



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2024 P 3015-14
Program	Step Therapy – Glaucoma Agents
Medication	Travatan Z <sup>®</sup> (travoprost)*, Vyzulta <sup>®</sup> (latanoprostene)*, Zioptan <sup>®</sup> (tafluprost)
P&T Approval Date	7/2013, 8/2013, 2/2014, 2/2015, 3/2016, 3/2017, 3/2018, 3/2019, 3/2020, 3/2021, 3/2022, 3/2023, 3/2024
Effective Date	6/1/2024

**1. Background:**

Lumigan (bimatoprost), Travatan Z (travoprost)\*, Xalatan (latanoprost)\*, Vyzulta (latanoprostene)\* and Zioptan (tafluprost) are ophthalmic agents indicated for reducing elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try latanoprost (generic Xalatan) before providing coverage for Vyzulta\* or Zioptan.

If a member has a prescription for latanoprost in the claims history within the previous 12 months, the claim for Travatan Z (travoprost)\*, Vyzulta\* or Zioptan will automatically process. Members, who have received at least a 90 day supply of Travatan Z (travoprost)\*, Vyzulta\* or Zioptan in the past 120 days as documented in claims history, will be allowed continued coverage of their current therapy.

**2. Coverage Criteria<sup>a</sup>:**

<p><b>A. Travatan Z (travoprost)*, Vyzulta* or Zioptan</b> will be approved based on the following criterion:</p> <p>1. History of failure, contraindication or intolerance to latanoprost (generic Xalatan)</p> <p><b>Authorization will be issued for 12 months.</b></p> <p><sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.</p>
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**\* Travatan Z (brand only), Vyzulta, and Xalatan (brand only) are typically excluded from coverage.**

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

**4. References:**

1. American Academy of Ophthalmology. Preferred Practice Pattern: Primary Open-Angle Glaucoma. September 2020.
2. Travatan Z [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2020.
3. Zioptan [package insert]. France: Akorn, Inc.; November 2018.
4. Vyzulta [package insert]. Bridgewater, NJ: Bausch Health US, LLC; May 2019.

Program	Step Therapy – Glaucoma Agents
<b>Change Control</b>	
Date	Change
7/2013	New program.
8/2013	Removal of Lumigan and Travatan Z from the step therapy program.
2/2014	Added Rescula to the step therapy program.
2/2015	Annual Review. Administrative changes.
3/2016	Annual Review. Updated references.
7/2016	Added Indiana and West Virginia coverage information.
11/2016	Administrative change. Added California coverage information.
3/2017	Annual Review. Updated reference. State mandate reference language updated.
3/2018	Added Vyzulta as a non-preferred option.
3/2019	Rescula removed from the step therapy program. Added statement regarding use of automated process and updated references.
3/2020	Annual review. Removed travoprost (generic Travatan) since no longer available. Added an authorization look back for current users and updated references. Updated references.
3/2021	Annual review. Updated references.
3/2022	Annual review. Added Travatan Z and brand only Xalatan are typically excluded from coverage.
3/2023	Annual review. No changes.
3/2024	Annual review. Travatan Z added to the step therapy.