MEDICAL MUTUAL®

Drug Policy

Policy:	**Corticosteroid Inhalers Preferred Step Therapy** • **Alvesco**	**Annual Review Date:** **01/16/2025** **Last Revised Date:** **01/16/2025**

OVERVIEW

All of the corticosteroid inhalers are indicated for the **maintenance treatment of asthma**. Flovent (Diskus and HFA), Qvar RediHaler, and Asmanex Twisthaler 110 mg are approved for patients ≥ 4 years of age; Arnuity Ellipta 50 mcg0, and Asmanex HFA are approved for patients ≥ 5 years of age; Pulmicort Flexhaler is approved for patients ≥ 6 years of age; Alvesco ArmonAir Digihaler,Arnuity Ellipta 100 or 200 mcg, and Asmanex Twisthaler 220 mcg are approved for patients ≥ 12 years of age. None of the corticosteroid inhalers are indicated for the relief of acute bronchospasm.

POLICY STATEMENT

A preferred step therapy program has been developed to encourage the use of a preferred product prior to the use of a non-preferred product. If the preferred step therapy rule is not met for a non-preferred product at the point of service, coverage will be determined by the preferred step therapy criteria below.

Automation: A patient with a history of one Preferred Product within the 130-day look-back period is excluded from Step Therapy.

Preferred products:

- Arnuity Ellipta
- Asmanex HFA
- Asmanex Twisthaler
- Qvar RediHaler

Non-preferred products:

- Alvesco

CRITERIA

1. If the patient has tried one preferred product, then authorization for a non-preferred product may be given.

Approval: 365 days (1 year)

Step Therapy Exception Criteria

In certain situations, the patient is not required to trial preferred products. Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred products. If so, please list diagnosis and/or patient characteristics *; **OR**
B. The patient has a contraindication to all preferred products. If so, please list the contraindications to each preferred product *; **OR**
C. The patient is continuing therapy with the requested non-preferred product after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:
    1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred product for 90 days within a 130-day look-back period AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product); OR
    2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred product for 90 days AND that the patient has been receiving the requested non-preferred product via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred product) AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product).

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other products, noted in the criteria as *. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

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