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.

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

Coverage Period:
One-time administration

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

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: 12/2023.

Review History

Date of Last Annual Review: 1Q2025

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