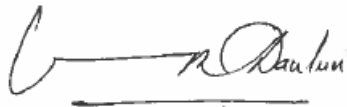


**Prior Authorization Review Panel**

**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.

<b>Plan: PA Health &amp; Wellness</b>	<b>Submission Date: 11/2021</b>
<b>Policy Number: PHW.PDL.033</b>	<b>Effective Date: 01/01/2020 Revision Date: 10/2021</b>
<b>Policy Name: Glucocorticoids, Inhaled</b>	
<p><b>Type of Submission – <u>Check all that apply:</u></b></p> <p> <input type="checkbox"/> New Policy  <input checked="" type="checkbox"/> Revised Policy*  <input type="checkbox"/> Annual Review - No Revisions  <input checked="" type="checkbox"/> <b>Statewide PDL</b> - <i>Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</i> </p>	
<p><b>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</b></p> <p><b>Please provide any changes or clarifying information for the policy below:</b></p> <p>Q1 2022: revised according to DHS revisions effective 01/03/2022.</p>	
<p><b>Name of Authorized Individual (Please type or print):</b></p> <p>Venkateswara R. Davuluri, MD</p>	<p><b>Signature of Authorized Individual:</b></p> 

## Clinical Policy: Glucocorticoids, Inhaled

Reference Number: PHW.PDL.033

Effective Date: 01/01/2020

Last Review Date: 10/2021

[Revision Log](#)

### 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 and Wellness® that Inhaled Glucocorticoids is **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Glucocorticoids, Inhaled

#### A. Prescriptions That Require Prior Authorization

Prescriptions for Glucocorticoids, Inhaled that meet any of the following conditions must be prior authorized:

1. A non-preferred Glucocorticoid, Inhaled. See the Preferred Drug List (PDL) for the list of preferred Glucocorticoids, Inhaled at: <https://papdl.com/preferred-drug-list>.
2. A Glucocorticoid, Inhaled with a prescribed quantity that exceeds the quantity limit.
3. A Glucocorticoid, Inhaled when there is a record of a recent paid claim for another agent that contains an inhaled glucocorticoid (therapeutic duplication).
4. An agent that contains an inhaled long-acting anticholinergic when there is a record of a recent paid claim for another product that contains an inhaled long-acting anticholinergic (therapeutic duplication).
5. An agent that contains an inhaled long-acting beta agonist when there is a record of a recent paid claim for another product that contains an inhaled long-acting beta agonist (therapeutic duplication).

#### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Glucocorticoid, Inhaled, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred single-ingredient Glucocorticoid, Inhaled (i.e., a product that contains only one active ingredient), has a history of therapeutic failure,

contraindication, or intolerance of the preferred single-ingredient  
Glucocorticoids, Inhaled; **AND**

2. For a non-preferred Glucocorticoid, Inhaled combination agent (i.e., a product that contains more than one active ingredient), has a history of therapeutic failure, contraindication, or intolerance of the preferred Glucocorticoid, Inhaled combination agents; **AND**
3. For therapeutic duplication, **one** of the following:
  - a. For an inhaled glucocorticoid, is being titrated to or tapered from another inhaled glucocorticoid,
  - b. For an inhaled long-acting anticholinergic, is being titrated to or tapered from another inhaled long-acting anticholinergic,
  - c. For an inhaled long-acting beta agonist, is being titrated to or tapered from another inhaled long-acting beta agonist,
  - b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

**AND**

4. If a prescription for an Glucocorticoid, Inhaled is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

**C. Clinical Review Process**

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Glucocorticoid, Inhaled. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

**D. Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020

Reviews, Revisions, and Approvals	Date
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022: revised according to DHS revisions effective 01/03/2022.	10/2021