Pharmacy Medical Necessity Guidelines:
Glaucoma Medications

Effective: September 9, 2025

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

The ophthalmic alpha-adrenergic agonists, carbonic anhydrase inhibitors and prostaglandin agonists are indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

The following table summarizes the formulary status for Tufts Health RITogether Members.

Brand Name	Generic Name	PDL Status
Alpha-adrenergic Agonists		
Brimonidine 0.2%* (Alphagan)	**Brimonidine**	**Covered**
Brimonidine 0.15% (Alphagan P)	Brimonidine	PA
Alphagan P 0.1%	Brimonidine	PA
Carbonic Anhydrase Inhibitors		
Dorzolamide 2%* (Trusopt)	**Dorzolamide**	**Covered**
Azopt 1%	Brinzolamide	PA
Prostaglandin Agonists		
Latanoprost 0.005%* (Xalatan)	**Latanoprost**	**Covered**
Bimatoprost 0.03%	Bimatoprost	PA
Lumigan 0.01%	Bimatoprost	PA
Tafluprost 0.0015% (Zioptan)	Tafluprost	PA
Travoprost 0.004% (Travatan Z)	Travoprost	PA
Rescula 0.15%	Unoprostone Isopropyl	PA
Vyzulta 0.024%	Latanoprostene Bunod	PA
Xelpros 0.005%	Latanoprost	PA
Rho Kinase Inhibitor		
Rhopressa 0.02%	Netarsudil	PA
Combination Medications		
Dorzolamide-Timolol 2-0.5%* (Cosopt)	**Dorzolamide HCl-Timolol**	**Covered**
Brimonidine-Timolol (Combigan) 0.2-0.5%	Brimonidine-Timolol	PA
Simbrinza 1-0.2%	Brinzolamide-Brimonidine	PA

* Preferred medications covered without prior authorization
Brand name medications with AB-rated generics are non-covered. They are included in the table to serve as a reference. Requests for the brand-name products, with AB-rated generics, will also require review according to Brand Name criteria.

COVERAGE GUIDELINES

The plan may authorize coverage of a nonpreferred ophthalmic medication for Members when the following criterion for a particular regimen is met and limitations do not apply:

Brimonidine 0.15%

1. The Member had an inadequate response, adverse reaction, or contraindication to brimonidine 0.2%

Brimonidine 0.1% (Alphagan P)

1. The Member had an inadequate response, adverse reaction, or contraindication to BOTH of the following: brimonidine 0.2% and brimonidine 0.15%

Azopt (brinzolamide)

1. The Member had an inadequate response, adverse reaction, or contraindication to dorzolamide

Bimatoprost 0.03%, Tafluprost 0.0015%, Travoprost 0.004%

1. The Member had an inadequate response, adverse reaction, or contraindication to generic latanoprost (Xalatan)

Lumigan (bimatoprost) 0.01%, Rescula (unoprostone isopropyl) 0.15%, Vyzulta (latanoprostene bunod) 0.024%, Xelpros (latanoprost) 0.005%

1. The Member had an inadequate response, adverse reaction, or contraindication to generic latanoprost (Xalatan)

AND

2. The Member had an inadequate response, adverse reaction, or contraindication to ONE of the following agents: bimatoprost 0.03%, tafluprost 0.0015%, travoprost 0.004%

Rhopressa (netarsudil)

1. The Member had an inadequate response, adverse reaction, or contraindication to at least two generic agents used for the treatment of glaucoma, each from a different class (e.g., alpha-adrenergics, carbonic anhydrase inhibitors, prostaglandin agonists)

Combigan 0.2-0.5% (brimonidine-timolol) or Simbrinza 1-0.2% (brinzolamide-brimonidine)

1. The Member had an inadequate response, adverse reaction, or contraindication to concomitant therapy with brimonidine 0.2% and an alternative agent (e.g., timolol, dorzolamide), or the provider indicates clinical inappropriateness of concomitant therapy with brimonidine 0.2% and an alternative agent.

