

Drug Policy

Policy: Impacted Drugs:	Intranasal Steroids Preferred Step Therapy <ul style="list-style-type: none"> • Azelastine/fluticasone • Mometasone furoate 	Annual Review Date: 01/16/2025 Last Revised Date: 01/16/2025
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OVERVIEW

Nasal corticosteroids are indicated for the treatment of symptoms of seasonal allergic rhinitis (SAR) and perennial allergic rhinitis (PAR). No clinical studies directly compare all of the agents in this class. In the absence of more comprehensive data, single comparison clinical trials must suffice to give a general indication of the comparability of these agents. Comparative clinical studies suggest that, at equipotent doses, the intranasal corticosteroids have similar efficacy in the treatment of allergic rhinitis (AR) and perhaps non-allergic rhinitis; however, individual responses to agents may vary. The newer single-agent nasal corticosteroids have demonstrated higher topical potency; the clinical significance of this difference in potency has not been established.

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 agent at the point of service, coverage will be determined by the preferred step therapy criteria below. All approvals are provided for 1 year in duration.

Automation: The following automation is applied in this policy:

- Patients with a history of one preferred product within the 130-day look-back period are excluded from step therapy; OR
- Requests for mometasone: The patient is between the ages of 2 and 4 years old; OR
- Requests for mometasone: ICD-10 codes for chronic rhinosinusitis with nasal polyps (ICD-10: J32* and J33*).

Preferred Medication

- Generic fluticasone propionate nasal spray
- Generic flunisolide nasal spray

Non-Preferred Medication

- Generic azelastine/fluticasone nasal spray
- Generic mometasone furoate nasal spray

PREFERRED STEP THERAPY CRITERIA

1. If the patient has experienced intolerance (i.e., sensitivity, drug allergy, or adverse effect) OR therapeutic failure with the use of a preferred product, then a nonpreferred product may be approved.

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2. If the patient is between the ages of 2 and 4 years old, approve mometasone furoate nasal spray.
3. If the patient has a diagnosis of chronic rhinosinusitis with nasal polyps, approve mometasone furoate nasal spray.

Approval Duration: 2 years

Step Therapy Exception Criteria

In certain situations, the patient is not required to trial preferred agents. 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 agents. If so, please list diagnosis and/or patient characteristics*; **OR**
- B. The patient has a contraindication to all preferred agents. If so, please list the contraindications to each preferred agent*; **OR**
- C. The patient is continuing therapy with the requested non-preferred agent 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 agent 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 agent for 90 days **AND** that the patient has been receiving the requested non-preferred agent 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 agent) **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 agents, 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

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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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