bimatoprost implant (Durysta)

Commercial Medical Benefit Drug Policy

Place of Service
Office Administration
Outpatient Facility Administration

Drug Details

USP Category: OPHTHALMIC AGENTS
Mechanism of Action: Prostaglandin analog
HCPCS:
J7351:Injection, bimatoprost, intracameral implant, 1 microgram
How Supplied:
Intracameral implant containing bimatoprost 10 mcg, in the drug delivery system

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

- Open Angle Glaucoma (OAG) or Ocular Hypertension (OHT)

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.

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

Open Angle Glaucoma (OAG) or Ocular Hypertension (OHT)
Meets medical necessity if all the following are met:
1. Inadequate response or intolerable side effect with at least two prostaglandin analog ophthalmic drops

Covered Doses:
Single intracameral administration of Durysta 10 mcg implant

Coverage Period:
One-time administration

ICD-10:
H40.051, H40.052, H40.053, H40.059, H40.10X, H40.111, H40.112, H40.113, H40.119, H40.131, H40.132, H40.133, H40.139, H40.141, H40.142, H40.143, H40.149

References

1. AHFS. Available by subscription at http://www.lexi.com

2. DrugDex. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
3. Durysta (bimatoprost) implant [prescribing information]. North Chicago, IL: AbbVie Inc; October 2024.

Review History

Date of Last Annual Review: 2Q2025
Changes from previous policy version:

- no clinical changes following annual review

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