



STEP THERAPY POLICY

- POLICY:** Ophthalmic Anti-Allergics – Miscellaneous Step Therapy Policy
- Alrex® (loteprednol etabonate 0.2% ophthalmic suspension – Bausch & Lomb, generic)
 - azelastine hydrochloride 0.05% ophthalmic solution (generic only)
 - Bepreve® (bepotastine besilate 1.5% ophthalmic solution – Bausch & Lomb, generic)
 - epinastine hydrochloride 0.05% ophthalmic solution (generic only)
 - olopatadine hydrochloride 0.2% ophthalmic solution (generic only)
 - olopatadine hydrochloride 0.1% ophthalmic solution (generic only)
 - Zerviate™ (cetirizine 0.24% ophthalmic solution – Harrow Eye)

REVIEW DATE: 01/28/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

All of the ophthalmic anti-allergic agents are generally indicated for the treatment of allergic conjunctivitis.¹⁻⁸ Table 1 provides mechanism of action, indication, and dosing information for the ophthalmic anti-allergic products. Of note, in 2020, all of the prescription olopatadine products had their FDA-approval switched from prescription to over-the-counter (OTC) status.⁹ Therefore, prescription brand olopatadine products are no longer available, but prescription generic olopatadine

products are still currently on the market. The OTC olopatadine products are not targeted in this policy. In December 2021, FDA approved the switch from prescription to OTC for Lastacaft. OTC Lastacaft became available March 2022; however, OTC Lastacaft is not targeted in this policy.

Table 1. Ophthalmic Anti-Allergics (by Mechanism of Action).¹⁻⁸

Brand (generic)	FDA-Approved Indications
Selective H₁-Antagonist	
Zerviate™ (cetirizine 0.24%)	Treatment of ocular itching associated with allergic conjunctivitis.
Corticosteroid	
Alrex® (loteprednol etabonate 0.2%, generic)	Temporary relief of the signs and symptoms of seasonal allergic conjunctivitis.
Selective H₁-Antagonist and Mast Cell Stabilizers (Dual Mechanism)	
azelastine HCl 0.05% (generic)	Treatment of itching of the eye associated with allergic conjunctivitis.
bepotastine besilate 1.5% (Bepreve®, generic)	Treatment of itching associated with allergic conjunctivitis.
epinastine HCl 0.05% (generic)	Prevention of itching associated with allergic conjunctivitis.
olopatadine HCl 0.1% (generic)*	Treatment of the signs and symptoms of allergic conjunctivitis.
olopatadine HCl 0.2% (generic)*	Treatment of ocular itching associated with allergic conjunctivitis.

H₁ – Histamine-1; * Olopatadine is available as prescription (generic) and over-the-counter (OTC). The OTC products are not targeted in this policy.

Guidelines

The American Academy of Ophthalmology Conjunctivitis Preferred Practice Pattern® (2023) note that mild allergic conjunctivitis can be treated with an OTC ophthalmic antihistamine/vasoconstrictor agent or with more effective second-generation ophthalmic histamine H₁-receptor antagonists. Ophthalmic mast-cell stabilizers can be used if the condition is frequently recurrent or persistent. Combination antihistamine with mast-cell stabilizers can be used for either acute or chronic disease. A brief course of an ophthalmic corticosteroid can be added to the regimen if symptoms are not adequately controlled.

POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration.

Note: OTC Pataday and OTC Lastacaft products are not targeted in this policy.

Step 1: generic azelastine hydrochloride 0.05% ophthalmic solution, generic epinastine hydrochloride 0.05% ophthalmic solution, prescription generic olopatadine 0.1% ophthalmic solution, prescription generic olopatadine 0.2% ophthalmic solution

Step 2: Alrex (brand and generic), Bepreve (brand and generic), Zerviate

Ophthalmic Anti-Allergics – Miscellaneous Step Therapy Policy product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.

CRITERIA

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.
2. If the patient requires the concurrent use of Alrex or generic loteprednol etabonate 0.2% ophthalmic suspension and an H₁ antagonist or an H₁ antagonist/mast cell stabilizer, approve Alrex or generic loteprednol etabonate 0.2% ophthalmic suspension.
Note: An example of an H₁ antagonist is Zerviate. Examples of H₁ antagonist/mast cell stabilizers are azelastine ophthalmic solution, epinastine ophthalmic solution, bepotastine ophthalmic solution (Bepreve, generic), Lastacaft, olopatadine 0.1% ophthalmic solution, and olopatadine 0.2% ophthalmic solution.
3. If the patient has tried a different ophthalmic steroid for the current condition, approve Alrex or generic loteprednol etabonate 0.2% ophthalmic suspension.

REFERENCES

1. Olopatadine hydrochloride 0.1% ophthalmic solution [prescribing information]. Bridgewater, NJ: Alembic; December 2018.
2. Azelastine hydrochloride 0.005% ophthalmic solution [prescribing information]. Bedminster NJ: Alembic; January 2024.
3. Epinastine hydrochloride 0.05% ophthalmic solution [prescribing information]. Hollywood, FL: Somerset; July 2021.
4. Olopatadine hydrochloride 0.2% ophthalmic solution [prescribing information]. Weston, FL: Apotex; December 2022.
5. Bepreve[®] ophthalmic solution [prescribing information]. Tampa, FL: Bausch & Lomb; August 2022.
6. Alrex[®] ophthalmic suspension [prescribing information]. Tampa, FL: Bausch & Lomb; March 2022.
7. Zerviate[™] ophthalmic solution [prescribing information]. Fort Worth, TX: Eyevance; November 2022.
8. FDA Prescription to Over-the-counter (OTC) Switch List. U.S. Food and Drug Administration Web site. Available at: <https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/prescription-over-counter-otc-switch-list>. Accessed on January 21, 2026.
9. American Academy of Ophthalmology. Conjunctivitis Preferred Practice Pattern[®]. Available at: <https://www.aao.org/education/preferred-practice-pattern/conjunctivitis-ppp-2023>. Accessed on January 21, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	02/14/2024

Selected Revision	Generic loteprednol etabonate 0.2% ophthalmic suspension: Added to Step 2 products. Regarding the exception criterion in reference to concurrent use of Alrex or generic loteprednol etabonate 0.2% ophthalmic suspension and an H ₁ antagonist or an H ₁ antagonist/mast cell stabilizer, the examples of H ₁ antagonist and H ₁ antagonist/mast cell stabilizers were moved to a Note. There were no other changes to the criteria.	02/21/2024
Annual Revision	No criteria changes.	02/05/2025
Selected Revision	Generic bepotastine besilate 1.5% ophthalmic solution: Moved from Step 1 to Step 2.	02/26/2025
Annual Revision	Lastacaft (prescription): This medication was removed from Step 2; prescription Lastacaft has not been available for > 3 years.	01/28/2026

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