**Clinical Policy: Ophthalmic Corticosteroids**

Reference Number: HIM.PA.03  
Effective Date: 01.01.20  
Last Review Date: 02.20  
Line of Business: HIM

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

**Description**

The following are ophthalmic corticosteroids requiring prior authorization: dexamethasone (Maxidex®), difluprednate (Durezol®), fluorometholone (FML®, FML® Forte), loteprednol (Alrex®, Lotemax®), prednisolone (Pred Mild®).

**FDA Approved Indication(s)**

Alrex is indicated for the temporary relief of the signs and symptoms of seasonal allergic conjunctivitis.

Durezol is indicated for the treatment of:
- Inflammation and pain associated with ocular surgery
- Endogenous anterior uveitis

FML and FML Forte are indicated for the treatment of corticosteroid-responsive inflammation of the palpebral and bulbar conjunctiva, cornea and anterior segment of the globe.

Lotemax is indicated for the treatment of:
- steroid responsive inflammatory conditions of the palpebral and bulbar conjunctiva, cornea and anterior segment of the globe such as allergic conjunctivitis, acne rosacea, superficial punctate keratitis, herpes zoster keratitis, iritis, cyclitis, selected infective conjunctivitides, when the inherent hazard of steroid use is accepted to obtain an advisable diminution in edema and inflammation.
- post-operative inflammation following ocular surgery

Maxidex is indicated for the treatment of steroid responsive inflammatory conditions of the palpebral and bulbar conjunctiva, cornea, and anterior segment of the globe such as allergic conjunctivitis, acne rosacea, superficial punctate keratitis, herpes zoster keratitis, iritis, cyclitis, selected infective conjunctivitides when the inherent hazard of steroid use is accepted to obtain an advisable diminution in edema and inflammation; corneal injury from chemical, radiation, or thermal burns, or penetration of foreign bodies.

Pred Mild is indicated for the treatment of mild to moderate noninfectious allergic and inflammatory disorders of the lid, conjunctiva, cornea, and sclera (including chemical and thermal burns).
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 Alrex, Durezol, FML, FML Forte, Lotemax, Maxidex, and Pred Mild are medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. All FDA-Approved Indications (must meet all):
      1. Request is for one of the following uses (a – d):
         a. Durezol, Lotemax: following ocular surgery;
         b. FML, FML Forte, Lotemax, Maxidex, Pred Mild: inflammation of the eye;
         c. Alrex: seasonal allergic conjunctivitis;
         d. Durezol: uveitis;
      2. If request is for FML or FML Forte: age ≥ 2 years;
      3. If request is for Alrex or Lotemax: age ≥ 18 years;
      4. Failure of at least two preferred generic ophthalmic corticosteroids (e.g., dexamethasone, fluorometholone, loteprednol, prednisolone) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
      5. If request is for the brand name drug with the same active ingredient as previously trialed, medical justification why the requested brand name drug will work despite inadequate response to the generic (e.g., contraindications to excipients);
      6. Request does not exceed one of the following:
         a. Alrex, FML Forte, Lotemax suspension, Pred Mild: 1 bottle/30 days;
         b. Durezol: 2 bottles/30 days;
         c. FML, Lotemax: 2 tubes/30 days;
         d. Lotemax gel: 3 bottles/30 days
         e. Maxidex: 4 bottles/30 days.
   Approval duration: 12 months
   
   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.PHAR.21 for health insurance marketplace.

II. Continued Therapy
   A. All FDA-Approved Indications (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, request does not exceed one of the following:
         a. Alrex, FML Forte, Lotemax suspension, Pred Mild: 1 bottle/30 days;
         b. Durezol: 2 bottles/30 days;
         c. FML, Lotemax: 2 tubes/30 days;

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C.  Lotemax gel: 3 bottles/30 days  
   e.  Maxidex: 4 bottles/30 days.  
   Approval duration: 12 months

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.PHAR.21 for health insurance marketplace.

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.PHAR.21 for health insurance marketplace 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexamethasone 0.1% solution</td>
<td>1 to 2 drops in affected eye four to six times per day.</td>
<td>12 drops/day in affected eye</td>
</tr>
<tr>
<td>Fluorometholone 0.1% suspension (FML Liquifilm)</td>
<td>1 drop in affected eye BID to QID.</td>
<td>4 drops/day in affected eye</td>
</tr>
<tr>
<td>Loteprednol 0.5% suspension (Lotemax)</td>
<td>1 to 2 drops in the affected eye QID.</td>
<td>8 drops/day in affected eye</td>
</tr>
<tr>
<td>Prednisolone 1% solution/suspension (Omnipred®, Pred Forte®, Pred Mild)</td>
<td>1 drop in affected eye BID to QID.</td>
<td>4 drops/day in affected eye</td>
</tr>
</tbody>
</table>

