

Vabysmo™ (faricimab-svoa)



Pharmacy Coverage Policy

Effective Date: May 25, 2022

Revision Date: May 25, 2022

Review Date: May 18, 2022

Line of Business: Medicare, Commercial, Medicaid - Humana, Medicaid - Ohio

Policy Type: Prior Authorization

Page: 1 of 4

Humana's documents are updated regularly online. When printed, the version of this document becomes uncontrolled. Do not rely on printed copies for the most up-to date version. Refer to http://apps.humana.com/tad/tad_new/home.aspx to verify that this is the current version before utilizing.

| Disclaimer Description Coverage Determination | Background Medical Terms References |
|---|--|
| Disclaimer | <p>State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over clinical policy and must be considered first in determining eligibility for coverage. Coverage may also differ for our Medicare and/or Medicaid members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Medical Review Policies (LMRP) and/or Local Coverage Determinations. See the CMS website at http://www.cms.hhs.gov/. The member's health plan benefits in effect on the date services are rendered must be used. Clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise without permission from Humana.</p> |
| Description | <p>Vabysmo (faricimab-svoa) is a vascular endothelial growth factor (VEGF) inhibitor and angiopoietin-2 (Ang-2) inhibitor.</p> <p>vabysmo (faricimab-svoa) is indicated for the treatment of neovascular (wet) age-related macular degeneration (wAMD) and Diabetic Macular Edema (DME).</p> <p>Faricimab-svoa is available as Vabysmo 6 mg intravitreal injection.</p> |
| Coverage Determination | <p>Please note the following regarding medically accepted indications:</p> <p>All reasonable efforts have been made to ensure consideration of medically accepted indications in this policy. Medically accepted indications are defined by CMS as those uses of a covered Part D drug that are approved under the federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. These compendia guide review of off-label and off-evidence prescribing and are subject to minimum evidence standards for each compendium. Currently, this review includes the following references when applicable and may be subject to change per CMS:</p> |

Humana's documents are updated regularly online. When printed, the version of this document becomes uncontrolled. Do not rely on printed copies for the most up-to date version. Refer to http://apps.humana.com/tad/tad_new/home.aspx to verify that this is the current version before utilizing.

- American Hospital Formulary Service-Drug Information (AHFS-DI)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Truven Health Analytics Micromedex DrugDEX
- Elsevier/Gold Standard Clinical Pharmacology
- Wolters Kluwer Lexi-Drugs

Vabysmo (faricimab-svoa) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:

Neovascular (Wet) Age-Related Exudative Macular Degeneration (AMD)

- Diagnosed with neovascular (wet) age-related macular degeneration **AND**
- Has a contraindication, or intolerance to bevacizumab.* **OR**
- Has had prior therapy with bevacizumab* and provider attests that the member has NOT demonstrated a positive clinical response to bevacizumab (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)
 - *For Medicare Part B requests, the step therapy requirement does not apply if the request is a continuation of prior therapy within the past 365 days

Diabetic Macular Edema (DME)

- Diagnosed with Diabetic Macular Edema **AND**
- Has a contraindication, or intolerance to bevacizumab.* **OR**
- Has had prior therapy with bevacizumab* and provider attests that the member has NOT demonstrated a positive clinical response to bevacizumab (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss).
 - *For Medicare Part B requests, the step therapy requirement does not apply if the request is a continuation of prior therapy within the past 365 days.

Vabysmo™ (faricimab-svoa)

Effective Date: 5/25/2022

Revision Date: 5/25/2022

Review Date: 5/18/2022

Line of Business: Medicare, Commercial, Medicaid - Humana, Medicaid - Ohio

Policy Type: Prior Authorization

Page: 3 of 4

Humana's documents are updated regularly online. When printed, the version of this document becomes uncontrolled. Do not rely on printed copies for the most up-to date version. Refer to http://apps.humana.com/tad/tad_new/home.aspx to verify that this is the current version before utilizing.

Vabysmo (faricimab-svoa) will be approved in plan year durations or as determined through clinical review.

Coverage Limitations

Vabysmo (faricimab-svoa) therapy is not considered medically necessary for members with the following concomitant conditions:

- Active intraocular inflammation
- Ocular or periocular infection
- Vabysmo should not be used concurrently with other VEGF inhibitors for intraocular use in the absence of documentation indicating that individual products are to be used in different eyes.
- Experimental/Investigational Use – Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

Background

This is a prior authorization policy about Vabysmo (faricimab-svoa).

Provider Claims Codes

For medically billed requests, please visit www.humana.com/PAL. Select applicable Preauthorization and Notification List(s) for medical and procedural coding information.

Medical Terms

Vabysmo; faricimab-svoa; Neovascular (wet) Age Related Macular Degeneration; AMD; Intravitreal; Diabetic Macular Edema; DME; Pharmacy

References

1. Lexi-Comp [database online]. Hudson, OH: Lexi-Comp, Inc.; URL: <http://online.lexi.com/crlsql/servlet/crlonline>. Updated periodically.
2. Vabysmo (faricimab-svoa) [package insert] San Francisco, CA: Genentech Inc; Revised January 2022.
3. Micromedex [database online]. New York, NY: Thomson Reuters, Inc.; URL:

See the [DISCLAIMER](#). All Humana member health plan contracts are NOT the same. All legislation/regulations on this subject may not be included. This document is for informational purposes only.

Vabysmo™ (faricimab-svoa)

Effective Date: 5/25/2022

Revision Date: 5/25/2022

Review Date: 5/18/2022

Line of Business: Medicare, Commercial, Medicaid - Humana, Medicaid - Ohio

Policy Type: Prior Authorization

Page: 4 of 4

Humana's documents are updated regularly online. When printed, the version of this document becomes uncontrolled. Do not rely on printed copies for the most up-to date version. Refer to http://apps.humana.com/tad/tad_new/home.aspx to verify that this is the current version before utilizing.

<http://www.thomsonhc.com/micromedex2/librarian/>. Updated periodically.

See the [DISCLAIMER](#). All Humana member health plan contracts are NOT the same. All legislation/regulations on this subject may not be included. This document is for informational purposes only.