Policy Title:	iDose TR (travoprost) (Implant)		
		Department:	PHA
Effective Date:	09/01/2024		
Review Date:	07/17/2024, 05/07/2025, 01/27/2026		

Purpose: To support safe, effective, and appropriate use of iDose TR (travoprost implant).

Scope: Medicaid, Commercial, Medicare

Policy Statement:

iDose TR (travoprost implant) is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:

Coverage of iDose TR (travoprost implant) will be reviewed prospectively via the prior authorization process based on criteria below.

Summary of Evidence:

iDose TR (travoprost) is a prostaglandin analog indicated for the reduction of intraocular pressure (IOP) in patients with open angle glaucoma (OAG) or ocular hypertension (OHT). The effectiveness of iDose TR was evaluated in two multicenter, 12-month, randomized, parallel-group, double-masked, active-controlled clinical trials in 1,150 patients with OAG or OHT. In both trials, iDose TR was compared to twice daily topical administration of timolol maleate 0.5% ophthalmic solution. In the first 3 months following administration, iDose TR demonstrated an IOP change from baseline of -6.6 to -8.4 mmHg in participants with a mean baseline IOP of 24 mmHg. iDose TR demonstrated non-inferiority to timolol ophthalmic solution in IOP reduction during the first 3 months. Subsequently, iDose TR did not demonstrate non-inferiority over the next 9 months. iDose TR should be used cautiously in patients with narrow angles or other angle abnormalities and monitored for device dislocation and potentially permanent increased pigmentation of the iris. The most common adverse events reported with iDose TR are increases in intraocular pressure, iritis, dry eye, and visual field defects.

Initial Criteria:

- Member is 18 years of age or older; AND
- Member has a diagnosis of open angle glaucoma or ocular hypertension; AND
- iDose TR (travoprost) has been prescribed by or in consultation with an ophthalmologist; AND
- Intolerance or an insufficient response to at least two ophthalmic prostaglandin analogs (e.g., latanoprost, travoprost, tafluprost, bimatoprost) and at least one other IOP reducing ophthalmic

product from a different medication class, such as beta-blockers, alpha-agonists, and carbonic anhydrase inhibitors (combination therapy should be used if warranted); AND

- Member has none of the following contraindications:
  - Active or suspected ocular or periocular infection
  - Diagnosis of corneal endothelial cell dystrophy (e.g., Fuchs' Dystrophy)
  - History of corneal transplantation or endothelial cell transplant (e.g., Descemet's Stripping Automated Endothelial Keratoplasty [DSAEK])
  - Absent or ruptured posterior lens capsule
  - Hypersensitivity to travoprost or to any other component of iDose TR (travoprost); AND
- The affected eye has not received prior treatment with iDose TR (travoprost); AND
- The member will not concurrently use iDose TR (travoprost intracameral implant) with Durysta (bimatoprost intracameral implant); AND
- Medicare members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

Coverage Duration:

- Coverage will be provided for one implant per eye per lifetime and may not be renewed.

Per §§ 42 CFR 422.101, this clinical medical policy only applies to Medicare in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD).

Policy Rationale:
iDose TR was reviewed by the Neighborhood Health Plan of Rhode Island Pharmacy & Therapeutics (P&T) Committee. Neighborhood adopted the following clinical coverage criteria to ensure that its members use iDose TR according to Food and Drug Administration (FDA) approved labeling and/or relevant clinical literature. Neighborhood worked with network prescribers and pharmacists to draft these criteria. These criteria will help ensure its members are using this drug for a medically accepted indication, while minimizing the risk for adverse effects and ensuring more cost-effective options are used first, if applicable and appropriate. For Medicaremembers, these coverage criteria will only apply in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Neighborhood will give individual consideration to each request it reviews based on the information submitted by the prescriber and other information available to the plan.

Dosage/Administration:

Indication	Dose	Maximum dose (1 billable unit = 1 mcg)
Open angle glaucoma or ocular hypertension	Intracameral implant containing 75 mcg of travoprost, pre-loaded in a single dose inserter for administration by a healthcare professional *Note:* iDose TR should not be readministered to an eye that previously received iDose TR.	75 units per eye per lifetime

Investigational use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

Applicable Codes:
Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all-inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.

The following HCPCS/CPT codes are:

HCPCS/CPT Code	Description
J7355	Injection, travoprost, intracameral implant, 1 microgram

References:

1. iDose® TR intracameral implant [prescribing information]. San Clemente, CA: Glaukos; December 2023. Accessed January 2026.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed July 9, 2024.
3. Gedde SJ, Vinod K, Wright MW, et al. Primary open-angle glaucoma Preferred Practice Pattern® guidelines. The American Academy of Ophthalmology. 2020. Available at: https://www.aao.org/education/preferred-practice-pattern/primary-open-angle-glaucomappp. Accessed on July 9, 2024.