

travoprost (iDose TR)

Commercial Medical Benefit Drug Policy

Place of Service

Office Administration

Outpatient Facility Infusion Administration

Drug Details

USP Category: OPHTHALMIC AGENTS

Mechanism of Action: Selective FP prostanoid receptor agonist

HCPCS:

J7355:Injection, travoprost, intracameral implant, 1 microgram

How Supplied:

75 mcg intracameral implant

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.

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.

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
2. Not being used in combination with Durysta (bimatoprost)

Covered Doses:

One intracameral implant per eye per year

Coverage Period:

Yearly, based on continued response to therapy

ICD-10:

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

Additional Information

- In Jan 2026, the prescribing information was updated for iDose TR to allow for re-administration for patients with healthy cornea. It is not recommended to readminister an iDose TR more than once per year.
- Per package insert, central corneal endothelial cell density should not be less than the recommended minimum listed table 1 below prior to the initial administration of iDose TR and prior to each readministration.

Table 1: Recommended Minimum Central Corneal Endothelial Cell Density

Age	Central Corneal Endothelial Cell Density	
	Phakic Eyes	Pseudophakic Eyes
≤ 45 years	2,200 (cells/mm ²)	1,540 (cells/mm ²)
46 to 55 years	2,000 (cells/mm ²)	1,400 (cells/mm ²)
56 to 65 years	1,800 (cells/mm ²)	1,260 (cells/mm ²)
> 65 years	1,600 (cells/mm ²)	1,120 (cells/mm ²)

Table 2: Dosage (Readministration) Modifications for Adverse Reactions

Adverse Reactions	Dosage Modification
Ocular or periocular infections	Withhold dose (readministration)
Prior iDose TR device dislocation	Withhold dose (readministration)
Central corneal endothelial cell loss of 10% or greater from pre-administration baseline (adjusted for age-related 1% loss per year and for a 10% loss following an anterior segment surgical procedure [e.g., cataract surgery])	Withhold dose (readministration)

References

1. AHFS. Available by subscription at <http://www.lexi.com>
2. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
3. Idose (travoprost intracameral implant) Prescribing Information. Glaukos Corp.Inc., San Clemente, CA: 1/2026.

Review History

Date of Last Annual Review: 1Q2026

Changes from previous policy version:

- Expanded coverage to include readministration. Rationale: In January 2026, the prescribing information was updated for iDose TR to allow for readministration

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