

Progressive Medication Program for Nasal Steroids (Beconase AQ, Rhinocort Aqua, Omnaris, and Veramyst)

Origination: 12/29/11	Revised:	Annual Review:
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Purpose:

To provide guidelines and criteria for the review and decision determination of requests for medications that requires prior authorization.

Background Information:

Medication Summary

- Nasal corticosteroids can be used for the management of nasal symptoms, including congestion, for seasonal or perennial allergic rhinitis as well as for perennial nonallergic rhinitis or perennial vasomotor rhinitis. Currently there are generic medications including flunisolide, fluticasone propionate, and triamcinolone acetonide. Brand name medications include Beconase AQ, Flonase, Nasacort AQ, Nasonex, Omnaris, Rhinocort Aqua, and Veramyst.

Reference Statement

- Guidelines are compiled from available US Food and Drug Administration (FDA) approved indications, general practice guidelines, and/or evidence-based uses established through phase III clinical studies without published conflicting data. Only clinical studies published in their entirety in reputable peer-reviewed journals will be evaluated.

Eligibility Criteria

- Member must be eligible and have applicable benefit coverage.
- Prior authorization requests that do not meet clinical criteria in this Procedure will be forwarded to a Clinical Pharmacist for review.

Exclusion Criteria

- Members with acute bronchospasm or status asthmaticus.

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Procedure:

- 1.0 Request for *initial therapy* with Beconase AQ, Rhinocort Aqua, Omnaris and Veramyst requires documentation from the Member's medical records maintained by the requesting independent practitioner's office verifying the following:
 - 1.1 Member is newly enrolled with AvMed (eligibility within the past 120 days) and has been on targeted medication prior to joining AvMed (evidenced by progress notes from independent practitioner (prescriber) indicating use or documented previous fill history with pharmacy);
 - OR-
 - 1.1 Member has tried and failed at least one (1) of the following generic nasal corticosteroid: flunisolide, fluticasone propionate, or triamcinolone acetonide AND the brand name medication Nasonex;
 - 1.2 If Member meets criteria, Member may be approved for one (1) canister per month. Refills should continue to process every month thereafter.

Reference:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2011. URL: <http://www.clinicalpharmacology.com>. Accessed December 23, 2011,

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed Health Plans service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.