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**Respiratory Agents: Inhaled Agents**

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| Criteria 1 | Non-Preferred Glucocorticoids: Aerospan HFA, Alvesco, Armonair Digihaler, Armonair Respiclick, Arnuity Ellipta, Asmanex HFA, Qvar (QL), Fluticasone HFA  Preferred Agents: Asmanex Twisthaler, Flovent, Pulmicort Flexhaler |
| Criteria 2 | Non-Preferred SABAs: Levalbuterol Nebulizer Sol, Proair Digihaler, Proair Respiclick, Xopenex HFA  Preferred Agents: Albuterol Nebulizer Soln, Albuterol HFA, Proair HFA, Proventil HFA, Ventolin HFA |
| Criteria 3 | Non-Preferred ICS with LABAs: Airduo Digihaler, Airduo Respiclick, Breo Ellipta (BvG), Budesonide/Formoterol\* (QL, Symbicort is BvG), Fluticasone/Salmeterol\* (Advair Diskus and Advair HFA are BvG), Wixela Inhub  Preferred agents: Advair Diskus, Advair HFA, Dulera, Symbicort |
| Criteria 4 | Non-Preferred Anticholinergics: Lonhala Magnair, Tudorza, Yupelri  Preferred: Atrovent HFA, Combivent Respimat, Incruse Ellipta, Ipratropium, Ipratropium/Albuterol Nebulizer Sol, Spiriva |
| Criteria 5 | Non-Preferred LABAs: Arformoterol, Formoterol Fumarate Nebulizer Sol  Preferred: Serevent Diskus, Striverdi Respimat |
| Criteria 6 | Non-Preferred ACH/LABA: Bevespi Aerosphere, Duaklir Pressair  Preferred Agents: Anoro Ellipta, Stiolto |
| Criteria 7 | Non-Preferred ACH/ICS/LABA: Breztri Aerosphere, Trelegy Ellipta |
| Criteria 8 | Albuterol Nebulizer Sol 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL)- P, AR |
| Criteria 9 | Budesonide Nebulizer Sol – P, AR |

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| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Non-Preferred Glucocorticoids | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ALVESCO | 058671 | GCNSeqNo |
| ALVESCO | 058672 | GCNSeqNo |
| ARMONAIR DIGIHALER, RESPICLICK | 081476 | GCNSeqNo |
| ARMONAIR DIGIHALER, RESPICLICK | 081478 | GCNSeqNo |
| ARMONAIR DIGIHALER, RESPICLICK | 081485 | GCNSeqNo |
| ARNUITY ELLIPTA | 072722 | GCNSeqNo |
| ARNUITY ELLIPTA | 072723 | GCNSeqNo |
| ARNUITY ELLIPTA | 078449 | GCNSeqNo |
| ASMANEX HFA | 073197 | GCNSeqNo |
| ASMANEX HFA | 073198 | GCNSeqNo |
| ASMANEX HFA | 080669 | GCNSeqNo |
| QVAR | 077643 | GCNSeqNo |
| QVAR | 077644 | GCNSeqNo |
| FLOVENT | 019317 | GCNSeqNo |
| FLOVENT | 019318 | GCNSeqNo |
| FLOVENT | 019319 | GCNSeqNo |
| FLOVENT | 021251 | GCNSeqNo |
| FLOVENT | 021253 | GCNSeqNo |
| FLOVENT | 021483 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0995 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0996 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0996 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0997 |
| N | 1235 |
| 3 | 0997 |  | Select and Free Text | Is the patient 12 years of age or younger?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0998 |
| 4 | 0998 |  | Select and Free Text | Is the patient disabled and unable to use a preferred inhaler?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0999 |
| 5 | 0999 |  | Select and Free Text | Has the patient been non-compliant on a preferred inhaler due to taste, dry mouth, or infection?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1000 |
| 6 | 1000 |  | Select and Free Text | Is the patient clinically unstable, as defined by current guidelines in terms of oral steroid use or patient’s current symptomatology?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1001 |
| 7 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  The preferred medications may include: Asmanex Twisthaler, Flovent, Pulmicort Flexhaler  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 8 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 9 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1005 |
| 10 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1005 |
| N | 1235 |
| 11 | 1005 |  | Select | Is the request for generic Fluticasone HFA (generic Flovent HFA)? | Y | 1006 |
| N | END (Pending Manual Review) |
| 12 | 1006 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 15 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 6/2/2023 | | | | |
| **Other** |  | | | | |
| **Criteria Title** | | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | | Non-Preferred SABAs | | |
| **Approval Level** | | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| LEVALBUTEROL NEBULIZER SOL | 041848 | GCNSeqNo |
| LEVALBUTEROL NEBULIZER SOL | 041849 | GCNSeqNo |
| LEVALBUTEROL NEBULIZER SOL | 049871 | GCNSeqNo |
| LEVALBUTEROL NEBULIZER SOL | 057879 | GCNSeqNo |
| PROAIR DIGIHALER, RESPICLICK | 073806 | GCNSeqNo |
| PROAIR DIGIHALER, RESPICLICK | 080260 | GCNSeqNo |
| XOPENEX HFA | 058890 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  The preferred medications may include:  Inhalers: Albuterol HFA, Proair HFA, Proventil HFA, Ventolin HFA  Nebulizers: Albuterol Nebulizer Soln  If yes, please submit the medication trials and dates. | Y | 3000 |
| N | 1002 |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 3000 |
| N | 1236 |
| 5 | 3000 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 3001 |
| N | END (Pending Manual Review) |
| 6 | 3001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Non-Preferred ICS with LABAs | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AIRDUO DIGIHALER, RESPICLICK | 077072 | GCNSeqNo |
| AIRDUO DIGIHALER, RESPICLICK | 077073 | GCNSeqNo |
| AIRDUO DIGIHALER, RESPICLICK | 077074 | GCNSeqNo |
| AIRDUO DIGIHALER, RESPICLICK | 081399 | GCNSeqNo |
| AIRDUO DIGIHALER, RESPICLICK | 081400 | GCNSeqNo |
| AIRDUO DIGIHALER, RESPICLICK | 081401 | GCNSeqNo |
| BREO ELLIPTA | 070972 | GCNSeqNo |
| BREO ELLIPTA | 071815 | GCNSeqNo |
| BUDESONIDE/FORMOTEROL | 062725 | GCNSeqNo |
| BUDESONIDE/FORMOTEROL | 062726 | GCNSeqNo |
| FLUTICASONE/SALMETEROL | 043366 | GCNSeqNo |
| FLUTICASONE/SALMETEROL | 043367 | GCNSeqNo |
| FLUTICASONE/SALMETEROL | 043368 | GCNSeqNo |
| FLUTICASONE/SALMETEROL | 061344 | GCNSeqNo |
| FLUTICASONE/SALMETEROL | 061345 | GCNSeqNo |
| FLUTICASONE/SALMETEROL | 061343 | GCNSeqNo |
| WIXELA INHUB | 043366 | GCNSeqNo |
| WIXELA INHUB | 043367 | GCNSeqNo |
| WIXELA INHUB | 043368 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0995 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0996 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0996 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0997 |
| N | 1235 |
| 3 | 0997 |  | Select and Free Text | Is the patient 12 years of age or younger?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0998 |
| 4 | 0998 |  | Select and Free Text | Is the patient disabled and unable to use a preferred inhaler?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0999 |
| 5 | 0999 |  | Select and Free Text | Has the patient been non-compliant on a preferred inhaler due to taste, dry mouth, or infection?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1000 |
| 6 | 1000 |  | Select and Free Text | Is the patient clinically unstable, as defined by current guidelines in terms of oral steroid use or patient’s current symptomatology?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1001 |
| 7 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  The preferred medications may include: Advair Diskus, Advair HFA, Dulera, Symbicort  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 8 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 9 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1005 |
| 10 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1005 |
| N | 1235 |
| 11 | 1005 |  | Select | Is the request for any of the following: generic Budesonide/Formoterol (generic Symbicort), generic Fluticasone/Salmeterol (generic Advair Diskus or Advair HFA), Brand Breo Ellipta, or generic Fluticasone/Vilanterol (generic Breo Ellipta)? | Y | 1006 |
