Premier Health Plan

# POLICY AND PROCEDURE

**POLICY NUMBER:** *RX.PA.175.E*
**REVISION DATE:** *12/15*
**PAGE NUMBER:** 1 of 3

**POLICY TITLE:** ***Non-preferred Inhaled Corticosteroid Step***
**DEPARTMENT:** **Clinical Pharmacy Services- Utilization Management**
**ORIGINAL DATE:** ***September 2011 (as adopted from UPMC Health Plan)***

**Last P & T Committee Approval Date:** *February 2018*

**Product Applicability:** *mark all applicable products below:*

| | |
|---|---|
| **COMMERCIAL** | [ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x ] All |
| **OTHER** | [ x ] Self-funded/ASO |

## PURPOSE

The purpose of this policy is to define the prior authorization process for Non-preferred Inhaled Corticosteroids.

Inhaled corticosteroids are indicated as prophylactic therapy for the maintenance treatment of asthma.

## DEFINITIONS

**Non-preferred medication** – a brand name medication for which a generic or other brand name medication is preferred at a lower tier. This medication is associated with the highest level of copayment

## POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002

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Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drugs, Non-preferred Inhaled Corticosteroids, are subject to the prior authorization process.

## PROCEDURE

**Initial Authorization Criteria:**

*Must meet all of the criteria listed under the respective header:*

1. **Automatic coverage:**
    - Must have a documented pharmacy claim history of prior therapy with Asmanex®, Flovent® or Arnuity Ellipta®.

2. **Members without claims history:**
    - Must have documentation indicating that the member has failed or has an intolerance or contraindication to Asmanex, Flovent or Arnuity Ellipta

**Limitations:**

| Length of Authorization (if above criteria met) | |
|---|---|
| Initial Authorization | Up to duration of member's membership with plan |
| Reauthorization | N/A |

If the established criteria are not met, the request is referred to a Medical Director for review.

## REFERENCES

1. Aerobid®, Aerobid-M® [package insert]. St. Louis, MO: Forest Pharmaceuticals, Inc; March 2002.
2. Alvesco® [package insert]. Marlborough, MA: Nycomed; 2007.
3. Azmacort® [package insert]. Cranbury, NJ: Kos Pharmaceuticals; 2007.
4. Asmanex Twisthaler [package insert]. Kenilworth, NJ: Schering Corporation; September 2010.
5. Flovent Diskus [package insert]. Research Triangle Park, NC: GlaxoSmithKline; May 2010.
6. Flovent HFA [package insert]. Research Triangle Park, NC: GlaxoSmithKline; January 2011.
7. Pulmicort Flexhaler® [package insert]. Wilmington, DE: AstraZeneca LP; July 2010.
8. QVAR [package insert]. Horsham, PA: Teva Respiratory, LLC; September 2010.
9. Arnuity™ Ellipta® [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 08/2014.

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## REVIEW HISTORY

| DESCRIPTION OF REVIEW / REVISION | DATE APPROVED |
|---|---|
| *Annual review* | *02/17, 02/18* |
| | |

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