Clinical Policy: Netarsudil (Rhopressa)
Reference Number: ERX.NPA.68
Effective Date: 02.13.18
Last Review Date: 05.18

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

Description
Netarsudil (Rhopressa®) is a Rho kinase inhibitor.

FDA Approved Indication(s)
Rhopressa is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

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 Envolve Pharmacy Solutions™ that Rhopressa is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Open-Angle Glaucoma (must meet all):
      1. Diagnosis of open-angle glaucoma or ocular hypertension;
      2. Age ≥ 18 years;
      3. Failure of two different classes of generic ophthalmic agents from the following, at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced: prostaglandin analog (e.g., latanoprost), ophthalmic beta-blocker (e.g., timolol), ophthalmic alpha-2 adrenergic agonist (e.g., brimonidine), parasympathomimetic (e.g., pilocarpine), or carbonic anhydrase inhibitor (e.g., dorzolamide);
      4. Dose does not exceed 1 drop/eye/day (2 bottles or 5 mL/30 days).
   Approval duration: Length of Benefit

   B. Other diagnoses/indications
      1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy
   A. Open-Angle Glaucoma (must meet all):
      1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, new dose does not exceed 1 drop/eye/day (2 bottles or 5 mL/30 days).
   Approval duration: Length of Benefit

   B. Other diagnoses/indications (must meet 1 or 2):
      1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
      2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 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 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>latanoprost (Xalatan®)</td>
<td>1 drop in the affected eye(s) once daily in the evening</td>
<td>1 drop/eye/day</td>
</tr>
<tr>
<td>timolol (Timoptic®)</td>
<td>1 drop in the affected eye(s) twice daily</td>
<td>2 drops/eye/day</td>
</tr>
<tr>
<td>brimonidine (Alphagan® P)</td>
<td>1 drop in the affected eye(s) three times daily</td>
<td>3 drops/eye/day</td>
</tr>
<tr>
<td>pilocarpine (Isoto Carpine®)</td>
<td>1 drop into the eye(s) up to four times a day</td>
<td>4 drops/eye/day</td>
</tr>
<tr>
<td>dorzolamide (Trusopt®)</td>
<td>1 drop in the affected eye(s) three times daily</td>
<td>3 drops/eye/day</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.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open-angle glaucoma</td>
<td>1 drop into the affected eye(s) once daily in the evening</td>
<td>1 drop/eye/day</td>
</tr>
</tbody>
</table>

VI. Product Availability
Ophthalmic solution: 0.02% (0.2 mg/mL) in a 2.5 mL total volume per bottle

VII. References

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created.</td>
<td>02.13.18</td>
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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.
This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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