aflibercept

Medical Benefit Drug Policy

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

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
Q5155:Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg

How Supplied:

Eylea or Pavblu or Yesafili:

- 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

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 California Code of Regulations (CCR), Title 22, Section 51303 and 51313 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.

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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.

Diabetic Macular Edema (DME)
Meets medical necessity if all the following are met:

Covered Doses:
Eylea or Pavblu or Yesafili: Up to 2 mg given by intravitreal injection every 25 days
Eylea HD: Up to 8 mg given by intravitreal injection every 21 days

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
E08.31-E08.3599, E09.31-E09.3599, E10.31-E10.3599, E11.31-E11.3599, E13.31-E13.3599

Diabetic Retinopathy (DR)
Meets medical necessity if all the following are met:

Covered Doses:
Eylea or Pavblu or Yesafili: Up to 2 mg given by intravitreal injection every 25 days
Eylea HD: Up to 8 mg given by intravitreal injection every 21 days

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
E08.31-E08.3599, E09.31-E09.3599, E10.31-E10.3599, E11.31-E11.3599, E13.31-E13.3599

Macular Edema (ME) following Central or Branch Retinal Vein Occlusion (RVO)
Meets medical necessity if all the following are met:

Covered Doses:
Eylea or Pavblu or Yesafili: Up to 2 mg given by intravitreal injection every 25 days
Eylea HD: Up to 8 mg given by intravitreal injection every 21 days

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
H34.81, H34.811, H34.8110, H34.8111, H34.8112, H34.812, H34.8120, H34.8121, H34.8122, H34.813, H34.8130, H34.8131, H34.8132, H34.819, H34.8190, H34.8191, H34.8192, H34.83, H34.831,

H34.8310, H34.8311, H34.8312, H34.832, H34.8320, H34.8321, H34.8322, H34.833, H34.8330, H34.8331, H34.8332, H34.839, H34.8390, H34.8391, H34.8392

Neovascular (WET) Age-Related Macular Degeneration (AMD)
Meets medical necessity if all the following are met:

Covered Doses:
Eylea or Pavblu or Yesafili: Up to 2 mg given by intravitreal injection every 25 days
Eylea HD: Up to 8 mg given by intravitreal injection every 21 days

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
H35.32, H35.321, H35.3210, H35.3211, H35.3212, H35.3213, H35.322, H35.3220, H35.3221, H35.3222, H35.3223, H35.323, H35.3230, H35.3231, H35.3232, H35.3233, H35.329, H35.3290, H35.3291, H35.3292, H35.3293

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 or Yesafili)

Covered Doses:
Eylea: Up to 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.
6. Yesafili (aflibercept-jbvf) Prescribing information. Biocon Biologics Inc., Cambridge, MA: 1/2026.

Review History

Date of Last Annual Review: 1Q2026

Changes from previous policy version:

- Added new biosimilar Yesafili (Rationale: FDA approval)

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