

POLICY NAME	Photrex Viscous (riboflavin 5'-phosphate)	POLICY #	2736P
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Criteria

Coverage Criteria

- ☐ 1.1 Photrex Viscous will be covered if the member has been approved for epithelium off-corneal cross- linking for the treatment of keratoconus by Utilization Management (UM)
 - Requests received without a UM request on file will be cancelled and review will not be conducted until UM has completed their coverage determination