UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Inhaled Corticosteroids – OHIO

Program	Prior Authorization
Medication	Inhaled Corticosteroids (Single Agents)
Markets In Scope	Ohio

1. Background:

Formulary Status

Preferred Products	**Non-preferred Products**
Arnuity Ellipta (fluticasone) Asmanex Twisthaler (mometasone) Asmanex HFA (mometasone)	Flovent Diskus (fluticasone) Flovent HFA (fluticasone) Qvar RediHaler (beclomethasone) Pulmicort Flexhaler (budesonide) Alvesco (ciclesonide) Aerospan (flunisolide) ArmonAir RespiClick (fluticasone)

2. Coverage Criteria:

A. Flovent HFA or Qvar RediHaler will be approved when the following circumstances are met:

1. **One** of the following:

   a. Patient is less than 12 years of age and meets **both** of the following:

      (1) Diagnosis of asthma

      -AND-

      (2) Provider attests that the patient is unable to master administration technique with Asmanex Twisthaler OR the patient has a history of failure, contraindication, or intolerance to Asmanex Twisthaler.

      -OR-

   b. Patient is 12 years of age or older and meets **both** of the following:

      (1) Diagnosis of asthma

      -AND-

(2) History of failure, contraindication, or intolerance to **both** of the preferred inhaled corticosteroids:
- Arunity Ellipta
- Asmanex HFA or Asmanex Twisthaler

-OR-

c. Patient is a premature infant diagnosed with bronchopulmonary dysplasia (BPD)/chronic lung disease (CLD)

-OR-

d. **Both** of the following:

(1) The request is for Flovent HFA and the patient has a diagnosis of eosinophilic esophagitis

-AND-

(2) Prescribed by an allergist, immunologist, or gastroenterologist

Authorization will be issued for 12 months.

B. Flovent Diskus, Pulmicort Flexhaler, Alvesco, ArmonAir RespiClick, or Aerospan will be approved when the following circumstances are met:

1. **Both** of the following:

a. Diagnosis of asthma

-AND-

b. History of failure, contraindication, or intolerance to **both** of the preferred inhaled corticosteroids:
- Arnuity Ellipta
- Asmanex HFA or Asmanex Twisthaler

Authorization will be issued for 12 months.

3. References:

1. Arnuity Ellipta Prescribing Information. GlaxoSmithKline, November 2016.
2. Asmanex HFA Prescribing Information. Merck, July 2016.

3. Asmanex Twisthaler Prescribing Information. Merck, September 2014.
4. Flovent HFA Prescribing Information. GlaxoSmithKline, July 2017.
5. Flovent Diskus Prescribing Information. GlaxoSmithKline, July 2017.
6. Pulmicort Flexhaler Prescribing Information. AstraZeneca, October 2016.
7. QVAR Prescribing Information. Teva, September 2017.
8. Alvesco Prescribing Information. Sunovion, January 2013.
9. Aerospan Prescribing Information. Meda Pharmaceuticals, November 2017.
10. National Heart, Lung, and Blood Institute (NHLBI). National Asthma Education and Prevention Program (NAEPP). Expert Panel Report 3: Guidelines for diagnosis and management of asthma. U.S Department of Health and Human Services. Full report August 28, 2007. Available at: http://www.nhlbi.nih.gov/guidelines/asthma/asth.
11. Global Initiative for Asthma (GINA). National Heart, Lung, and Blood Institute (NHLBI). Global strategy for asthma management and prevention 2006.
12. ArmonAir RespiClick Prescribing Information. Teva, January 2017.

Program	Program type – ICS Single Agents
Change Control	
Date	Change
2/2018	Ohio specific policy created for 4/1/18 since Ohio will be moving to a Single PDL later in 2018.