

## New Hampshire Medicaid Fee-for-Service Program

### Rho Kinase Inhibitor Criteria

Approval Date: December 3, 2019

#### Medications

Brand Names	Generic Names	Dosage
Rhopressa™	netarsudil	0.02% (0.2 mg/mL) 2.5 mL vial
Rocklatan™	netarsudil/latanoprost	0.02%/0.005% 2.5ml vial

#### Indication

Rhopressa™ (netarsudil) is indicated to reduce intraocular pressure (IOP) in patients with ocular hypertension (OHT) or open-angle glaucoma (OAG).

Rocklatan™ (netarsudil/latanoprost) is indicated for the reduction of elevated IOP in patients with open-angle glaucoma or ocular hypertension.

#### Criteria for Approval

1. Patient must be  $\geq 18$  years old; **AND**
2. Have a diagnosis of ocular hypertension or open-angle glaucoma; **AND**
3. Have had an adequate trial and failure of a prostaglandin inhibitor or beta-adrenergic antagonist **AND**
4. Is to be used in conjunction with another medication for glaucoma (Rhopressa™ only); **AND**
5. Patient must **NOT** have had:
  - a. Previous glaucoma intraocular surgery or glaucoma laser procedure in the affected eye; **OR**
  - b. Ocular surgery or laser treatment within three months prior to initiation; **AND**
6. Not currently have:
  - a. Ocular infection; **OR**
  - b. Inflammation; **OR**
  - c. Blepharitis; **OR**

- d. Conjunctivitis; **OR**
- e. Ocular Disease.

**Approval period:** One year

**Renewal Criteria:**

1. Patient must continue to meet above criteria; **AND**
2. Have demonstrated efficacy (e.g., reduction in IOP).

**Renewal approval period:** One year

**Criteria for Denial**

Failure to meet criteria for approval.

**References**

Available upon request.

**Revision History**

Reviewed by	Reason for Review	Date Approved
DUR Board	New	03/12/2019
Commissioner Designee	New	04/05/2019
DUR Board	Review	10/28/2019
Commissioner Designee	Approve	12/03/2019