blue california
Promise Health Plan

ranibizumab implant (Susvimo)

Medical Benefit Drug Policy

Place of Service
Office Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: OPHTHALMIC AGENTS
Mechanism of Action: Ranibizumab is a recombinant humanized IgG1 kappa isotype monoclonal antibody fragment designed for intraocular use. Ranibizumab binds to and inhibits the biologic activity of human vascular endotheli
HCPCS:
J2779:Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg
How Supplied:
100 mg/mL (single-dose)

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

- Diabetic Macular Edema (DME) or Diabetic Retinopathy (DR)
- 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) or Diabetic Retinopathy (DR)
Meets medical necessity if all the following are met:
1. Patient has previous response to at least two intravitreal injections of a VEGF inhibitor

Covered Doses:
Up to 2 mg given intravitreally per affected eye every 6 months

Coverage Period:
Yearly

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

Neovascular (Wet) Age-Related Macular Degeneration (AMD)
Meets medical necessity if all the following are met:
1. Patient has prior use of preferred biosimilar (e.g., Byooviz or Cimerli) and one other VEGF inhibitor

Covered Doses:
Up to 2 mg given intravitreally per affected eye every 6 months

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. Susvimo (ranibizumab) Prescribing Information. Genentech, Inc., South San Francisco, CA: 5/2025.

Review History

Date of Last Annual Review: 1Q2025
Changes from previous policy version:

- Diabetic Retinopathy: Added new coverage for this indication *(Rationale: In May 2025, the FDA approved Susvimo for the treatment of patients with diabetic retinopathy who have previously responded to at least two intravitreal injections of a VEGF inhibitor.)*

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