Faricimab-svoa (Vabysmo™)	Place of Service Office Administration Home Infusion Administration Infusion Center Administration Outpatient Facility Infusion Administration HCPCS: J2777 per 0.1 mg

Condition(s) listed in policy (*see criteria for details*)

- Diabetic macular edema (DME)
- Macular edema following retinal vein occlusion (RVO)
- Neovascular (WET) age-related macular degeneration (AMD)

AHFS therapeutic class: ophthalmic agents, other

Mechanism of action: Inhibits vascular endothelial growth factor (VEGF) and angiopoietin-2 (Ang-2)

(1) Special Instructions and pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Vabysmo™ (Faricimab-svoa) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Diabetic macular edema (DME)

1. Intolerable side effect with preferred biosimilar Cimerli, that is not expected with Vabysmo, or contraindication to Cimerli

Covered Doses
6 mg administered by intravitreal injection every 4 weeks (approximately every 28 days ± 7 days, monthly)

Coverage Period
Yearly

ICD-10: (X= 0-9)
E08.3XXX, E09.3XXX,
E10.3XXX, E11.3XXX
E13.3XXX

Macular edema following retinal vein occlusion (RVO)

1. Intolerable side effect with preferred biosimilar Byooviz or Cimerli, that is not expected with Vabysmo, or contraindication to Byooviz and Cimerli

Covered Doses
6 mg administered by intravitreal injection every 4 weeks (approximately every 28 ± 7 days, monthly)

Coverage Period
6 months

ICD-10:
H34.8110-8112, H34.8120-8122 H34.8130- 8132, H34.8190-8192, H34.8310-8312, H34.8320-8322, H34.8330-8332, H34.8390-8392

Neovascular (WET) age-related macular degeneration (AMD)

2. Intolerable side effect with preferred biosimilar Byooviz or Cimerli, that is not expected with Vabysmo, or contraindication to Byooviz and Cimerli

Covered Doses
6 mg administered by intravitreal injection every 4 weeks (approximately every 28 ± 7 days, monthly)

Coverage Period
Yearly

ICD-10:
H35.3210-3213
H35.3220-3223
H35.3230-3233
H35.3290-3293

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for Vabysmo™ (Faricimab-svoa) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT COVERED for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 120 mg/mL solution in a single-dose glass vial. Each glass vial contains an overfill amount to allow for administration of a single 0.05 mL dose of solution containing 6 mg of Vabysmo.

- Each Vabysmo carton contains one glass vial and one sterile 5-micron blunt transfer filter needle (18-gauge x 1½ inch, 1.2 mm x 40 mm)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Vabysmo (faricimab-svoa) [Prescribing information]. South San Francisco, CA: Genentech, Inc.;1/2022.

(7) Policy Update

Date of last revision: 4Q2023
Date of next review: 1Q2024
Changes from previous policy version:

- New indication in Section (2): Added coverage for treatment of macular edema following retinal vein occlusion (RVO)
  Rationale: On October 26, 2023, the FDA approved Vabysmo for treatment of macular edema following retinal vein occlusion

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee