Clinical Policy: Pilocarpine (Qlosi, Vuity)

Reference Number: CP.PMN.270
Effective Date: 12.01.21
Last Review Date: 11.25
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Pilocarpine (Qlosi™, Vuity®) is a cholinergic muscarinic receptor agonist.

FDA Approved Indication(s)

Qlosi and Vuity are indicated for the treatment of presbyopia in adults.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Qlosi and Vuity are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Presbyopia (must meet all)**:**

1. Diagnosis of presbyopia;
2. Prescribed by or in consultation with an optometrist or ophthalmologist;
3. Member meets one of the following at the time of therapy initiation (a or b):
   a. Vuity: Age between 40 and 55 years;
   b. Qlosi: Age between 45 and 64 years;
4. Failure of corrective eyeglasses or contact lenses to resolve the presbyopia symptoms, unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Requested agent is not prescribed concurrently with any other ophthalmic pilocarpine formulation or with Vizz™;
6. Dose does not exceed one of the following (a or b):
   a. Vuity: 1 drop per eye per day, followed by an additional dose in each eye administered 3 to 6 hours after first dose;
   b. Qlosi: 1 drop per eye per day, followed by an additional dose administered 2 to 3 hours after first dose.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Presbyopia (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Requested agent is not prescribed concurrently with any other ophthalmic pilocarpine formulation or with Vizz;
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Vuity: 1 drop per eye per day, followed by an additional dose in each eye administered 3 to 6 hours after first dose;
   b. Qlosi: 1 drop per eye per day, followed by an additional dose administered 2 to 3 hours after first dose.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to the active ingredient or to any of the excipients
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Pilocarpine hydrochloride (Vuity)	1 drop per eye per day; a second dose (one additional drop in each eye) may be administered 3-6 hours after the first dose	2 drops per eye/day
Pilocarpine hydrochloride (Qlosi)	1 drop per eye per day; a second dose (one additional drop in each eye) may be administered 2-3 hours after the first dose for an effect up to 8 hours	2 drops per eye/day

VI. Product Availability

Drug Name	Availability
Pilocarpine (Vuity)	Ophthalmic solution bottle: 1.25%
Pilocarpine (Qlosi)	Ophthalmic solution single-patient-use vials: 0.4%

VII. References

1. Vuity Prescribing Information. North Chicago, IL: AbbVie Inc.; March 2023. Available at: https://www.rxabbvie.com/pdf/vuity_pi.pdf. Accessed August 6, 2025.
2. Qlosi Prescribing Information. Ponte Vedra, FL: Orasis Pharmaceuticals Inc.; May 2025. Available at: www.qlosi.com. Accessed August 6, 2025.

3. Lievens CW, Hom MM, McLaurin EB, et al. Pilocarpine HCl 1.25% for treatment of presbyopia after laser vision correction: pooled analysis of two phase 3 randomized trials (GEMINI 1 and 2). J Cataract Refract Surg. 2024 Jan 1;50(1):57-63. doi: 10.1097/j.jcrs.0000000000001313.
4. Holland E, Karpecki P, Fingeret M, et al. Efficacy and Safety of CSF-1 (0.4% Pilocarpine Hydrochloride) in Presbyopia: Pooled Results of the NEAR Phase 3 Randomized, Clinical Trials. Clin Ther. 2024 Feb;46(2):104-113. doi: 10.1016/j.clinthera.2023.12.005.
5. Presbyopia. American Academy of Ophthalmology review March 4, 2024. Available at: https://eyewiki.org/Presbyopia#Management. Accessed August 6, 2025.
6. American Academy of Ophthalmology Refractive Management/Intervention Preferred Practice Pattern Panel. Preferred Practice Pattern® Guidelines. Refractive Errors. San Francisco, CA: American Academy of Ophthalmology; 2020. Available at: https://www.aao.org/education/preferred-practice-pattern/refractive-errors-ppp-2022. Accessed August 6, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	10.19.21	11.21
Drug is now FDA-approved – criteria updated per FDA labeling: no significant changes; references reviewed and updated.	10.29.21	
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	07.18.22	11.22
4Q 2023 annual review: updated criteria maximum dosing from "one drop in each eye daily" to "one drop in each eye daily, followed by an additional dose in each eye administered 3 to 6 hours after first dose" per prescriber information update; updated section V dosing to reflect dosing update; references reviewed and updated.	07.30.23	11.23
RT4: added newly approved agent Qlosi to criteria.	11.03.23	
4Q 2024 annual review: no significant changes; references reviewed and updated.	09.17.24	11.24
4Q 2025 annual review: removed requirement that member does not have glaucoma or ocular hypertension per PI and current literature; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; added step therapy bypass for IL HIM per IL HB 5395; added requirement that pilocarpine is not prescribed concurrently with Vizz; references reviewed and updated.	08.06.25	11.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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