Policy Name	Clinical Policy - iDose® TR
Policy Number	1350.00
Department	Clinical Product Development
Subcategory	Medical Management
Original Approval Date	01/08/2025
Current MPC/CCO Approval Date	01/08/2025
Current Effective Date	05/01/2025

Company Entities Supported (Select All that Apply):

X Superior Vision Benefit Management
X Superior Vision Services
X Superior Vision of New Jersey, Inc.
X Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
X Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

ACRONYMS	
IOL	Intraocular lens
IOP	Intraocular pressure

PURPOSE

To provide the medical necessity criteria to support the indication(s) for iDose TR©. Applicable procedure codes are also defined.

POLICY

A. Background

iDose® TR is an intracameral anterior segment eye implant that delivers travoprost in a sustained release into the anterior chamber. It is indicated to lower intraocular pressure (IOP) in the treatment of both open-angle glaucoma (OAG) and ocular hypertension (OHT).

The mechanism of action of iDose is via sustained release of the prostaglandin analog drug to increase outflow rate of intraocular fluid via the uveoscleral pathway, thus reducing IOP.

B. Medically Necessary

iDose may be considered medically necessary for patients who:

a. Have an established diagnosis of open angle glaucoma and ocular hypertension with uncontrolled intraocular pressure; and,
b. Have previously undergone a selective laser trabeculoplasty (SLT) procedure and still present with sub optimal intraocular pressure;[1] and,
c. Have undergone a trial of prostaglandin analog ocular hypotensive therapy with a positive intraocular pressure response; and,
d. Are unable to either accurately administer or adhere to topical regiment for ocular hypotensive drops.

C. Not Medically Necessary

1. iDose may be medically necessary in patients who do not meet the above criteria or have any one of the following:

   a. The patient's ocular hypertension requires multiple eye medications beyond a prostaglandin analog; or,
   b. Corneal endothelial dystrophy or pathology; or,
   c. Prior corneal transplantation; or,
   d. Active or suspected ocular or periocular infections; or,
   e. Peripheral anterior synechiae; or,
   f. Posterior capsular tear secondary to cataract surgery.

2. At this time, iDose is not FDA approved for more than one implant, or repeat implant, per eye.
3. Due to iDose' s relatively novel status, safety outcomes for use after other drugs (e.g. Durysta) are unknown. Any combination use of iDose and Durysta does not meet medical necessity.

D. Documentation

Medical necessity must be supported by adequate and complete documentation in the patient's medical record that describes the procedure and the medical rationale for it as in requirements above. All items must be available upon request to initiate or sustain previous payments. For any retrospective review, a full operative report and/or the medical plan of care is needed.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). Services provided/ordered must be

[1] FDA adverse events reporting system. The glaucoma experts of Versant Health MPC determined that safety profile of iDose TR is not yet fully determined and that the potentially safer SLT procedure is required prior to iDose use.

authenticated by the physician, in a handwritten or electronic signature. Stamped signatures are not acceptable.

E. Procedural Detail

HCPCS Code	
J7355	Injection, travoprost, intracameral implant, 1 mcg (iDose TR; no injection code required)
Required Modifiers	
RT	Right Side
LT	Left Side

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RELATED POLICIES AND PROCEDURES	
1349	Durysta

DOCUMENT HISTORY		
Approval Date	**Revision**	**Effective Date**
01/08/2025	Initial policy	05/01/2025

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