



Verkazia Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
02-20-2026

Date of Origin
04-01-2015

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Verkazia	cyclosporine (ophth) emulsion	0.1 %	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Verkazia	cyclosporine (ophth) emulsion	0.1 %	120	Vials	30	DAYS			650860 00112 ; 826670 01401

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Verkazia	cyclosporine (ophth) emulsion	0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Verkazia	cyclosporine (ophth) emulsion	0.1 %	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
PA	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has a diagnosis of vernal keratoconjunctivitis (VKC) AND ONE of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has tried and had an inadequate response to combination of a topical ophthalmic mast cell stabilizer AND an antihistamine used in the treatment of VKC OR B. The patient has an intolerance or hypersensitivity to combination of a topical ophthalmic mast cell stabilizer AND an antihistamine used in the treatment of VKC OR C. The patient has an FDA labeled contraindication to ALL topical ophthalmic mast cell stabilizers AND antihistamines OR B. The patient has another FDA labeled indication for the requested agent OR C. The patient has another indication that is supported in compendia for the requested agent and route of administration AND 2. The patient will NOT be using the requested agent in combination with Cequa, Restasis, Vevye, or Xiidra AND 3. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Compendia Allowed: AHFS or DrugDex 1, 2a, or 2b level of evidence</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>BCBSIL: 12 months</p> <p>ALL other plans: 4 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet]

Module	Clinical Criteria for Approval
	<p>supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</p> <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review] AND 2. The patient has had clinical benefit with the requested agent AND 3. The patient will NOT be using the requested agent in combination with Cequa, Restasis, Vevye, or Xiidra AND 4. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication OR C. BOTH of the following:

Module	Clinical Criteria for Approval
	<ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval:</p> <p>Initial:</p> <ul style="list-style-type: none"> • BCBSIL members: 12 months • ALL other plans: 4 months <p>Renewal: 12 months</p>