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):
  - Viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures
- Pred Mild: acute untreated purulent ocular infections
- Alrex, FML, FML Forte, Lotemax, Maxidex, and Pred Mild: hypersensitivity
- Boxed warning(s): none reported

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>dexamethasone (Maxidex)</td>
<td>Steroid responsive inflammatory conditions</td>
<td>1 to 2 drops in affected eye. In severe disease, drops may be used hourly, being tapered to discontinuation as the inflammation subsides. In mild disease, drops may be used up to four to six times daily.</td>
<td>12 drops/day in affected eye; 4 bottles/30 days</td>
</tr>
<tr>
<td>difluprednate (Durezol)</td>
<td>Ocular surgery</td>
<td>1 drop in affected eye QID beginning 24 hours after surgery and continuing throughout the first 2 weeks of the postoperative period, followed by BID dosing for 1 week and then tapered based on response.</td>
<td>4 drops/day in affected eye; 2 bottles/30 days</td>
</tr>
<tr>
<td>difluprednate (Durezol)</td>
<td>Endogenous anterior uveitis</td>
<td>1 drop in affected eye QID for 14 days followed by tapering as clinically indicated.</td>
<td>4 drops/day in affected eye; 2 bottles/30 days</td>
</tr>
<tr>
<td>fluorometholone ointment (FML)</td>
<td>Steroid responsive inflammatory conditions</td>
<td>Approximately ½ inch ribbon of ointment in affected eye QD to TID. During the initial 24 to 48 hours, the dosing frequency may be increased to one application every four hours.</td>
<td>4 drops/day in affected eye; 2 bottles/30 days</td>
</tr>
</tbody>
</table>
## Clinical Policy
### Ophthalmic Corticosteroids

<table>
<thead>
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<th>Drug Name</th>
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<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluorometholone suspension (FML Forte)</td>
<td>Steroid responsive inflammatory conditions</td>
<td>1 drop in affected eye BID to QID. During the initial 24 to 48 hours, the dosing frequency may be increased to one application every four hours.</td>
<td>4 drops/day in affected eye; 1 bottle/30 days</td>
</tr>
<tr>
<td>loteprednol (Alrex)</td>
<td>Seasonal allergic conjunctivitis</td>
<td>1 drop in the affected eye QID</td>
<td>4 drops/day in affected eye; 1 bottle/30 days</td>
</tr>
<tr>
<td>loteprednol (Lotemax)</td>
<td>Steroid Responsive Disease</td>
<td>Suspension/gel: 1 to 2 drops in the affected eye QID. During the initial treatment within the first week, dosing may be increased up to 1 drop every hour if necessary.</td>
<td>Suspension/gel: 8 drops/day in affected eye; 1 bottle (suspension) or 3 bottles (gel)/30 days</td>
</tr>
<tr>
<td>loteprednol (Lotemax)</td>
<td>Ocular surgery</td>
<td>Begin treatment 24 hours after surgery for 2 weeksSuspension/gel: 1 to 2 drops in the affected eye QID. Ointment: Approximately 1/2 inch ribbon of ointment in affected eye QID.</td>
<td>Suspension/gel: 8 drops/day in affected eye; 1 bottle (suspension) or 3 bottles (gel)/30 days Ointment:</td>
</tr>
<tr>
<td>prednisolone (Pred Mild)</td>
<td>Steroid responsive inflammatory conditions</td>
<td>1 drop in affected eye BID to QID. During the initial 24 to 48 hours, the dosing frequency may be increased to one application every four hours.</td>
<td>4 drops/day in affected eye; 1 bottle/30 days</td>
</tr>
</tbody>
</table>
VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>dexamethasone (Maxidex)</td>
<td>Multidose bottle: 0.1% suspension, 5 mL</td>
</tr>
<tr>
<td>difluprednate (Durezol)</td>
<td>Multidose bottle: 0.05%, 5 mL</td>
</tr>
<tr>
<td>fluorometholone ointment (FML)</td>
<td>Tube: 0.1% ointment, 3.5 g</td>
</tr>
<tr>
<td>fluorometholone suspension (FML Forte)</td>
<td>Multidose bottle: 0.25% suspension, 5 mL, 10 mL</td>
</tr>
<tr>
<td>loteprednol (Alrex)</td>
<td>Multidose bottle: 0.2% suspension, 5 mL, 10 mL</td>
</tr>
<tr>
<td>loteprednol (Lotemax)</td>
<td>Multidose bottle: 0.5% suspension, 5 mL, 10 mL, 15 mL Tube: 0.5% ointment, 3.5 g</td>
</tr>
<tr>
<td>prednisolone (Pred Mild)</td>
<td>Multidose bottle: 0.12% suspension, 5 mL, 10 mL</td>
</tr>
</tbody>
</table>

VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created per SDC and prior clinical guidance.</td>
<td>12.11.19</td>
<td>02.20</td>
</tr>
</tbody>
</table>

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.

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Note:
For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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