PRIOR AUTHORIZATION POLICY

POLICY: Ophthalmology – Verkazia Prior Authorization Policy
- Verkazia® (cyclosporine 0.1% ophthalmic emulsion – Santen)

REVIEW DATE: 01/21/2026

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

Verkazia, a calcineurin inhibitor immunosuppressant, is indicated for the treatment of **vernal keratoconjunctivitis** (VKC) in children and adults.[1] Efficacy and safety of Verkazia have been established in pediatric patients ≥ 4 years of age.

Disease Overview

VKC, a type of allergic conjunctivitis, is a recurrent, bilateral allergic inflammation of the conjunctiva and the superficial cornea.[2-4] VKC is more common in males and is more prevalent in hot, dry climates and in tropical and sub-tropical countries.[4] Common symptoms include itching, photophobia, burning, foreign body sensation, mucoid discharge, and tearing. It is thought that both immunoglobulin E (IgE)-mediated and cell-mediated immune mechanisms are responsible for exacerbations.

General treatment modalities include modifying the environment to minimize exposure to allergens or irritants and using cool compresses and ocular lubricants.[2]

Pharmacologic treatment modalities include ophthalmic and oral antihistamines, ophthalmic mast cell stabilizers, ophthalmic cyclosporine, and ophthalmic corticosteroids.

Guidelines

Verkazia is not specifically addressed in the American Academy of Ophthalmology (AAO) Conjunctivitis Preferred Practice Pattern (PPP) guidelines but ophthalmic cyclosporine (0.05%, 0.1%, 2%) are noted. Ophthalmic cyclosporine products have been shown to reduce signs and symptoms compared with placebo in patients with VKC.[2] Furthermore, use of ophthalmic cyclosporine has shown to be effective for the treatment of severe vernal conjunctivitis and for prevention of seasonal recurrence. Ophthalmic cyclosporine may be helpful in cases that are refractory to steroid treatment and may also result in reduced use of ophthalmic corticosteroids. Supratarsal injection of corticosteroids may be needed for treatment of severe sight-threatening VKC that is not responsive to ophthalmic therapies. With regards to vernal conjunctivitis, the AAO Panel notes ophthalmic mast cell stabilizers and ophthalmic and oral antihistamines are helpful to maintain comfort. In addition, ophthalmic corticosteroids are usually necessary to control signs and symptoms of acute exacerbations of vernal conjunctivitis.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Verkazia. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Verkazia as well as the monitoring required for adverse events and long-term efficacy, approval requires Verkazia to be prescribed by or in consultation with a physician who specializes in the condition being treated.

- **Verkazia® (cyclosporine 0.1% ophthalmic emulsion – Santen) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

FDA-Approved Indication

1. **Vernal Keratoconjunctivitis.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 4 years of age; AND
   - **B)** According to the prescriber, the patient has moderate to severe vernal keratoconjunctivitis; AND
   - **C)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has tried two single-action ophthalmic medications (i.e., ophthalmic mast cell stabilizers or ophthalmic antihistamines) for the maintenance treatment of vernal keratoconjunctivitis; OR

Note: Examples of single-action ophthalmic medications for the maintenance treatment of vernal keratoconjunctivitis include ophthalmic mast cell stabilizers (e.g., cromolyn ophthalmic solution) and ophthalmic antihistamines (e.g., Zerviate [cetirizine ophthalmic solution]).

ii. Patient has tried one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis; AND
Note: Examples of dual-action ophthalmic mast cell stabilizer/antihistamine products include azelastine ophthalmic solution, bepotastine ophthalmic solution, epinastine ophthalmic solution, Lastacaft (alfcatadine ophthalmic solution), and olopatadine ophthalmic solution; AND
Note: An exception to the requirement for a trial of two single-action ophthalmic medications (i.e., ophthalmic mast cell stabilizers or ophthalmic antihistamines) or one dual-action ophthalmic mast cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis can be made if the patient has already tried at least one ophthalmic cyclosporine product (e.g., Cequa [cyclosporine 0.09% ophthalmic solution], cyclosporine 0.05% ophthalmic emulsion [Restasis, generic], Vevye [cyclosporine 0.1% ophthalmic solution]) other than the requested medication.

D) The medication is prescribed by or in consultation with an optometrist or ophthalmologist.

CONDITIONS NOT COVERED

- **Verkazia® (cyclosporine 0.1% ophthalmic emulsion – Santen) is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.**

REFERENCES

1. Verkazia® ophthalmic emulsion [prescribing information]. Emeryville, CA: Santen; June 2022.
2. Cheung AY, Choi DS, Ahmad S, et al. American Academy of Ophthalmology Preferred Practice Pattern Cornea/External Disease Committee. Conjunctivitis Preferred Practice Pattern®. Available at: https://www.aao.org/education/preferred-practice-pattern/conjunctivitis-ppp-2023. Accessed on January 15, 2026
3. Burrow MK, Patel BC. Keratoconjunctivitis. [Updated February 6, 2025]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK542279/. Accessed on January 15, 2026.
4. Kaur K, Gurnani B. Vernal Keratoconjunctivitis. [Updated 2023 Jun 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK576433/. Accessed on January 15, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date

Annual Revision	No criteria changes.	01/24/2024
Annual Revision	No criteria changes.	01/29/2025
Annual Revision	No criteria changes.	01/21/2026