Intranasal Allergy Drugs

Goals:

- Restrict use of intranasal allergy inhalers for conditions funded by the OHP and where there is evidence of benefit.
- Treatment for allergic or non-allergic rhinitis is funded by the OHP only if it complicates asthma, sinusitis or obstructive sleep apnea. Only intranasal corticosteroids have evidence of benefit for these conditions.
- Allow case-by-case review for members covered under the EPSDT program.

Length of Authorization:

- 30 days to 12 months

Requires PA:

- Preferred intranasal corticosteroids without prior claims evidence of asthma for people 21 years of age and older.
- Preferred intranasal antihistamines for people 21 years of age and older.
- Non-preferred intranasal corticosteroids and antihistamines
- Intranasal ipratropium and cromolyn sodium

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/
- Preferred intranasal corticosteroids, preferred antihistamines DO NOT require prior authorization for children and adolescents up to their 21st birthday.

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code	
2. Is the prescribed drug intranasal ipratropium or cromolyn?	**Yes:** Pass to RPh. Deny; not funded by the OHP	**No:** Go to #3
3. Does patient have co-morbid conditions funded by the OHP? • Chronic Sinusitis (J320-J329) • Acute Sinusitis (J0100; J0110; J0120; J0130; J0140; J0190) • Sleep Apnea (G4730; G4731; G4733; G4739)	**Yes:** Document ICD10 code(s) and approve for up to 12 months for chronic sinusitis or sleep apnea and approve for no more than 30 days for acute sinusitis	**No:** Go to #4
4. Is there a diagnosis of asthma or reactive airway disease in the past 1 year (J4520-J4522; J45901-45998)?	**Yes:** Go to #5	**No:** Go to #6

Approval Criteria		
5. Is there a claim for an *orally* inhaled corticosteroid in the past 90 days? Note: Asthma-related outcomes are not improved by the addition of an intranasal corticosteroid to an orally inhaled corticosteroid.	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Approve for up to 6 months
6. Is the prescribed drug a preferred product?	**Yes:** Go to #8	**No:** Go to #7
7. Will the prescriber consider switching to a preferred product? Note: Preferred products are reviewed for comparative effectiveness and safety by the Oregon Pharmacy & Therapeutics Committee	**Yes:** Inform prescriber of preferred alternatives. Go to #8	**No:** Go to #8
8. Is the patient 20 years of age or younger AND is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc)?	**Yes:** Approve for 6 months	**No:** Go to # 9
9. RPh only: Is the diagnosis funded by the OHP?	**Funded:** Deny; medical appropriateness. (eg, COPD; Obstructive Chronic Bronchitis; or other Chronic Bronchitis [J449; J40; J410-418; J42; J440-449] Use clinical judgment to APPROVE for 1 month starting today to allow time for appeal. Message: "The request has been denied because it is considered medically inappropriate; however, it has been APPROVED for 1 month to allow time for appeal."	**Not Funded:** Deny; not funded by the OHP. (eg, allergic rhinitis (J300-J309); chronic rhinitis (J310-312); allergic conjunctivitis (H1045); upper respiratory infection (J069); acute nasopharyngitis (common cold) (J00); urticaria (L500-L509); etc.)

1. Medicaid Early Periodic Screening, Diagnostic, and Treatment benefit. Accessed June 9, 2022. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

P&T / DUR Review: *8/22 (DM);11/15 (AG); 7/15; 9/08; 2/06; 9/04; 5/04; 5/02*
Implementation: *10/1/22; 10/13/16; 1/1/16; 8/25/15; 8/09; 9/06; 3/06; 5/05; 10/04; 8/02*