

## **aflibercept**

### **Commercial Medical Benefit Drug Policy**

aflibercept (Eylea)  
aflibercept (Eylea HD)  
aflibercept-ayyh (Pavblu)

#### Place of Service

Office Administration  
Outpatient Facility Infusion  
Administration  
Infusion Center Administration

### **Drug Details**

**USP Category:** OPHTHALMIC AGENTS

**Mechanism of Action:** Vascular endothelial growth factor (VEGF) inhibitor

#### **HCPCS:**

J0177:Injection, aflibercept hd, 1 mg  
J0178:Injection, aflibercept, 1 mg  
Q5147:Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg

#### **How Supplied:**

##### Eylea:

- 2 mg (0.05 mL of 40 mg/mL) solution in a single-dose pre-filled syringe
- 2 mg (0.05 mL of 40 mg/mL) solution in a single-dose vial

##### Eylea HD:

- 8 mg (0.07 mL of 114.3 mg/mL solution) in a single-dose vial

##### Pavblu:

- 2 mg (0.05 mL of 40 mg/mL) solution in a single-dose prefilled syringe
- 2 mg (0.05 mL of 40 mg/mL) solution in a single-dose vial

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

- Diabetic Macular Edema (DME)
- Diabetic Retinopathy (DR)
- Macular Edema (ME) following Central or Branch Retinal Vein Occlusion (RVO)
- Neovascular (WET) Age-Related Macular Degeneration (AMD)
- Retinopathy of Prematurity (ROP)

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

### **Special Instructions and Pertinent Information**

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

#### **Coverage Criteria**

**The following condition(s) require Prior Authorization/Preservice.**

#### **Diabetic Macular Edema (DME)**

**Meets medical necessity if all the following are met:**

##### **Covered Doses:**

Eylea or Pavblu: Not to exceed 2 mg given by intravitreal injection every 25 days

Eylea HD: Not to exceed 8 mg given by intravitreal injection every 21 days

##### **Coverage Period:**

Yearly, based on continued response to therapy

##### **ICD-10:**

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

#### **Diabetic Retinopathy (DR)**

**Meets medical necessity if all the following are met:**

##### **Covered Doses:**

Eylea or Pavblu: Not to exceed 2 mg given by intravitreal injection every 25 days

Eylea HD: Not to exceed 8 mg given by intravitreal injection every 21 days

##### **Coverage Period:**

Yearly, based on continued response to therapy

##### **ICD-10:**

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

#### **Macular Edema (ME) following Central or Branch Retinal Vein Occlusion (RVO)**

**Meets medical necessity if all the following are met:**

1. Request is for Eylea or Pavblu (Not FDA approved for Eylea HD)

##### **Covered Doses:**

Eylea or Pavblu: Not to exceed 2 mg given by intravitreal injection every 25 days

Eylea HD: Not to exceed 8 mg given by intravitreal injection every 3 weeks

##### **Coverage Period:**

Yearly, based on continued response to therapy

##### **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)**

**Meets medical necessity if all the following are met:**

#### **Covered Doses:**

Eylea or Pavblu: Not to exceed 2 mg given by intravitreal injection every 25 days

Eylea HD: Not to exceed 8 mg given by intravitreal injection every 21 days

#### **Coverage Period:**

Yearly, based on continued response to therapy

#### **ICD-10:**

H35.3210-3213, H35.3220-3223, H35.3230-3233, H35.3290-3293

### **Retinopathy of Prematurity (ROP)**

**Meets medical necessity if all the following are met:**

1. Request is for Eylea (Not FDA approved for Eylea HD or Pavblu)

#### **Covered Doses:**

Eylea: Not to exceed 0.4 mg given by intravitreal injection every 10 days

#### **Coverage Period:**

Yearly, based on continued response to therapy

#### **ICD-10:**

H35.109

### **References**

1. AHFS. Available by subscription at <http://www.lexi.com>
2. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
3. Eylea (aflibercept) Prescribing Information. Regeneron Pharmaceuticals, Inc., Tarrytown, NY: 10/2024.
4. Eylea HD (aflibercept) Prescribing Information. Regeneron Pharmaceuticals, Inc., Tarrytown, NY: 11/2025.
5. Pavblu (aflibercept-ayyh) Prescribing information. Amgen, Inc., Thousand Oaks, CA. 8/2024.

### **Review History**

Date of Last Annual Review: 1Q2026

Changes from previous policy version:

- Eylea HD: Added coverage for macular edema following retinal vein occlusion (RVO) (Rationale: In November 2025, the FDA expanded approval of Eylea HD to include macular edema following RVO)

*Blue Shield of California Medication Policy to Determine Medical Necessity  
Reviewed by P&T Committee*

