UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Optivar

Program	Step Therapy
Medication	Optivar (azelastine)
Issue Date	12/2009
Pharmacy and Therapeutics Approval Date	11/2017
Effective Date	1/2018

1. Background:

Optivar is indicated in adult and pediatric patients for the treatment of itching of the eye associated with allergic conjunctivitis.

Zaditor OTC is indicated for the treatment of allergic conjunctivitis.

2. Coverage Criteria:

A. Automated Step Therapy Critieria

1. A claim for Optivar will process at the point of sale if the patient's drug fill history shows a previous trial on Zaditor OTC, Alaway, or ketotifen.

B. Requests that DO NOT Meet Automated Step Criteria

1. Optivar will be approved for patients who have not met the automated step criteria when the following circumstances is met:

    a. The patient has a history of failure, contraindication, or intolerance to Zaditor OTC, Alaway, or ketotifen.

Authorization will be issued for 12 months.

3. References:

1. Optivar® Prescribing Information. MedPointe Pharmaceuticals, July 2003.
2. Zaditor® Prescribing Information. Novartis. June 2008.
3. Clinical Pharmacology Gold Standard. 2017.

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4. American Academy of Ophthalmology Cornea/External Disease Panel. Preferred Practice Pattern® Guidelines. Conjunctivitis. San Francisco, CA: American Academy of Ophthalmology; 2013. Available at: www.aao.org/ppp.

Program	Step Therapy –Optivar (azelastine)
Change Control	
Date	Change
12/2009	Criteria were taken from the previously approved AmeriChoice policy. Policy was reformatted.
12/2010	Annual review, no change
3/2011	Annual review, no change
3/2012	Annual review, no change
3/2013	Annual review, no change
11/2016	Annual review, updated policy template and added standard authorization duration of 12 months
11/2017	Annual review. Updated references. Combined all requirements into one statement to align with standard language found in other policies.