Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/1/2018**
Policy Number: PA.CP.PMN.84	**Effective Date: 10/17/2018** **Revision Date: 10/17/2018**
Policy Name: Timothy Grass Pollen Allergen Extract (Grastek)	**HC Approval Date:**

Type of Submission – Check all that apply:

- ✓ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review – No Revisions**
- ☐ **Attestation of HC PARP Policy –** *This option should only be used during Readiness Review for Community HealthChoices. The policy must be identical to the PARP approved policy for the HealthChoices Program, with the exception of revisions/clarifications adding the term "Community HealthChoices" to the policy.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

New Policy created.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:**

Clinical Policy: Timothy Grass Pollen Allergen Extract (Grastek)

Reference Number: PA.CP.PMN.84
Effective Date: 10.17.18
Last Review Date: 10.17.18 Revision Log

Description
Timothy grass pollen allergen extract (Grastek®) is an allergen extract.

Commented [ZL1]: Please be aware that there are currently no products eligible for coverage by MA.

FDA Approved Indication(s)
Grastek is indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. Grastek is approved for use in persons 5 through 65 years of age.

Grastek is not indicated for the immediate relief of allergic symptoms.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health & Wellness® that Grastek is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Allergic Rhinitis (must meet all)**:**

1. Diagnosis of grass-pollen-induced allergic rhinitis;
2. Prescribed by or in consultation with an allergist or immunologist;
3. Age ≥ 5 years and < 65 years;
4. Confirmation of a positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass pollen or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard, Perennial Rye, Kentucky Blue/June Grass, Meadow Fescue, or Redtop);
5. Failure of one intranasal corticosteroid unless all are contraindicated or clinically significant adverse effects are experienced;
6. Failure of one oral antihistamine at up to maximally indicated doses unless all are contraindicated or clinically significant adverse effects are experienced:
7. Dose does not exceed 1 tablet daily.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

II. Continued Therapy

A. Allergic Rhinitis (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1 tablet daily.
   12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – PA.CP.PMN.53.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
BAU: bioequivalent allergy unit
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
OTC loratadine (Claritin®)	2 to 5 years: 5 mg PO QD ≥ 6 years: 10 mg PO QD	10 mg/day
OTC loratadine-D (Claritin-D® 12 and 24 hour)	≥ 12 years: 1 tablet PO BID (12 hr) QD (24 hr)	10 mg/day
OTC cetirizine (Zyrtec®)	2 to 5 years: 2.5-5 mg PO QD ≥ 6 years: 10 mg PO QD	10 mg/day
OTC fexofenadine (Allegra Allergy®)	6-months to 2 years: 15 mg PO QD 2 to 11 years: 30 mg PO QD ≥ 12 years: 60 mg PO BID or 180 mg PO QD	180 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
fluticasone propionate (Flonase®)	≥ 4 years: 1-2 sprays each nostril QD ≥ 12 years: 1-2 sprays each nostril QD	2 sprays each nostril/day
triamcinolone acetonide (Nasacort AQ®)	2-11 years: 1 spray each nostril QD ≥ 12 years: 1-2 sprays each nostril QD	2-11 years: 1 spray each nostril/day > 12 years: 2 sprays each nostril/day
Nasonex® (mometasone furoate monohydrate)	2-11 years: 1 spray each nostril QD ≥ 12 years: 2 sprays each nostril QD	2-11 years: 1 spray each nostril/day > 12 years: 2 sprays each nostril/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications

- Severe, unstable or uncontrolled asthma
- A history of eosinophilic esophagitis

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Grass pollen-induced allergic rhinitis	One tablet sublingually daily Treatment should be initiated at least 12 weeks before the expected onset of each grass pollen season and continue treatment throughout the season. For sustained effectiveness for one grass pollen season after cessation of treatment, Grastek may be taken daily for three consecutive years.	1 tablet per day

VI. Product Availability

Tablet: 2800 bioequivalent allergy units (BAUs)

VII. References

1. Grastek Prescribing Information. Whitehouse Station, NJ: Merck Sharp & Dohme Corp.; April 2017. Available at: https://www.grastek.com/. Accessed April 2, 2018.
2. Wallace DV, Dykewicz MS, Oppenheimer J et al. Pharmacologic treatment of seasonal allergic rhinitis: synopsis of guidance from the 2017 Joint Task Force on Practice Parameters. Ann Intern Med. 2017 Dec 19;167(12):876-881. doi: 10.7326/M17-2203.
3. Seidman MD, Gurgel RK, Lin SY, et al. Clinical practice guideline: Allergic rhinitis. Otolaryngol Head Neck Surg. 2015 Feb;152(1 Suppl):S1-43. doi: 10.1177/0194599814561600.
4. Wallace DV, Dykewicz MS, Bernstein DI, Blessing-Moore J, Cox L, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph CC, Schuller D, Spector SL, Tilles SA, Joint Task Force on Practice, American Academy of Allergy, Asthma&Immunology,

American College of Allergy, Asthma and Immunology, Joint Council of Allergy, Asthma and Immunology. The diagnosis and management of rhinitis: an updated practice parameter. J Allergy Clin Immunol. 2008;122(2 Suppl):S1-84.
5. Cox L, Nelson H, Lockey R, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.
6. Brozek, JL, Bousquet J, Agache I et al. Allergic rhinitis and its impact on asthma (ARIA) guidelines-2016 revision. J Allergy Clin Immunol. 2017 Oct;140(4):950-958. doi: 10.1016/j.jaci.2017.03.050.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy Created	10/18	