## OCULAR DRUG TREATMENTS

| DRUG NAME | BRANDS REIMBURSED | DOSAGE FORM/ STRENGTH | REIMBURSEMENT CRITERIA (Refer to pages 2 and 3 for general disclaimers regarding the EAP funding criteria.) | STANDARD APPROVAL DURATION |
|---|---|---|---|---|
| Mycophenolate Mofetil | Cellcept and generics | 250 mg capsules<br><br>500 mg tablets<br><br>200mg/mL oral suspension | **For the treatment of non-infectious ocular inflammation (e.g., uveitis, scleritis and ocular mucous membrane pemphigoid)** in patients meeting the following criteria;<br>• Experienced failure, intolerance, or contraindication to at least one Formulary immunosuppressant; OR<br>• First-line use for the treatment of severe non-infectious ocular inflammation<br>• Patient must be followed by a uveitis specialist, a retina specialist familiar with ocular inflammatory diseases, or a pediatric ophthalmologist.<br><br>**Renewals** will be considered for requests where consultation notes or a letter is provided by the requesting physician to confirm that treatment has resulted in improvement/stability of vision and other treatment goals (e.g., remission from/control of ocular inflammation) have been met. | Initials: 1 year<br><br>Renewals: 2 years |
| Infliximab | Remicade | 100 mg/ 10 mL Injection for intravenous infusion | **For the treatment of severe non-infectious ocular inflammatory disease (OID)** in patients meeting one of the following criteria;<br><br>○ Experienced failure, intolerance, or contraindication to oral corticosteroid (or topical corticosteroid for anterior uveitis) and failure or intolerance to at least one immunosuppressive therapy; OR<br>○ For the treatment of chronic Juvenile Idiopathic Arthritis (JIA)-associated uveitis after failure or intolerance to a first-line immunosuppressive agent; OR | Initials: 1 year |

| DRUG NAME | BRANDS REIMBURSED | DOSAGE FORM/ STRENGTH | REIMBURSEMENT CRITERIA (Refer to pages 2 and 3 for general disclaimers regarding the EAP funding criteria.) | STANDARD APPROVAL DURATION |
|---|---|---|---|---|
| | | | • For patients who have immediately vision-threatening OID and do not meet the above criteria, where consultation notes/ letter from an ophthalmologist expert specializing in OIDs (who may be the requesting physician) confirm the severity of the patient's condition and indicate detailed rationale for an immediate biologic therapy (e.g. ocular inflammation associated with Behcet's disease; severe non-necrotizing scleritis; necrotizing scleritis; etc.); AND<br><br>• Patient must be followed by a uveitis specialist, a retina specialist familiar with ocular inflammatory diseases, or a pediatric ophthalmologist.<br><br>**Approved Dose:** Infliximab 5-10 mg/kg IV at weeks 0, 2, 6 and maintenance every 4-8 weeks<br><br>**Renewals** will be considered for requests where consultation notes or a letter is provided by the requesting physician to confirm that treatment has resulted in improvement/stability of vision and other treatment goals (e.g., remission from/control of ocular inflammation) have been met. | Renewals: 2 years |
| Adalimumab | Humira | 40 mg per 0.8 mL Injection | **For the treatment of severe non-infectious ocular inflammatory disease (OID)** in patients meeting one of the following criteria;<br><br>• Experienced failure, intolerance, or contraindication to oral corticosteroid (or topical corticosteroid for anterior uveitis) and failure or intolerance to at least one immunosuppressive therapy; OR<br>• For the treatment of chronic Juvenile Idiopathic Arthritis (JIA)- | Initials: 1 year |

| DRUG NAME | BRANDS REIMBURSED | DOSAGE FORM/ STRENGTH | REIMBURSEMENT CRITERIA (Refer to pages 2 and 3 for general disclaimers regarding the EAP funding criteria.) | STANDARD APPROVAL DURATION |
|---|---|---|---|---|
| Adalimumab | Humira | 40 mg per 0.8 mL Injection | associated uveitis after failure or intolerance to a first-line immunosuppressive agent; OR<br>• For patients who have immediately vision-threatening OID and do not meet the above criteria, where consultation notes/ letter from an ophthalmologist expert specializing in OIDs (who may be the requesting physician) confirm the severity of the patient's condition and indicate detailed rationale for an immediate biologic therapy (e.g. ocular inflammation associated with Behcet's disease; severe non-necrotizing scleritis; necrotizing scleritis; etc.); AND<br>• Patient must be followed by a uveitis specialist, a retina specialist familiar with ocular inflammatory diseases, or a pediatric ophthalmologist.<br><br>**Approved Dose:** Adalimumab 40 mg subcutaneous every 1 to 2 weeks.<br><br>**Renewals** will be considered for requests where consultation notes or a letter is provided by the requesting physician to confirm that treatment has resulted in improvement/stability of vision and other treatment goals (e.g., remission from/control of ocular inflammation) have been met. | Renewals: 2 years |
| Rituximab | Rituxan | 10 mg/mL intravenous injection | **For the treatment of severe non-infectious ocular inflammatory disease (OID)** in patients failed or did not tolerate treatment with infliximab or adalimumab; OR has contraindication to anti-TNF therapy AND who meet one of the following criteria;<br><br>• Experienced failure, intolerance, or contraindication to oral corticosteroid (or topical corticosteroid for anterior uveitis) and | Initials: 1 year |

| DRUG NAME | BRANDS REIMBURSED | DOSAGE FORM/ STRENGTH | REIMBURSEMENT CRITERIA (Refer to pages 2 and 3 for general disclaimers regarding the EAP funding criteria.) | STANDARD APPROVAL DURATION |
|---|---|---|---|---|
| Rituximab | Rituxan | 10 mg/mL intravenous injection | failure or intolerance to at least one immunosuppressive therapy; OR<br>• For the treatment of chronic Juvenile Idiopathic Arthritis (JIA)-associated uveitis after failure or intolerance to a first-line immunosuppressive agent; OR<br>• For patients who have immediately vision-threatening OID and do not meet the above criteria, where consultation notes/ letter from an ophthalmologist expert specializing in OIDs (who may be the requesting physician) confirm the severity of the patient's condition and indicate detailed rationale for an immediate biologic therapy (e.g. ocular inflammation associated with Behcet's disease; severe non-necrotizing scleritis; necrotizing scleritis; etc.); AND<br>• Patient must be followed by a uveitis specialist, a retina specialist familiar with ocular inflammatory diseases, or a pediatric ophthalmologist.<br><br>**Approved Dose:** Rituximab up to 1000 mg IV per infusion at days 1 & 15 and 3rd infusion at 6-12 months.<br><br>Note that maintenance rituximab infusions are not funded.<br><br>**Renewals** will be considered for requests where;<br>• Consultation notes or a letter is provided by the requesting physician to confirm that treatment has resulted in improvement/stability of vision and other treatment goals (e.g., remission from/control of ocular inflammation) have been met; AND<br>• Patients must also have demonstrated subsequent deterioration of symptoms, at least 6 months from the last dose of rituximab. | Renewals: 2 years |