AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Tyrvaya	Page:	1 of 2
Effective Date:	3/16/2023	Last Review Date:	2/2023

Applies to:	☒Illinois	☐Florida	☐Florida Kids
	☐New Jersey	☐Maryland	☐Michigan
	☐Pennsylvania Kids	☐Virginia	☐Texas

Intent:

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

Description:

Tyrvaya (varenicline solution) nasal spray is indicated for the treatment of the signs and symptoms of dry eye disease.

Applicable Drug List:

Non-Formulary: Tyrvaya

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

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

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit: 2 nasal spray bottles (1 carton) per month

References:

1. Tyrvaya [package insert]. Princeton, NJ: Oyster Point Pharma, Inc, October 2021.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2021; Accessed October 29, 2021.
3. Preferred Practice Pattern. Dry Eye Syndrome. American Academy of Ophthalmology. November 2018.