blue california
Promise Health Plan

faricimab-svoa (Vabysmo)

Medical Benefit Drug Policy

Place of Service
Office Administration
Infusion Center Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: OPHTHALMIC AGENTS
Mechanism of Action: Inhibits vascular endothelial growth factor (VEGF) and angiopoietin-2 (Ang-2)
HCPCS:
J2777:Injection, faricimab-svoa, 0.1 mg
How Supplied:
6 mg (0.05 mL of 120 mg/mL solution) in a single-dose prefilled syringe
6 mg (0.05 mL of 120 mg/mL solution) in a single-dose vial

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

- Diabetic Macular Edema (DME)
- Macular Edema following Retinal Vein Occlusion (RVO)
- Neovascular (WET) Age-Related Macular Degeneration (AMD)

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.

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:
1. Intolerable side effect with preferred biosimilar Cimerli, that is not expected with Vabysmo, or contraindication to Cimerli

Covered Doses:

6 mg administered by intravitreal injection given as often as every 3 weeks for the first 4 doses, followed by every 4 weeks thereafter

Coverage Period:
Yearly

ICD-10: (X= 0-9)
E08.3XXX, E09.3XXX, E10.3XXX, E11.3XXX, E13.3XXX

Macular Edema following Retinal Vein Occlusion (RVO)
Meets medical necessity if all the following are met:
1. Intolerable side effect with preferred biosimilar Byooviz or Cimerli, that is not expected with Vabysmo, or contraindication to Byooviz and Cimerli

Covered Doses:
6 mg administered by intravitreal injection every 3-5 weeks

Coverage Period:
6 months
No reauthorization

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

Neovascular (WET) Age-Related Macular Degeneration (AMD)
Meets medical necessity if all the following are met:
1. Intolerable side effect with preferred biosimilar Byooviz or Cimerli, that is not expected with Vabysmo, or contraindication to Byooviz and Cimerli

Covered Doses:
6 mg administered by intravitreal injection every 3-5 weeks for the first 4 doses followed by every 4 weeks thereafter

Coverage Period:
Yearly

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. Vabysmo (faricimab-svoa) Prescribing Information. Genentech, Inc., South San Francisco, CA; 7/2024.

Review History

Date of Last Annual Review: 1Q2025

Changes from previous policy version:

- No clinical change to policy following annual review.

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