

POLICY AND PROCEDURE

POLICY NUMBER: *RX.PA.238.E*

REVISION DATE: *N/A*

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POLICY TITLE: *Non-preferred Long-Acting Beta-Agonist Step*
DEPARTMENT: *Clinical Pharmacy Services- Utilization Management*
ORIGINAL DATE: *November 2014 (as adopted from UPMC Health Plan)*

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

Product Applicability: *mark all applicable products below:*

COMMERCIAL	<input type="checkbox"/> HMO <input type="checkbox"/> PPO Products: <input type="checkbox"/> Small Exchange: <input type="checkbox"/> Shop <input checked="" type="checkbox"/> All <input type="checkbox"/> Indiv. <input type="checkbox"/> Indiv. <input type="checkbox"/> Large
OTHER	<input checked="" type="checkbox"/> Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Non-preferred Long-Acting Beta-Agonist.

Formoterol fumarate (Foradil® Aerolizer®) is indicated for treatment of asthma in patients 2'5 years as an add-on to a long-term asthma control medication such as an inhaled corticosteroid, for prevention of exercise-induced bronchospasm 2'5 years, and for maintenance treatment of bronchoconstriction in patients with chronic obstructive pulmonary disease (COPD). It is not indicated for the relief of acute bronchospasm.

Indacaterol maleate (Arcapta™ Neohaler™) is indicated for long term, once-daily maintenance bronchodilator treatment of airflow obstruction in patients with COPD, including chronic bronchitis and/or emphysema. It is not indicated to treat acute deteriorations of chronic obstructive pulmonary disease and is not indicated for asthma.

Olodaterol (Striverdi® Respimat®) is indicated for long-term, once-daily maintenance bronchodilator treatment of airflow obstruction in patients with COPD, including chronic bronchitis and/or emphysema. It is not indicated to treat acute deterioration of COPD and is not indicated to treat asthma.

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Salmeterol xinafolate (Serevent® Diskus®) is indicated for treatment of asthma in patients aged 4 years and older, for prevention of exercise-induced bronchospasm in patients aged 4 years and older, and for maintenance treatment of bronchospasm associated with COPD. It is not indicated for the relief of acute bronchospasm.

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

The non-preferred long-acting beta-agonists 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 Foradil Aerolizer or Servent Diskus

2. Members without a documented claims history:

- Must have documentation indicating that the member has failed or has an intolerance or contraindication to Foradil Aerolizer or Servent Diskus

Limitations:

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



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

REFERENCES

1. Arcapta Neohaler [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; September 2012.
2. Foradil Aerolizer [prescribing information]. Whitehouse Station, NJ: Merck & Co., Inc.; November 2012.
3. Serevent Diskus [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline. April 2014.
4. Striverdi Respimat [prescribing in

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
<i>Annual review</i>	<i>02/17, 02/18</i>

