

Pharmacy Policy

Step Therapy Policy – Oral and Nasal Allergy Agents

Policy Number: 9.142

Version Number: 2

Version Effective Date: 1/1/2022

Product Applicability **All Plan⁺ Products**

Well Sense Health Plan

New Hampshire Medicaid

Boston Medical Center Healthnet Plan

Masshealth - MCO

Masshealth - ACO

Qualified Health Plans

Senior Care Options

Note: Disclaimer and Audit Information Is Located At The End Of This Document.

Prior Authorization Policy

POLICY STATEMENT:

A step therapy program has been developed to encourage the use of generic Step-1 products prior to the use of a Step-2 or Step-3 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 or Step-3 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

Standard Criteria:

The Plan May Authorize Coverage Of The Products in Appendix A For Members Meeting The Following Criteria When Step Therapy Is Not Met At Point Of Sale From Claims History:

1. Prescribers must provide documentation (including dates of trial and outcome) that the member has tried and failed the appropriate number of Step 1 agents as indicated in Appendix A and in the coverage criteria requirements; OR

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2. Prescriber must provide documentation that the member has a contraindication to or other clinical rationale preventing the use of ALL Step 1 agents indicated in Appendix A

Appendix A: Step Therapy Details

Oral Antihistamine		
Step 1	Step 2	Coverage Criteria
Cetirizine Hcl Solution Cetirizine Hcl Tablet Cetirizine/Pse Tablet Loratadine Tablet Loratadine Solution Loratadine Tablet Chewable	Desloratadine Tablet Desloratadine Oral Tablet Dispersible Fexofenadine Hcl Susp Fexofenadine Hcl Tablet Fexofenadine Hcl/ Pseudoephedrine	Pharmacy Claims Indicating The Use Of OTC Loratadine And OTC Cetirizine Agents In The Previous 365 Days

Nasal Corticosteroids		
Step 1	Step 2	Coverage Criteria
Budesonide Suspension 32 Mcg/Act Nasal Fluticasone 50mcg/Actuation Nasal Spray (Rx/Otc) Triamcinolone Acetonide Aerosol 55 Mcg/Act Nasal	Beconase Aq Nasal 42mcg/Actuation Flunisolide Solution 25 Mcg/Act (0.025%) Nasal Mometasone Furoate Suspension 50 Mcg/Act Nasal Qnasl 40mcg/Actuation Qnasl 80mcg/MI Actuation	Pharmacy Claims Indicating The UseOf One Step 1 Agent In The Past 365 Days

Nasal Sprays			
Step 1	Step 2	Step 3	Coverage Criteria
Azelastine Hcl Solution 0.1 % Nasal	Azelastine Hcl Nasal S 0.15% Olopatadine Hcl Nasal 0.6%	Azelastine-Fluticasone Nasal Suspension 137- 50 Mcg/Act	Step 2: Pharmacy Claims Indicating The Use Of An Oral Antihistamine, Nasal Corticosteroid And Azelastine 0.1% Nasal Spray In The Past 365 Days

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			Step 3: Pharmacy Claims Indicating The Use of A Nasal Antihistamine And A Nasal Corticosteroid In The Past 365 Days
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Original Approval Date	Original Effective Date	Policy Owner	Approved By
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	Summary Of Revisions	Revision Effective Date	Approved By
12/1/2020	Created separate policies per applicable line of business. Coverage duration changed to 1 year. Addition of policy statement and standard criteria.	1/1/2021	P&T Committee
8/12/2021	Annual P&T Review: Aligned step criteria with new simplified standard criteria	1/1/2022	P&T Committee

Next Review Date

8/2022

Other Applicable Policies

Reference To Applicable Laws And Regulations, If Any

Disclaimer Information

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Medical Policies Are The Plan's Guidelines For Determining The Medical Necessity Of Certain Services Or Supplies For Purposes Of Determining Coverage. These Policies May Also Describe When A Service Or Supply Is Considered Experimental Or Investigational, Or Cosmetic. In Making Coverage Decisions, The Plan Uses These Guidelines And Other Plan Policies, As Well As The Member's Benefit Document, And When Appropriate, Coordinates With The Member's Health Care Providers To Consider The Individual Member's Health Care Needs.

Plan Policies Are Developed In Accordance With Applicable State And Federal Laws And Regulations, And Accrediting Organization Standards (Including NCQA). Medical Policies Are Also Developed, As Appropriate, With Consideration Of The Medical Necessity Definitions In Various Plan Products, Review Of Current Literature, Consultation With Practicing Providers In The Plan's Service Area Who Are Medical Experts In The Particular Field, And Adherence To FDA And Other Government Agency Policies. Applicable State Or Federal Mandates, As Well As The Member's Benefit Document, Take Precedence Over These Guidelines. Policies Are Reviewed And Updated On An Annual Basis, Or More Frequently As Needed. Treating Providers Are Solely Responsible For The Medical Advice And Treatment Of Members.

The Use Of This Policy Is Neither A Guarantee Of Payment Nor A Final Prediction Of How A Specific Claim(S) Will Be Adjudicated. Reimbursement Is Based On Many Factors, Including Member Eligibility And Benefits On The Date Of Service; Medical Necessity; Utilization Management Guidelines (When Applicable); Coordination Of Benefits; Adherence With Applicable Plan Policies And Procedures; Clinical Coding Criteria; Claim Editing Logic; And The Applicable Plan – Provider Agreement.

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