chen et al. (2019) completed the BRILLIANCE study, a randomized, double-blind phase III study to demonstrate if ranibizumab treatment guided by either disease activity or BCVA is superior to verteporfin PDT. The study involved 48 centers in 5 countries and enrolled a total of 457 patients with 431 patients completing all 12 months of follow-up. Patients were randomized on a 2:2:1 ratio to three treatment groups: (1) ranibizumab 0.5mg at day 1 and month 1 followed by monthly injections from month 2 to month 12 if stability criterion for BCVA was not achieved (no change in BCVA as compared with 2 preceding monthly visits), (2) ranibizumab 0.5mg at day 1 followed by observation of disease activity and administration of ranibizumab injections if there was vision impairment attributable to intraretinal fluid, subretinal fluid, or active leakage associated with pathologic myopia based on optical coherence tomography or fluorescein angiography, and (3) verteporfin PDT on day 1 followed by verteporfin PDT, ranibizumab 0.5mg, or a combination of verteporfin PDT and ranibizumab 0.5mg based on disease activity criteria. Drug dosing of ranibizumab and verteporfin was based on FDA-approved drug labels. Group 1 (ranibizumab and BCVA) contained 173 patients, group 2 (ranibizumab and disease activity monitoring) contained 175 patients, and group 3 (verteporfin PDT) contained 83 patients. Baseline mean age was 52.0 years (group 1), 51.5 years (group 2), 49.1 years (group 3), and 51.2 years (overall). Baseline mean BCVA was 53.6 letters (group 1), 54.2 letters (group 2), 52.1 letters (group 3), and 53.5 letters (overall). Baseline mean CSFT was 341.3 µm (group 1), 340.7 µm (group 2), 334.8 µm (group 3) and 339.8 µm (overall). The percentage of CNV location for group 1 was 73.1% subfoveal, 8.8% juxtafoveal, and 16.5% extrafoveal. The percentage of CNV location for group 2 was 70.1% subfoveal, 12.0% juxtafoveal, and 17.4% extrafoveal. The percentage of CNV location for group 3 was 70.9% subfoveal, 11.4%

juxtafoveal, and 16.2% extrafoveal. Results for BCVA showed that ranibizumab guided by either BCVA or disease activity criteria was statistically superior to verteporfin PDT. The mean average change in BCVA from baseline to month 1 through month 3 was +9.5 letters (group 1), +9.8 letters (group 2), and +4.5 letters (group 3). The mean change in BCVA from baseline to month 12 was +12.0 letters (group 1), +13.1 letters (group 2), and +10.3 letters (group 3). Researchers noted that "most patients in both ranibizumab groups gained ≥10 letters from baseline or reached 84 letters at months 3, 6, or 12." In terms of CSFT, researchers noted that both ranibizumab groups has a rapid and clinically significant decrease from baseline to month 3 followed by a stabilization period that persisted through month 12 and the verteporfin PDT group noted smaller decreases than the ranibizumab groups from baseline to month 1 with a plateau at month 3. Further decreases after month 3 in the verteporfin PDT group were achieved if patients received ranibizumab.

In the PLACE trial (NCT01797861), van Dijk et al. (2018) compared half-dose photodynamic therapy (PDT) to high-density subthreshold laser (HSML) for the treatment of patients with chronic central serous chorioretinopathy. This was a large, open-label, multi-center prospective randomized controlled study that included 179 patients; of which 89 were randomly assigned to the half dose phototherapy group and 90 were randomly assigned to the high-density subthreshold laser group. The primary outcome was complete resolution of the subretinal fluid at 6 to 8 weeks post treatment. The subretinal fluid was also measured as secondary outcome at a final visit 7 to 8 months after treatment. Additional secondary outcomes were functional: best corrected visual acuity (BCVA) and retinal sensitivity as measured by microperimetry, and assessment of quality of life using a 25-question validated questionnaire. On the first post treatment visit patient subretinal fluid was found to be resolved in 51.2% of PDT patients and 13.8% of HSML patients ($p < 0.001$). At the final assessment patients treated with PDT, 67.2% had a resolution of SRF compared to 28.8% in patients treated with HSML ($p < 0.001$). At the final visit, the PDT group had a 4.60 EDTRS letter improvement in BCVA in comparison to a 1.39 letter improvement in the HSML group ($P = 0.011$). The PDT group also had a significantly higher increases in retinal sensitivity that the HSML group at both the first and final evaluation. The improvement in vision related quality of life for the PDT and HSML groups were similar. The author found that for chronic serous chorioretinopathy half-dose PDT was more effective at than HSML, with significantly higher complete resolution of subretinal fluid and functional improvement. Short term resolution of subretinal fluid was most significantly impacted by half-dose or half- fluence PDT (OR: 20.6; 95% CI: 6.3–66.7; $p < 0.0001$) and threshold conventional laser therapy (OR: 36.4; 95% CI: 2.0–655.7; $p = 0.015$) and less significantly by selective retinal therapy (OR: 3.4; 95% CI: 1.7–6.8; $p = 0.00075$). Conventional laser therapy closes the defect to the retinal pigment epithelium, but photocoagulation carries the risk vision loss, central scotoma, and risk of foveal neovascularization. Selective retinal therapy is based on microlaser technology and is thought to cause retinal pigment epithelium damage without impacting the photoreceptors. Currently selective retinal therapy remains experimental. The authors concluded that half-dose or half-fluence PDT "is the only viable treatment option for patients with cCSC" and is "widely considered the first line and preferred therapy for cCSC".

