

To: AmeriHealth Caritas Louisiana Providers

Date: May 8, 2026

Subject: Approved Physician Administered Drug Policies

Summary: Two approved Physician Administered Drug Policies

AmeriHealth Caritas Louisiana would like to inform you of two updated physician-administered drug policies approved by the Louisiana Department of Health in accordance with La. R.S.46:460.54. The guidelines are effective **June 7, 2026**, and will be located at the following link on our website under Pharmacy Prior Authorization Criteria:

<https://www.amerihealthcaritasla.com/pdf/pharmacy/acla-non-pdl-prior-auth-criteria.pdf>.

1. Papzimeos
2. Vascular Endothelial Growth Factor (VEGF) Inhibitors for Ophthalmic Conditions

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions:

Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your [Provider Network Management Account Executive](#).

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Need to update your provider information? Send full details to network@amerihealthcaritasla.com

Field Name	Field Description
Prior Authorization Group Description	Vascular Endothelial Growth Factor (VEGF) Inhibitors for Ophthalmic Conditions
Drugs	<p>Preferred Vascular Endothelial Growth Factor (VEGF) Inhibitor(s):</p> <ul style="list-style-type: none"> • Avastin (bevacizumab) • Byooviz (ranibizumab-nuna) • Cimerli (ranibizumab-eqrn) <p>Non-Preferred Vascular Endothelial Growth Factor (VEGF) Inhibitor(s):</p> <ul style="list-style-type: none"> • Beovu (brolucizumab) • Eylea (aflibercept) • Lucentis (ranibizumab) • Susvimo (ranibizumab) • Vabysmo (faricimab) • Pavblu (aflibercept-ayyh) • Any newly marketed agent in this class
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See “other criteria”
Age Restrictions	Eylea: approvable in pediatric patients for diagnosis of retinopathy of prematurity All other agents and indications: Approvable for adults 18 years of age and older only
Prescriber Restrictions	Ophthalmologist
Coverage Duration	If the above conditions are met, the request will be approved with a 3 month duration for initial and 12 months for renewal. Retinopathy of Prematurity: approvable for a 6 month duration for initial and renewal requests.

<p>Other Criteria</p>	<p>**Drug is being requested through the member's medical benefit**</p> <p>Initial Authorization</p> <p>Avastin:</p> <ul style="list-style-type: none"> • Request is for compendia supported dosing for an ophthalmic indication <p>Byooviz or Cimerli:</p> <ul style="list-style-type: none"> • Request is for an FDA-approved dosing regimen <p>Non-Preferred VEGF Inhibitor:</p> <ul style="list-style-type: none"> • Request is for an FDA-approved dosing regimen; AND • Documented trial and failure with a preferred VEGF inhibitor for all FDA-approved indications OR: a medical justification for not using a preferred VEGF inhibitor (e.g. experienced a severe ADR such as hypersensitivity, arterial thromboembolism, cerebrovascular accident, raised intraocular pressure, retinal detachment). • Requests for Eylea (aflibercept) may be approved for a diagnosis of retinopathy of prematurity without a trial and failure of a preferred VEGF inhibitor. Patients must have a diagnosis of retinopathy of prematurity in at least one eye with one of the following retinal findings: <ul style="list-style-type: none"> ○ ROP Zone I Stage 1+, 2+, 3 or 3+, or ○ ROP Zone II Stage 2+ or 3+, or ○ AP-ROP (aggressive posterior ROP) <p>Re-Authorization:</p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response • Medication is prescribed at an FDA approved or compendia supported dose <p>Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.</p>
<p>Revision/Review Date 10/2025</p>	