Clinical Policy: Glucocorticoids, Inhaled

Reference Number: PHW.PDL.033
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 PA Health & 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.

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 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 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 of or a contraindication or an intolerance of the preferred single-ingredient Glucocorticoids, Inhaled approved or medically accepted for the member's

diagnosis; **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 of or a contraindication or an intolerance of the preferred Glucocorticoid, Inhaled combination agents approved or medically accepted for the member's diagnosis; **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 drugs that is supported by peer-reviewed literature or national treatment guidelines;

   AND

4. If a prescription for a Glucocorticoid, Inhaled is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **one** of the following:
   a. The guidelines set forth in PA.CP.PMN.59 Quantity Limit Override,
   b. For Glucocorticoid, Inhaled containing a beta agonist for the treatment of asthma, **both** of the following:
      i. The member is using the requested drug as part of a therapy that is supported by consensus treatment guidelines [e.g., Single Maintenance and Reliever Therapy (SMART)];
      ii. The prescribed dose is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

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**

E. References:

1. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention: 2024 update. Online. Accessed July 31, 2025.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
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
Q1 2023: revised according to DHS revisions effective 01/09/2023.	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025