Clinical Policy: Cyclosporine (Cequa, Restasis)

Reference Number: CP.PMN.48
Effective Date: 05.01.12
Last Review Date: 05.21
Line of Business: HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Cyclosporine ophthalmic (Cequa™, Restasis®) is a topical calcineurin inhibitor immunosuppressant.

FDA Approved Indication(s)

Cequa is indicated to increase tear production in patients with keratoconjunctivitis sicca (dry eye).

Restasis is indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Cequa and Restasis are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Keratoconjunctivitis Sicca (must meet all)**:**

1. Diagnosis of keratoconjunctivitis sicca with suppressed tear production due to ocular inflammation;
2. Member meets one of the following:
   a. For Restasis: Age ≥ 16 years;
   b. For Cequa: Age ≥ 18 years;
3. Failure of artificial tears at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of at least one ophthalmic anti-inflammatory agent (*see Appendix B for examples*) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Request does not exceed 60 vials per 30 days.

Approval duration:
HIM – 6 months
Medicaid – Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Keratoconjunctivitis Sicca (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy;
3. If request is for a dose increase, request does not exceed 60 vials per 30 days.

Approval duration:
HIM – 12 months
Medicaid – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
artificial tears (e.g., Visine dry eye relief)	1 to 2 drops in affected eye(s) BID or QID	various
ophthalmic anti-inflammatory agents for keratoconjunctivitis sicca (e.g., loteprednol etabonate)	1 to 2 drops in each eye BID to QID for up to 2 weeks	various

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Note: Ophthalmic NSAIDs are not indicated.		

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Cequa: none reported
  - Restasis: hypersensitivity to cyclosporine or any of the ingredients in the formulation
- Boxed warning(s): none reported

Appendix D: General Information

- Artificial tears are the standard therapy for all severity of dry eyes.
- Restasis is likely to be given in conjunction with artificial tears.
- Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.
- Emulsion from one individual, single-use vial is to be used immediately after opening for administration to one or both eyes, and the remaining contents should be discarded immediately after administration.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Moderate to severe keratoconjunctivitis sicca	1 drop BID in each eye approximately 12 hours apart	2 drops/day in each eye; 60 vials/30 days

VI. Product Availability

Drug Name	Availability
Cyclosporine ophthalmic solution (Cequa)	Single use vial: 0.09%, 0.25 mL each of 60 vials/tray
Cyclosporine ophthalmic emulsion (Restasis)	• Single use vial: 0.05%, 0.4 mL each of 30 vials/tray and 60 vials/tray • MultiDose bottle: 0.05%, 5.5 mL total

VII. References

1. Cequa Prescribing Information. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; September 2019. Available at: www.cequapro.com. Accessed February 15, 2021.
2. Restasis Prescribing Information. Irvine, CA: Allergan, Inc.; July 2017. Available at: https://www.restasis.com. Accessed February 15, 2021.
3. The International Dry Eye Workshop. *Ocul Surf*. 2007; 5(2):65-204.
4. American Academy of Ophthalmology Cornea/External Disease Committee. Preferred Practice Pattern® Guidelines. Dry Eye Syndrome. Chicago, IL: American Academy of

Ophthalmology; November 2018. Available at: www.aao.org/ppp. Accessed February 15, 2021.
5. Restasis. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed February 15, 2021

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Medicaid: No clinical changes to criteria: • Converted to new template • Removed age criteria as age is not an absolute contraindication per FDA labeling Updated references	01.17	05.17
2Q 2018 annual review: combined Medicaid, HIM, and commercial lines of business criteria; commercial: removed ophthalmologist or optometrist prescriber requirement; expanded requirement of any OTC wetting agent to artificial tears and anti-inflammatory agent; Medicaid: expanded approval duration from 6 months (initial) and 12 months (continued) to length of benefit	02.02.18	05.18
2Q 2019 annual review: no significant changes; added contraindications; added examples of alternative anti-inflammatory agents; references reviewed and updated	02.06.19	05.19
Updated therapeutic alternatives table.	08.24.19	
2Q 2020 annual review: no significant changes; updated contraindications; references reviewed and updated	02.07.20	05.20
Added Cequa to policy per SDC and prior clinical guidance.	02.19.20	
Per December SDC and prior clinical guidance, removed Commercial line of business as PA no longer required.		
2Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	02.15.21	05.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.