| N | END (Pending Manual Review) |
| 12 | 1006 |  | Select | Which product is being requested? | Budesonide/Formoterol (generic Symbicort) | 1007 |
| Fluticasone/Salmeterol Diskus (generic Advair Diskus) | 1007 |
| Fluticasone/Salmeterol HFA (generic Advair HFA) | 1007 |
| Breo Ellipta | END (Pending Manual Review) |
| Fluticasone/Vilanterol (generic Breo Ellipta) | 1007 |
| Other | 1235 |
| 13 | 1007 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 15 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 16 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Non-Preferred Anticholinergics | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| LONHALA MAGNAIR | 078010 | GCNSeqNo |
| LONHALA MAGNAIR | 078007 | GCNSeqNo |
| TUDORZA | 069855 | GCNSeqNo |
| YUPELRI | 079272 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  The preferred medications may include:  Inhalers: Atrovent HFA, Combivent Respimat, Incruse Ellipta, Ipratropium, Spiriva; Nebulizers: Ipratropium/Albuterol Nebulizer Sol  If yes, please submit the medication trials and dates. | Y | 3000 |
| N | 1002 |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 3000 |
| N | 1236 |
| 5 | 3000 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 3001 |
| N | END (Pending Manual Review) |
| 6 | 3001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Non-Preferred LABAs | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BROVANA | 061579 | GCNSeqNo |
| FORMOTEROL FUMARATE NEBULIZER SOL | 063016 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  The preferred medications may include: Serevent Diskus, Striverdi Respimat.  If yes, please submit the medication trials and dates. | Y | 3000 |
| N | 1002 |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 3000 |
| N | 1236 |
| 5 | 3000 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 3001 |
| N | END (Pending Manual Review) |
| 6 | 3001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Non-Preferred ACH/LABA | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BEVESPI AEROSPHERE | 075984 | GCNSeqNo |
| DUAKLIR PRESSAIR | 073344 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  The preferred medications may include: Anoro Ellipta, Stiolto.  If yes, please submit the medication trials and dates. | Y | 3000 |
| N | 1002 |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 3000 |
| N | 1236 |
| 5 | 3000 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 3001 |
| N | END (Pending Manual Review) |
| 6 | 3001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| --- | --- |
| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Non-Preferred ACH/ICS/LABA | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BREZTRI AEROSPHERE | 081351 | GCNSeqNo |
| TRELEGY ELLIPTA | 077780 | GCNSeqNo |
| TRELEGY ELLIPTA | 081555 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0995 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0996 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0996 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0997 |
| N | 1235 |
| 3 | 0997 |  | Select and Free Text | Is the patient 12 years of age or younger?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0998 |
| 4 | 0998 |  | Select and Free Text | Is the patient disabled and unable to use a preferred inhaler?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 0999 |
| 5 | 0999 |  | Select and Free Text | Has the patient been non-compliant on a preferred inhaler due to taste, dry mouth, or infection?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1000 |
| 6 | 1000 |  | Select and Free Text | Is the patient clinically unstable, as defined by current guidelines in terms of oral steroid use or patient’s current symptomatology?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1001 |
| 7 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action?  If yes, please submit the medication trials and dates. | Y | 3000 |
| N | 1002 |
| 8 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 3000 |
| N | 1236 |
| 9 | 3000 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 3001 |
| N | END (Pending Manual Review) |
| 10 | 3001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 12 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 13 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| --- | --- |
| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| --- | --- | --- | --- |
| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Albuterol Nebulizer Sol | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ALBUTEROL NEBULIZER SOL 0.021% (0.63 mg/3 mL), 0.042%(1.25 mg/3mL) | 048698 | GCNSeqNo |
| ALBUTEROL NEBULIZER SOL 0.021% (0.63 mg/3 mL), 0.042%(1.25 mg/3mL) | 048699 | GCNSeqNo |

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| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1234 |  | Select | Is the patient 13 years of age and older?  Please note: a PA is only required for patients 13 years of age and older. | Y | 1235 |
| N | 1236 |
| 2 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 3 | 1236 |  | Free Text | A PA is not required for those younger than 13 years of age. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

|  |  |
| --- | --- |
| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| --- | --- | --- | --- |
| **Criteria Title** | Respiratory Agents: Inhaled Agents | | |
| **Criteria Subtitle** | Budesonide Nebulizer Sol | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BUDESONIDE NEBULIZER SOL | 018165 | GCNSeqNo |
| BUDESONIDE NEBULIZER SOL | 046525 | GCNSeqNo |
| BUDESONIDE NEBULIZER SOL | 046526 | GCNSeqNo |

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| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1234 |  | Select | Is the patient 7 years of age and older?  Please note: a PA is only required for patients 7 years of age and older. | Y | 1235 |
| N | 1236 |
| 2 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 3 | 1236 |  | Free Text | A PA is not required for those younger than 7 years of age. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

|  |  |
| --- | --- |
| **Last Approved** | 6/2/2023 |
| **Other** |  |