A Cochrane review of 5 trials indicated that treatment with the vascular endothelial growth factor medication ranibizumab resulted in fewer patients losing at least 15 letters than verteporfin. Furthermore, the combination of the two therapies was more effective than verteporfin alone (Solomon et al. 2019).

PDT combined with anti-VEGF Treatment
Gao et al. (2018) completed a meta-analysis of 16 studies with a total of 1260 participants receiving either anti-VGEF monotherapy (n=587) or anti-VGEF and PDT combination therapy (n=673) for neovascular AMD. Combination therapy consisted of either standard-fluence (50 J/m^2) verteporfin PDT or reduced-fluence (25 J/m^2) verteporfin PDT and anti-VGEF treatment. Retreatment therapy consisted of either verteporfin PDT and anti-VGEF therapy or anti-VGEF therapy alone depending on study. Researchers found that the addition of reduced-fluence PDT to anti-VEGF significantly improved BCVA and central retinal thickness and required fewer subsequent injections in comparison to patients receiving growth factor as monotherapy.

National and Specialty Organizations

The American Academy of Ophthalmology (AAO) 2019 guidelines indicate that verteporfin is an approved treatment option for AMD, however VEGF remains the preferred therapy. Intravitreal injectable therapy with anti-VEGF agents (e.g., aflibercept, bevacizumab, and ranibizumab) is the most effective approach to manage neovascular AMD and represents the first line of treatment, according to the AAO (2019). Current evidence is not conclusive regarding PDT and anti-VEGF combo therapy (AAO 2019). The AAO 2019 AMD preferred practice

pattern guideline listed verteporfin PDT as an FDA-approved treatment option for subfoveal AMD lesions and primarily classic CNV. Anti-VEGF treatments are now the first-line treatment and stabilization option for the majority of AMD cases. Verteporfin PDT is a less prevalent treatment for neovascular AMD. According to recommendations, the following diagnoses are eligible for verteporfin PDT:

- Macular CNV, new or recurrent, where the classic component is >50% of the lesion and the entire lesion is ≤5400 µm in greatest linear diameter
- Occult CNV may be considered for PDT with vision <20/50 or if the CNV is <4 MPS [macular photocoagulation study] disc areas in size when the vision is >20/50
- Juxtafoveal CNV is an off-label indication for PDT but may be considered in select cases

The National Institute for Health and Care Excellence (NICE) (2018) revised its previous guidance on the use of PDT for AMD to include the following recommendations:

- Recommend *against* using PDT as monotherapy for late (wet) AMD and as first-line adjuvant therapy to anti-VEGF medications for late (wet) AMD; and
- In a clinical trial setting, PDT was recommended as a second-line adjunctive therapy to anti-VEGF therapies for late (wet) AMD.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology) Codes

Code	Description
67221	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
67225	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)
92235	Fluorescein angiography (includes multi-frame imaging) with interpretation and report, unilateral or bilateral

HCPCS (Healthcare Common Procedure Coding System) Code

Code	Description
J3396	Injection, verteporfin, 0.1 mg

AVAILABLE DOSAGE FORMS: 15 mg (2 mg/mL after reconstitution) single-use vial; for IV infusion only

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

08/14/2024 Policy reviewed. Change to coverage criteria include addition of chronic central serous chorioretinopathy as an indication. Updated Overview, Summary of Medical Evidence and References. IRO Peer Review on July 10, 2024, by a practicing physician board-certified in Ophthalmology.

08/09/2023 Policy reviewed, no changes to criteria. Updated Overview, Summary of Medical Evidence, and References. Updated code description for code 92235. Grammatical edits to Disclaimer section and Documentation Requirements disclaimer. Removed Supplemental Information section.

08/10/2022 Policy reviewed and updated. No changes in coverage position. Updated references.

08/11/2021 Policy revised. IRO Peer Review. 7/1/2021. Practicing Physician. Board certified in Ophthalmology. Notable revisions include:

- Added CMS section outlining CMS NCD for Verteporfin
- Added 'Diagnosis of subfoveal CNV due to ONE of the following: AMD; Pathologic myopia; or Presumed ocular histoplasmosis' in the initial coverage criteria #2 under the 'Diagnosis/Indication' criteria:
- Added brolucizumab (Beovu) where anti-VEGF is referenced
- In reauthorization/continuation section, #2 under 'Labs/Reports/Documentation' added criteria: 'Positive clinical response to Visudyne as evidenced by at least ONE of the following: Detained neovascularization; Improvement or

stabilization in visual acuity from baseline/prior treatment; Reduction in the number of episodes of severe visual acuity loss; or Supportive findings from OCT or fluorescein angiography'
- In reauthorization/continuation section, under #4 the 'Discontinuation of Treatment' criteria, added: Absence of unacceptable toxicity from the agent, including extravasation, decrease in visual acuity, etc.
- Removed the following from the policy: #2 'Compliance' criteria place holder due to non-applicability to policy. Intention of policy did not change with this update.

Q4 2020 Policy reviewed and updated, no changes in coverage criteria, updated references.
Q4 2019 Policy reviewed and updated, no changes in coverage criteria, updated references.
07/10/2018 New policy. IRO Peer Review. 5/18/2018. Practicing Physician. Board certified in Ophthalmology

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