New Hampshire Medicaid Fee-for-Service Program
Rho Kinase Inhibitor Criteria

Approval Date: May 12, 2026

Medications

Brand Names	Generic Names	Dosage
Rhopressa®	netarsudil	0.02% (0.2 mg/mL) 2.5 mL vial
Rocklatan®	netarsudil/latanoprost	0.02%/0.005% 2.5 mL vial

Indication

Rhopressa® (netarsudil) is indicated to reduce intraocular pressure (IOP) in patients with ocular hypertension (OHT) or open-angle glaucoma (OAG).

Rocklatan® (netarsudil/latanoprost) is indicated to indicated for the reduction of elevated IOP in patients with open-angle glaucoma or ocular hypertension.

Criteria for Approval

1. The patient has had an adequate trial and failure (within the last 60 days) of a generic prostaglandin inhibitor or beta-adrenergic antagonist

Approval period: One year

Renewal Criteria:

1. Patient must continue to meet above criteria; **AND**
2. Have demonstrated efficacy (e.g., reduction in IOP).

Renewal approval period: One year

Criteria for Denial

Failure to meet criteria for approval.

References

Available upon request.

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Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	03/12/2019
Commissioner Designee	New	04/05/2019
DUR Board	Review	10/28/2019
Commissioner Designee	Approve	12/03/2019
DUR Board	Review	06/30/2020
Commissioner Designee	Approve	08/07/2020
DUR Board	Review	12/02/2021
Commissioner Designee	Approve	01/14/2022
DUR Board	Review	06/19/2023
Commissioner Designee	Approve	06/29/2023
DUR Board	Review	10/15/2024
Commissioner Designee	Approve	11/21/2024
DUR Board	Review	04/21/2026
Commissioner Designee	Approve	05/12/2026

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