



PRIOR AUTHORIZATION POLICY

POLICY: Ophthalmology – Dry Eye Disease – Tryptyr Prior Authorization Policy

- Tryptyr (acoltremon ophthalmic solution – Alcon)

REVIEW DATE: 04/01/2026

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

Tryptyr, a transient receptor potential melastatin 8 (TRPM8) thermoreceptor agonist, is indicated for the treatment of the signs and symptoms of **dry eye disease**.¹

The safety and efficacy of Tryptyr in pediatric patients have not been established.

Guidelines

The American Academy of Ophthalmology (AAO) Dry Eye Syndrome Preferred Practice Pattern[®] (2024) notes dry eye syndrome is also known as dry eye disease or keratoconjunctivitis sicca.² Dry eye is generally classified according to both symptoms and signs (i.e., mild, moderate, or severe); however, there is an emphasis on symptoms over signs. Management of dry eye is listed as a four-step staged approach, but specific therapies may be chosen from any step, regardless of the level of disease severity, depending on provider experience and patient preference. Tryptyr is not addressed in the AAO dry eye syndrome preferred practice pattern but other FDA-approved therapies for dry eye disease (e.g., cyclosporine ophthalmic products, Miebo[®] [perfluorohexyloctane ophthalmic solution], Tyrvaya[®] [varenicline nasal spray], and Xiidra [lifitegrast ophthalmic solution]) are noted as

Step 2 options. The AAO notes use of any of these FDA-approved products may result in improvement of patient symptoms and/or signs; there are no head-to-head trials to show superiority of one agent over another.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Tryptyr. All approvals are provided for the duration noted below.

• **Tryptyr (acoltremon ophthalmic solution - Alcon)**
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. Dry Eye Disease. Approve for 1 year if the patient is \geq 18 years of age.

Note: Examples of dry eye disease include dry eye syndrome and keratoconjunctivitis sicca.

CONDITIONS NOT COVERED

Tryptyr (acoltremon ophthalmic solution - Alcon)
is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. Concomitant Use with an Ophthalmic Cyclosporine Product, Tyrvaya (varenicline nasal solution), or Xiidra (lifitegrast 5% ophthalmic solution). There are no data to support the concomitant use of Tryptyr with an ophthalmic cyclosporine product, Tyrvaya, or Xiidra.

Note: Ophthalmic cyclosporine products are Cequa, Restasis/generic, and Vevye.

REFERENCES

1. Tryptyr[®] ophthalmic solution [prescribing information]. Fort Worth, TX: Alcon; May 2025.
2. Amescua G, Ahmad S, Cheung AY, et al. American Academy of Ophthalmology Preferred Practice Pattern Cornea and External Disease Panel. Dry Eye Syndrome Preferred Practice Pattern[®]. *Ophthalmology*. 2024;131(4);P1-P49.

HISTORY

Type of Revision	Summary of Changes	Review Date
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New Policy	--	06/25/2025
Early Annual Revision	No criteria changes.	04/01/2026

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