

Drug Use Criteria

Intranasal Corticosteroids

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Revised: 09/23/15, 05/21/17

Includes:

<i>Beclomethasone</i>	(Beconase AQ, QNasal)
<i>Budesonide</i>	(Rhinocort, Rhinocort Allergy)
<i>Ciclesonide</i>	(Omnaris, Zetonna)
<i>Flunisolide</i>	
<i>Fluticasone furoate</i>	(Veramyst)
<i>Fluticasone propionate</i>	(Flonase, Flonase Allergy Relief)
<i>Mometasone</i>	(Nasonex)
<i>Triamcinolone</i>	(Nasacort, Nasacort Allergy 24HR)

**Generic Flonase (fluticasone propionate nasal spray) will be covered as a plan benefit when the below drug use criteria 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.*

GUIDELINES 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, or covered comorbid condition, such as chronic sinusitis, acute sinusitis, or sleep apnea?
 - a. If yes, approve for up to 6 months for chronic sinusitis or sleep apnea and approve for no more than 30 days for acute sinusitis.



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b. If no, go to #4

**Please note there is insufficient evidence supporting use of intranasal corticosteroids for COPD.*

4. Does the patient have a diagnosis of asthma or reactive airway disease in the past one year?
 - a. If yes, approve for 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 (eg documented intolerance to formulary agent, etc.)?
 - a. If yes and request is for Nasacort Allergy 24 HR approve for 6 months.
 - b. If no, deny as nonformulary and request use formulary agents.
 - 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, not the least costly alternative for OHP. .

Rationale: To restrict the use of intranasal corticosteroids to 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
<i>Beclomethasone</i> (Beconase AQ)	Allergic, non-allergic rhinitis ≥ 6yo
<i>Beclomethasone</i> (QNASL)	Allergic rhinitis ≥ 4 yo
<i>Budesonide</i> (Rhinocort, Rhinocort Allergy)	Allergic rhinitis ≥ 6 yo
<i>Ciclesonide</i> (Omnaris)	Allergic rhinitis ≥ 6 yo
<i>Ciclesonide</i> (Zetonna)	Allergic rhinitis ≥12 yo
<i>Flunisolide</i>	Allergic rhinitis ≥ 6 yo
<i>Fluticasone furoate</i> (Veramyst)	Allergic rhinitis ≥ 2 yo
<i>Fluticasone propionate</i> (Flonase, Flonase Allergy Relief)	Allergic rhinitis ≥ 4yo
<i>Mometasone</i> (Nasonex)	Allergic rhinitis ≥ 2yo, Nasal polyps ≥18 yo
<i>Triamcinolone</i> (Nasacort, 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. www.orpdl.org/durm/meetings/meetingdocs/2015_07_30_IntranasalAllergyDrugsClassReview_FINAL.pdf.
2. Western Oregon Advanced Health Drug Use Criteria. Last updated 09/23/2015.