



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Xiidra

Page: 1 of 2

Effective Date: 3/4/2023

Last Review Date: 2/2023

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Texas

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Xiidra under the patient's prescription drug benefit.

### Description:

Xiidra (lifitegrast ophthalmic solution) 5% is indicated for the treatment of the signs and symptoms of dry eye disease (DED).

### Applicable Drug List

Non-Formulary: Xiidra

### Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The request is not for continuation of therapy  
**AND**
- The requested drug is being prescribed for dry eye disease  
**AND**
  - The patient has experienced an inadequate treatment response to an artificial tears product  
**OR**
  - The patient has experienced an intolerance to an artificial tears product  
**OR**
  - The patient has a contraindication that would prohibit a trial of an artificial tears product  
**AND**
- The patient is unable to take cyclosporine ophthalmic emulsion for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication  
**OR**
- The request is for continuation of therapy  
**AND**
- The requested drug is being prescribed for dry eye disease  
**AND**
- The patient achieved or maintained improvement in their signs and symptoms of dry eye disease from baseline, (e.g., ocular irritation, redness, mucous discharge, reduced visual function, ocular surface damage, reduced tear production)

Quantity Limits apply



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Xiidra

Page: 2 of 2

Effective Date: 3/4/2023

Last Review Date: 2/2023

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Texas

### Approval Duration and Quantity Restrictions:

**Approval:** 12 months

**Quantity Level Limit:** 60 containers (1 carton) per month

### References:

1. Xiidra [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp.; June 2020.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2021; Accessed October 5, 2021.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com>. Accessed October 5, 2021.
4. Preferred Practice Pattern. Dry Eye Syndrome. American Academy of Ophthalmology. November 2018.