Clinical Policy: Bimatoprost Implant (Durysta)

Reference Number: CP.PHAR.486
Effective Date: 06.01.20
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Bimatoprost intracameral implant (Durysta®) is a prostaglandin analog.

FDA Approved Indication(s)

Durysta is indicated for the reduction of intraocular pressure (IOP) in patients with open angle glaucoma (OAG) or ocular hypertension (OHT).

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 Durysta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Open Angle Glaucoma and Ocular Hypertension (must meet all)**:**

1. Diagnosis of OAG or OHT;
2. Prescribed by or in consultation with an ophthalmologist;
3. Age ≥ 18 years;
4. Medical justification supports inability to manage regular glaucoma eye drop use (e.g., due to age or comorbidities including visual impairment);*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. The affected eye has not received prior treatment with Durysta;
6. Member has none of the following contraindications (a-e):
   a. Active or suspected ocular or periocular infection;
   b. Diagnosis of corneal endothelial cell dystrophy (e.g., Fuchs' Dystrophy);
   c. History of corneal transplantation or endothelial cell transplant (e.g., Descemet's Stripping Automated Endothelial Keratoplasty [DSAEK]);
   d. Absent or ruptured posterior lens capsule;
   e. Hypersensitivity to bimatoprost or to any other component of Durysta;
7. Dose does not exceed both of the following (a and b):
   a. 10 mcg per eye;
   b. One implant per eye.

Approval duration: one implant per eye (lifetime total)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Open Angle Glaucoma and Ocular Hypertension
1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, 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 – CP.CPA.09 for commercial, 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

DSAEK: Descemet's Stripping Automated Endothelial Keratoplasty
FDA: Food and Drug Administration
IOP: intraocular pressure
OAG: open angle glaucoma
OHT: ocular hypertension

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): ocular or periocular infections, corneal endothelial cell dystrophy, prior corneal transplantation, absent or ruptured posterior lens capsule, hypersensitivity to bimatoprost or to any other components of the product
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
OAG, IOH	Intracameral implant containing 10 mcg of bimatoprost in a drug delivery system General Information: Durysta is an ophthalmic drug delivery system for a single intracameral administration of a biodegradable implant. Durysta should not be readministered to an eye that received a prior Durysta. Administration: The intracameral injection procedure must be performed under magnification that allows clear visualization of the anterior chamber structures and should be carried out using standard aseptic conditions for intracameral procedures, with the patient's head in a stabilized position. The eye should not be dilated prior to the procedure. Remove the foil pouch from the carton and examine for damage. Then, open the foil pouch over a sterile field and gently drop the applicator on a sterile tray. Once the foil pouch is opened, use promptly. *See package insert for additional instructions.*	One implant per eye

VI. Product Availability

Intracameral implant in a single-use applicator that is packaged in a sealed foil pouch containing desiccant: 10 mcg bimatoprost

VII. References

1. Durysta Prescribing Information. North Chicago, IL: AbbVie, Inc.; October 2024. Available at https://www.rxabbvie.com/pdf/durysta_pi.pdf. Accessed February 7, 2025.
2. Lewis RA, Christie WC, Day DG, et al. Bimatoprost sustained-release implants for glaucoma therapy: 6-month results from a phase I/II clinical trial. *Am J Ophthalmol* 2017; 175:137-147.
3. Craven ER, Walters T, Christie WC, et al. 24-month phase I/II clinical trial of bimatoprost sustained-release implant (Bimatoprost SR) in glaucoma patients. *Drugs* 2020; 80:167-179.
4. Bacharach J, Tatham A, Ferguson G, et al; ARTEMIS 2 study group. Phase 3, randomized, 20-month study of the efficacy and safety of bimatoprost implant in patients with open-angle glaucoma and ocular hypertension (ARTEMIS 2). *Drugs*. 2021 Nov;81(17):2017-2033. doi: 10.1007/s40265-021-01624-9.
5. Gedde SJ, Vinod K, Wright MM, et al. Primary Open-Angle Glaucoma Preferred Practice Pattern® Guidelines. Ophthalmology; November 2020. Available at: https://www.aao.org/preferred-practice-pattern/primary-open-angle-glaucoma-ppp. Accessed February 7, 2025.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7351	Injection, bimatoprost, intracameral implant, 1 microgram

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; added Coding Implications section; references reviewed and updated.	01.11.21	05.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	01.13.22	05.22
Template changes applied to other diagnoses/indications.	10.03.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.02.23	05.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.31.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated.	01.22.25	05.25
Added step therapy bypass for IL HIM per IL HB 5395	06.27.25	

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.

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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.

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