

Anti-Vascular Endothelial Growth Factor (VEGF) Therapy Adjudication Guideline

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**Related Adjudication
Guidelines:**

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1. Abstract

1.1 For Members

Anti-Vascular endothelial growth factor drugs are given to treat a variety of retinal conditions like age-related macular degeneration (AMD), diabetic retinopathy and retinal vein via, intravitreal injection.

An intravitreal injection is a procedure to place a medication directly into the space in the back of the eye called the vitreous cavity, which is filled with a jellylike fluid called the vitreous humor gel. The procedure is usually performed by a trained retina specialist in the office setting.

Daman covers anti-VEGF if medically justified as per the best international medical practice and as per the policy terms and conditions of each Health Insurance Plan administered by Daman.

1.2 For Medical Professionals

Anti-Vascular endothelial growth factor drugs are given to treat a variety of retinal conditions like age-related macular degeneration (AMD), diabetic retinopathy and retinal vein via, intravitreal injection.

Repeat injections are usually safely tolerated over several years. The need for a repeat injection is determined during the clinical examination, often with the use of diagnostic testing.

Daman covers anti-VEGF as medically necessary for the diagnosis given further in this guideline as per the best international medical practice and as per the policy terms and conditions of each Health Insurance Plan administered by Daman.

There is a requirement to fill in a pre-requisite form for intravitreal injection the requested information given below. This is a mandatory step in order to proceed further. Failure to provide information relevant for approval will delay the processing of the applicant request. The provider will be contacted in case further clarifications are required.

2. Scope

This guideline emphasizes on the medical indications, frequency of administration, correct methodology for prior- authorization (case management) and claim adjudication, payment requirements and coverage of Anti-Vascular Endothelial Growth Factor (Anti- VEGF) therapy by Daman as per policy terms and conditions.

The drugs mentioned in the guideline are given below:

1. **Ranibizumab** which is a recombinant humanized IgG1 kappa isotope monoclonal antibody fragment for intraocular use. It slows the growth of abnormal new blood vessels in the eye and decreases leakage from these blood vessels.
2. **Aflibercept** has indications similar to the aforementioned drug.
3. **Faricimab** which is Angiopoietin-2 Inhibitor that targets both VEGF-A and Ang-2. By inhibiting VEGF-A, Faricimab suppresses endothelial cell proliferation, reduces neovascularization, and decreases vascular permeability.

4. **Brolucizumab** which is a recombinant humanized monoclonal antibody vascular endothelial growth factor (VEGF) inhibitor that binds to the 3 major isoforms of VEGF-A, thereby inhibiting endothelial cell proliferation, neovascularization, and capillary permeability to slow vision loss.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

Anti-vascular endothelial growth factor intravitreal injection will be covered for all the health insurance plans administered by Daman, except for the Visitor's plan.

Indications:

1. Neovascular (wet) age-related macular degeneration (AMD).
2. Diabetic macular edema (DME).
3. Macular edema secondary to retinal vein occlusion (RVO).
4. Diabetic Retinopathy (DR) in patients with DME.
5. Myopic Choroidal neo vascularization (mCNV) secondary to pathologic myopia (Ranibizumab only).
6. Diabetic Retinopathy (Proliferative and Non- Proliferative)
7. Retinopathy of Prematurity

3.2 Requirements for Coverage

ICD and drug codes must be coded to the highest level of specificity.
Submit preapproval questionnaire , refer to below .

3.3 Non-Coverage

Anti-VEGF therapy is not covered in the below cases:

1. Intravitreal Bevacizumab injections are considered experimental and investigational for the treatment of indications aforementioned because their effectiveness has not been established.
2. The policy is visitor's plan.
3. If "Pre-requisite for Intravitreal Injection" form is not submitted along with the authorization request.

3.4 Payment and Coding Rules

Please apply regulator payment rules and regulations and relevant coding manuals for ICD, CPT, etc.

4. Denial Codes

Code	Code Description
MNEC-004	Service is not clinically indicated based on good clinical practice, without additional supporting diagnosis/activities.
AUTH-001	Prior approval is required and was not obtained
PDL01	Service(s) is (are) not covered.
MNEC-005	Service/supply may be appropriate, but too frequent
CODE-014	Activity/Diagnosis inconsistent with the patient's age/gender.

5. Appendices

5.1 References

- https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125156s128lbl.pdf
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- <https://www.medicines.org.uk/emc/product/307/smpc#gref>
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- https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761125s021lbl.pdf
- https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125156s128lbl.pdf
- https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125387s087lbl.pdf
- <https://www.medicines.org.uk/emc/product/2879/smpc#gref>

5.2 Revision History

Date	Version No.	Change(s)
27/03/2018	V1/0	Release of V1.0
10/01/2023	V2.0	Questionnaire link update
23/05/2023	V3.0	Updated: Questionnaire link
26/11/2024	V4.0	Added diagnosis- Retinopathy of Prematurity
20/10/2025	V5.0	Adding of Faricimab and Brolucizumab

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Drug Pre-requisite Form- INTRAVITREAL INJECTION

<https://www.damanhealth.ae/main/pdf/support/Questionnaire/PDFFormatQuestionnaire.pdf>

This is a pre-requisite form provided upon request for intravitreal injection of Ranibizumab or Aflibercept, AntiVascular endothelial growth factor for diabetics and senile macular degeneration. Kindly fill in all the requested information given below. This is a mandatory step in order to proceed further. Failure to provide information relevant for approval will delay the processing of the applicant request. The provider will be contacted in case further clarifications are required.

GENERAL INFORMATION	
Patient's Name: _____	☐ New ☐ Established
Patient's Card #: _____	
Age: ☐ Under 18 ☐ Above 18 years.	
Providers Name: _____	
Prescribing Physician Speciality: _____	
Diagnosis (ICD-I0): _____	
Requested Drug: _____	
Date of last intravitreal injection: _____	

Kindly attach the (following) (if applicable):

- ☐ Optical Coherence Tomography ☐ (current) report ☐ Previous OCT
- ☐ Fundus Angiography/ Fluorescein Angiography ☐ (current) ☐ Previous
- ☐ Report of previous administration of anti-VEGF in the past month.

INITIAL REQUEST (new patient)
Visual Acuity: _____
IOP: _____
Anterior Segment Examination: _____
Dilated eye exam findings: (posterior segment examination)
Optical Coherence Tomography (OCT) findings:

Fundus Photo, Fluorescein angiography findings (if applicable):

REFILL REQUEST

☐ Right Eye ☐ Left Eye ☐ Both

- Approximate number of injections:

ADDITIONAL COMMENTS:
