AdvancedHealth
Bridging the Future of Healthcare

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Intranasal Corticosteroids Drug Use Criteria

Created: 6/9/10
Revised: 9/23/15, 5/21/17

Includes:

Beconase AQ©, QNasal©	*Beclomethasone*
Rhinocort©, Rhinocort Allergy©	*Budesonide*
Omnaris©, Zetonna©	*Ciclesonide*
Nasalide©, Nasarel©	*Flunisolide*
Veramyst©	*Fluticasone furoate*
Flonase©, Flonase Allergy Relief©	*Fluticasone propionate*
Nasonex©	*Mometasone*
Nasacort©, Nasacrot Allergy 24HR©	*Triamcinolone*

*Highlighted in yellow is preferred agent and in green is second line agent.

**Generic fluticasone propionate nasal spray will be covered as a plan benefit when the drug use criteria below is met. Fluticasone propionate nasal spray is formulary intranasal corticosteroid as it is the least costly alternative. Nasacort Allergy 24HR© (triamcinolone) may be considered as a second line agent for those patients unable to tolerate generic fluticasone nasal spray and meeting the below drug use criteria.*

Guideline for Use:

1. Is the patient being treated for an above the line diagnosis for which a substantial body of evidence exists to support use of intranasal corticosteroids?
   a. If yes, continue to 2
   b. If no, deny as below the line
2. Is the requested drug a preferred product?
   a. If yes, go to 3
   b. If no, go to 5
3. Does the patient have a funded condition such as chronic sinusitis, acute sinusitis, or sleep apnea for which a substantial body of evidence exists to support use of intranasal corticosteroids?
   a. If yes, approve for requested duration of therapy up to 6 months for chronic sinusitis or sleep apnea and approve for 30 days for acute sinusitis.
   b. If no, go to 4
   **Please note there is insufficient evidence supporting use of intranasal corticosteroids for COPD.*

Approved by WOAH P&T on 5/22/2017
Approved by Advanced Health Pharmacy and Therapeutics Committee 4/22/2019

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4. Does the patient have a diagnosis of asthma or reactive airway disease, or a covered comorbid condition?
    a. If yes, approve for requested duration of therapy up to 6 months
    b. If no, deny as not meeting criteria
5. Will the provider consider changing to a preferred product (preferred products are highlighted in yellow above, secondary agent is highlighted in green)?
    a. If yes, change prior authorization request to preferred product and go to 3 for consideration of coverage
    b. If no, go to 6
6. Is there a clinical rationale for use of a nonformulary agent (e.g. documented intolerance to formulary agent, etc.)?
    a. If yes and request is for Nasacort Allergy 24HR©, approve for the requested duration of therapy up to 6 months
    b. If no, deny as nonformulary and request use of formulary alternative
    c. If yes and request is for nonformulary agent, and documented failure or intolerance to both fluticasone propionate and Nasacort Allergy 24HR© has been substantiated in the chart note and prescription fill history, review price comparison of intranasal steroids and recommend use of next least costly option. If next least costly alternative prescribed, approve for 6 months. Otherwise deny as not meeting criteria; does not meet the least costly alternative rule for OHP

Rationale: To promote the use of intranasal corticosteroids for conditions funded for coverage by Oregon Health Plan and where there is evidence of benefit. Treatment for allergic or non-allergic rhinitis is only funded for coverage when it exacerbates asthma, sinusitis, or obstructive sleep apnea. Evidence is insufficient to draw any conclusions about comparative effectiveness, efficacy, or safety between intranasal corticosteroid formulations for management of asthma-related outcomes, obstructive sleep apnea, acute sinusitis and chronic rhinosinusitis, therefore the least costly formulations will be covered. Also, to align coverage with the State FFS drug use criteria for intranasal corticosteroids.

FDA Approved Indication: *Generic Name (*Brand Name*)*	FDA Approved Indications
Beclomethasone (Beconase AQ©)	Allergic, non-allergic rhinitis ≥ 6yo
Beclomethasone (QNASL©)	Allergic rhinitis ≥ 4 yo
Budesonide (Rhinocort Aqua, Rhinocort Allergy)	Allergic rhinitis ≥ 6 yo
Ciclesonide (Omnaris)	Allergic rhinitis ≥ 12yo
Ciclesonide (Zetonna)	Allergic rhinitis ≥12 yo
Flunisolide	Allergic rhinitis ≥ 6 yo
*Fluticasone furoate (*Veramyst)	Allergic rhinitis ≥ 2 yo
*Fluticasone propionate (*Flonase, Flonase Allergy Relief)	Allergic rhinitis ≥ 4yo
*Mometasone (*Nasonex)	Allergic rhinitis ≥ 2yo, Nasal polyps ≥18 yo

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*Triamcinolone (*Nasacort AQ, Nasacort Allergy 24HR)	Allergic rhinitis ≥ 2 yo

References:

1. Intranasal Allergy Drug Class Review. Oregon State University Drug Use Research and Management Program. July 2015. http://www.orpdl.org/durm/meetings/meetingdocs/2015_07_30/archives/2015_07_30_IntranasalAllergyDrugsClassReview_FINAL.pdf
2. Advanced Health Drug Use Criteria. Last updated 09/23/2015.
3. Beconase AQ© Prescribing Information. Revised 2015
4. Rhinocort Aqua© Prescribing Information. Revised 12/2010
5. Omnaris© Prescribing Information. Revised 10/2019
6. Zetonna© Prescribing Information. Revised 1/2012
7. Veramyst© Prescribing Information. Revised 4/2007
8. Flonase© Prescribing Information. Revised 1/2015
9. Nasonex© Prescribing Information. Revised 1/2011
10. Nasacort AQ© Prescribing Information. Revised 2008
11. Oregon State University Drug Use Research and Management Class Review: Intranasal Allergy Drugs. July 2015
12. Oregon Administrative Rule 410-120-1200 (2)(n)
13. Oregon Administrative Rule 410-141-0480 (8)(a)(C)

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