

ranibizumab-nuna (Byooviz)

Commercial Medical Benefit Drug Policy

Place of Service

Infusion Center Administration

Office Administration

Outpatient Facility Infusion Administration

Drug Details

USP Category: OPHTHALMIC AGENTS

Mechanism of Action: A vascular endothelial growth factor (VEGF) inhibitor

HCPCS:

Q5124:Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg

How Supplied:

2 mL single-dose vial

Single-dose glass vial provides 0.05 mL for intravitreal injections: 10 mg/mL solution (0.5 mg/0.05 ml dose)

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

- Macular Edema following Retinal Vein Occlusion (RVO)
- Myopic Choroidal Neovascularization (MCNV)
- Neovascular (Wet) Age-Related Macular Degeneration (NAMD)

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.

Macular Edema following Retinal Vein Occlusion (RVO)

Meets medical necessity if all the following are met:

Covered Doses:

Not to exceed 0.5 mg administered by intravitreal injection once monthly into the affected eye

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

Myopic Choroidal Neovascularization (MCNV)

Meets medical necessity if all the following are met:

Covered Doses:

Not to exceed 0.5 mg administered by intravitreal injection once monthly into the affected eye

Coverage Period:

Yearly, based on continued response to therapy

ICD-10:

H35.051-H35.053, H35.059, H44.21-H44.23

Neovascular (Wet) Age-Related Macular Degeneration (NAMD)

Meets medical necessity if all the following are met:

Covered Doses:

Not to exceed 0.5 mg administered by intravitreal injection once monthly into the affected eye

Coverage Period:

Yearly, based on continued response to therapy

ICD-10:

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

References

1. AHFS. Available by subscription at <http://www.lexi.com>
2. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
3. Byooviz (ranibizumab-nuna) Prescribing Information. Biogen Inc., Cambridge, MA: 8/2025.

Review History

Date of Last Annual Review: 1Q2026

Changes from previous policy version:

- No clinical change following annual review

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