Drug Coverage Policy

Effective Date 5/1/2026
Coverage Policy Number.....IP0218
Policy Title..... Durysta

Ophthalmology – Durysta

- Durysta® (bimatoprost implant, for intracameral administration – Allergan)

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 Healthcare Coverage Policies

OVERVIEW

Durysta, a prostaglandin analog, is indicated for the reduction of intraocular pressure (IOP) in **open-angle glaucoma** or **ocular hypertension**.[1]

Disease Overview

Glaucoma, a disease that damages the eye's optic nerve, is the leading cause of blindness in people > 60 years of age.[2] Reduction of IOP, regardless of the pretreatment IOP, reduces the risk of disease progression.[3] In addition, IOP reduction may prevent the onset of early glaucoma in patients with ocular hypertension.

Ophthalmic prostaglandins (e.g., bimatoprost, latanoprost), beta-blockers (e.g., levobunolol, timolol), alpha-agonist (brimonidine), carbonic anhydrase inhibitors (brizolamide, dorzolamide), rho kinase inhibitor (netarsudil), and fixed combination products are used to treat glaucoma.[3] The choice of product is influenced by potential cost, adverse event profile, dosing schedule, and the degree of pressure lowering needed.

Dosing Considerations
Durysta, a biodegradable implant, is given as a single intracameral administration.[1] Each intracameral implant contains 10 mcg of bimatoprost. Durysta should not be re-administered to an eye that was previously treated with Durysta.

Coverage Policy

Policy Statement
Prior Authorization is required for prescription benefit coverage of Durysta. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for one implant per treated eye (i.e., one implant per treated eye; maximum of two implants per patient). Note that a 3-month (90 days) approval duration is applied to allow for the one-time treatment of one or both eye(s). Because of the specialized skills required for evaluation and diagnosis of patients treated with Durysta as well as the monitoring required for adverse events and long-term efficacy, approval requires Durysta to be prescribed by a physician who has consulted with or who specializes in the condition.

Durysta is considered medically necessary when ONE of the following is met:

FDA-Approved Indications

1. **Ocular Hypertension.** Approve for a one-time use in each treated eye (i.e., one implant per treated eye; a total of two implants per patient) if the patient meets ALL of the following (A, B, C, D, and E):
   A) Patient is ≥ 18 years of age; AND
   B) Patient is not receiving re-treatment of eye(s) previously treated with Durysta; AND
   C) Patient meets BOTH of the following (i and ii):
      i. Patient has tried at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy) for the treatment of open-angle glaucoma or ocular hypertension; AND
      Note: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan (bimatoprost 0.01% ophthalmic solution), Vyzulta (latanoprostene bunod 0.024% ophthalmic solution), Xelpros (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% ophthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution).
      ii. Patient has tried at least two other ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes for the treatment of open-angle glaucoma or ocular hypertension; AND
      Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil).

D) For each of the ophthalmic medications that were tried, the patient meets ONE of the following (i or ii):
- **i.** According to the prescriber, patient has had inadequate efficacy to the previously tried ophthalmic products, according to the prescriber; OR
- **ii.** According to the prescriber, patient has experienced adverse event(s) severe enough to warrant discontinuation of the previously tried ophthalmic products, according to the prescriber; AND

E) The medication is administered by or under the supervision of an ophthalmologist.

Dosing. Approve up to one Durysta implant per treated eye(s) [two implants per patient].

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2. **Open-Angle Glaucoma.** Approve for a one-time use in each treated eye (i.e., one implant per treated eye; a total of two implants per patient) if the patient meets ALL of the following (A, B, C, D, and E):

A) Patient is ≥ 18 years of age; AND

B) Patient is not receiving re-treatment of eye(s) previously treated with Durysta; AND

C) Patient meets BOTH of the following (i and ii):
- **i.** Patient has tried at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy) for the treatment of open-angle glaucoma or ocular hypertension; AND
  Note: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan (bimatoprost 0.01% ophthalmic solution), Vyzulta (latanoprostene bunod 0.024% ophthalmic solution), Xelpros (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% ophthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution).
- **ii.** Patient has tried at least two other ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes for the treatment of open-angle glaucoma or ocular hypertension; AND
  Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil).

D) For each of the ophthalmic medications that were tried, the patient meets ONE of the following criteria (i or ii):
- **i.** According to the prescriber, patient has had inadequate efficacy to the previously tried ophthalmic products, according to the prescriber; OR
- **ii.** According to the prescriber, patient has experienced adverse event(s) severe enough to warrant discontinuation of the previously tried ophthalmic products, according to the prescriber; AND

E) The medication is administered by or under the supervision of an ophthalmologist.

Dosing. Approve up to one Durysta implant per treated eye(s) [two implants per patient].

Conditions Not Covered
Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive):

1. **Re-Treatment of Previously Treated Eye(s).** Durysta is approved for a one-time use in each treated eye. Repeating administration in previously treated eye(s) is not approvable.

2. **Concurrent use of Durysta with iDose TR (travoprost intracameral implant).** iDose TR is another intracameral prostaglandin analog implant and should not be used with Durysta.

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J7351	Injection, bimatoprost, intracameral implant, 1 mcg

References

1. Durysta® [prescribing information]. North Chicago, IL: AbbVie; October 2024.
2. Goyal A. Understanding glaucoma: symptoms, causes, diagnosis, treatment. Available at: https://www.aao.org/eye-health/diseases/what-is-glaucoma. Published January 5, 2026. Accessed on February 19, 2026.
3. Gedde SJ, Vinod K, Wright MW, et al. The American Academy of Ophthalmology. Primary Open-Angle Glaucoma Preferred Practice Pattern.® 2020 Available at: https://www.aaojournal.org/article/S0161-6420(20)31024-1/fulltext. Accessed on Feburary 19, 2026.
4. iDose® TR intracameral implant [prescribing information]. San Clemente, CA: Glaukos;January 2026.

Revision Details

Summary of Changes	Review Date	Effective Date
Updated policy title: from Bimatoprost Ophthalmic Implant **All covered uses (Ocular Hypertension, Open-Angle Glaucoma):** Added is not receiving re-treatment of eye(s) previously treated with Durysta **Conditions Not Covered:** Added Concurrent use of Durysta with iDose TR (travoprost intracameral implant)	3/14/2024	6/1/2024
No criteria changes.	2/27/2024	5/1/2025
Policy Statement: Approval duration was changed from 1 month (30 days) to 3 months (90 days) for Durysta to align with implant-based administration and allow adequate time for treatment scheduling. Language was also clarified that approvals are limited to one implant per treated eye (maximum of two implants per patient).	3/26/2026	5/1/2026

The policy effective date is in force until updated or retired.