

## Inhaled Corticosteroids (ICS)

### Goals:

- To optimize the safe and effective use of ICS therapy in patients with asthma and COPD.

### Length of Authorization:

- Up to 12 months

### Requires PA:

- Non-preferred ICS products

### Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at [www.orpdl.org](http://www.orpdl.org)
- Searchable site for Oregon FFS Drug Class listed at [www.orpdl.org/drugs/](http://www.orpdl.org/drugs/)

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 Code	
2. Will the prescriber consider a change to a preferred product?  <u>Message:</u> Preferred products are reviewed for comparative effectiveness and safety by the Oregon Pharmacy and Therapeutics (P&T) Committee.	<b>Yes:</b> Inform prescriber of covered alternatives in class.	<b>No:</b> Go to #3
3. Is the request for treatment of asthma or reactive airway disease?	<b>Yes:</b> Go to #6	<b>No:</b> Go to #4

## Approval Criteria

4. Is the request for treatment of COPD, mucopurulent chronic bronchitis and/or emphysema?	<b>Yes:</b> Go to #5	<b>No:</b> Pass to RPh. Deny; medical appropriateness.  Need a supporting diagnosis. If prescriber believes diagnosis is appropriate, inform prescriber of the appeals process for Medical Director Review. Chronic bronchitis is unfunded.
5. Does the patient have an active prescription for an inhaled long-acting bronchodilator (anticholinergic or beta-agonist)?	<b>Yes:</b> Approve for up to 12 months	<b>No:</b> Pass to RPh. Deny; medical appropriateness.
6. Does the patient have an active prescription for an on-demand short-acting beta-agonist (SABA) or an alternative rescue medication for acute asthma exacerbations?	<b>Yes:</b> Approve for up to 12 months	<b>No:</b> Pass to RPh. Deny; medical appropriateness

P&T/DUR Review: 2/24 (DM); 10/23 (SF); 10/22 (KS), 10/20 (KS), 5/19 (KS), 1/18; 9/16; 9/15  
Implementation: 3/1/18; 10/13/16; 10/9/15