

Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or summary plan description (SPD) and applicable state and/or federal laws.

Photodynamic Therapy with Visudyne® (verteprofin) for Ocular Indications MP9660

Covered Service: Yes

Prior Authorization Required: No

Additional Information: See [Laser Treatments for Choroidal Neovascularization Associated with Macular Degeneration MP9565](#) for additional information.

Prevea360 Health Plan Medical Policy:

- 1.0 Verteporfin (Visudyne®) photodynamic therapy using a non-thermal laser **does not** require prior authorization and is considered medically necessary for the treatment of subfoveal choroidal neovascularization (predominantly classic, minimally classic, or occult) when associated with **ANY** of the following:
 - 1.1 Wet age-related macular degeneration (AMD)
 - 1.2 Pathologic myopia
 - 1.3 Presumed ocular histoplasmosis syndrome
 - 1.4 Central serous chorioretinopathy
 - 1.5 Polypoidal choroidal vasculopathy
 - 1.6 Choroidal hemangioma
- 2.0 Verteporfin photodynamic therapy for the treatment of other ocular conditions, including, but not limited to choroidal melanoma is considered experimental and investigational and therefore not medically necessary.

	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Health Services Division	June 21, 2023
Revised:	Medical Policy Committee/Health Services Division	February 21, 2024
Reviewed:	Medical Policy Committee/Health Services Division	February 21, 2024

Published: 03/01/2024
Effective: 03/01/2024