Pharmacy Medical Necessity Guidelines: Ophthalmic Corticosteroids

Effective: May 12, 2026

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

Inveltys (loteprednol etabonate ophthalmic suspension) 1% is a corticosteroid indicated for the treatment of post-operative inflammation and pain following ocular surgery. Inveltys is administered twice daily beginning the day after surgery and continuing through the first two weeks of the post-operative period.

Lotemax SM (loteprednol etabonate ophthalmic gel) 0.38% is a corticosteroid indicated for the treatment of post-operative inflammation and pain following ocular surgery. Lotemax SM is applied to the affected eye three times daily beginning the day after surgery and continuing through the first two weeks of the post-operative period.

COVERAGE GUIDELINES

The plan may authorize coverage of **Inveltys (loteprednol etabonate ophthalmic suspension)** or **Lotemax SM (loteprednol etabonate ophthalmic gel)** for Members when the following criteria are met and limitations do not apply:

1. The Member has a planned ocular surgery

AND

2. Clinical rationale why other ophthalmic corticosteroids (e.g., prednisolone) are not appropriate for the Member

LIMITATIONS

1. Approvals will be limited to one month.

CODES

None

REFERENCES

1. Inveltys (loteprednol) [prescribing information]. Fort Worth, TX: Alcon Laboratories, Inc; November 2023.
2. Lotemax SM (loteprednol etabonate ophthalmic gel) [prescribing information]. Bridgewater, NJ: Bausch & Lomb Americas Inc.; March 2023.

APPROVAL HISTORY

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

Subsequent endorsement date(s) and changes made:

1. August 8, 2023: No changes.
2. May 14, 2024: Effective June 1, 2024 updated RxUM fax number.
3. May 13, 2025: No changes
4. May 12, 2026: 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