LIMITATIONS

1. Requests for brand-name products, with AB-rated generics, will also be reviewed according to Brand Name criteria.

CODES

None

REFERENCES

1. Alphagan P (brimonidine 0.1% and 0.15%) [prescribing information]. Irvine, CA: Allergan, Inc; June 2024 .
2. American Academy of Ophthalmology Glaucoma Panel. Preferred Practice Pattern Guidelines. Primary Open-Angle Glaucoma. American Academy of Ophthalmology, 2010. Available from: http://one.aao.org/preferred-practice-pattern/primary-openangle-glaucoma-ppp--october-2010
3. Azopt (brinzolamide) [prescribing information]. Fort Worth, TX: Alcon Laboratories, Inc; June 2023.
4. Brimonidine 0.2% solution [prescribing information]. Gurnee, IL: Akorn Operating Company LLC; May 2022.
5. Chabi A, et al. Randomized Clinical Trial of the Efficacy and Safety of Preservative-free Tafluprost and Timolol in Patients With Open-Angle Glaucoma or Ocular Hypertension. Am J Ophthalmol. 2012 Jun;153(6):1187-96. [Abstract]
6. Combigan (brimonidine tartrate/timolol maleate) [prescribing information]. Irvine, CA: Allergan; July 2024.
7. Dorzolamide/timolol [prescribing information]. Fairfield, NJ: Leading Pharma, LLC; March 2022.
8. European Glaucoma Society. Terminology and Guidelines for Glaucoma: 3rd Edition. May 2008. Available from: http://www.eugs.org/eng/reguser.asp
9. Hommer A, et al. Switching patients from preserved prostaglandin-analog monotherapy to preservative-free tafluprost. Clin Ophthalmol. 2011;5:623-31. Epub 2011 May 17.

10. Hommer A, et al. Unoprostone as adjunctive therapy to timolol: a double masked randomized study versus brimonidine and dorzolamide. *Br J Ophthalmol*. 2003;87:592-598.
11. Nordmann JP, et al. A double-masked randomized comparison of the efficacy and safety of unoprostone with timolol and betaxolol in patients with primary openangle glaucoma including pseudoexfoliation glaucoma or ocular hypertension. 6 month data. *Am J Ophthalmol*. 2002;133:1-10.
12. Ranno S, et al. A Prospective Study Evaluating IOP Changes after Switching from a Therapy with Prostaglandin Eye Drops Containing Preservatives to Nonpreserved Tafluprost in Glaucoma Patients. ScientificWorldJournal; 2012:804730.
13. Rhopressa (netarsudil) [prescribing information]. Irvine, CA: Aerie Pharmaceuticals, Inc.; March 2019.
14. Simbrinza (brinzolamide/brimonidine) [prescribing information]. Fort Worth, TX: Alcon Laboratories, Inc; May 2023.
15. Stewart WC, et al. Additive efficacy of unoprostone isopropyl 0.12% (Rescula) to latanoprost 0.005%. *Am J Ophthalmol*. 2001;131:339-344.8.
16. Stewart WC, et al. The safety and efficacy of unoprostone 0.15% versus brimonidine 0.2%. *Acta Ophthalmol Scand*. 2004;82:161-165.
17. Travatan Z (travoprost) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2023.
18. Uusitalo H, et al. Efficacy and safety of tafluprost 0.0015% versus latanoprost 0.005% eye drops in open-angle glaucoma and ocular hypertension: 24-month results of a randomized, double-masked phase III study. Acta Ophthalmol. 2010 Feb;88(1):12-9. [Abstract]
19. Vyzulta (latanoprostene bunod) [prescribing information]. Bridgewater, NJ: Bausch and Lomb; February 2024.
20. Xelpros (latanoprost 0.005%) [prescribing information]. Cranbury, NJ: Sun Pharmaceuticals Industrices, Inc: June 2022.
21. Zioptan (tafluprost) [prescribing information]. Lake Forest, IL: Akorn, Inc; October 2022.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. September 12, 2023: Effective December 1, 2023, updated previous trial language throughout the guideline. Updated criteria for Lumigan, Rescula, Vyzulta and Xelpros to require step through with two generic products.
2. September 10, 2024: Administrative change to fax number.
3. September 9, 2025: No changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services