Inhaled Respiratory Agents  
Effective 05/01/2021

<table>
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<tr>
<th>Plan</th>
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<tbody>
<tr>
<td>☐ MassHealth</td>
<td>☑ Prior Authorization ☑ Quantity Limit ☐ Step Therapy</td>
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<td>☒ MassHealth (PUF)</td>
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<tr>
<td>☐ Commercial/Exchange</td>
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<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>☑ Pharmacy Benefit</td>
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<tr>
<td>☐ Medical Benefit (NLX)</td>
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<tr>
<th>Specialty Limitations</th>
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<tr>
<th>Contact Information</th>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
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<tr>
<td></td>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
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<td>Medical Specialty Medications (NLX)</td>
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<tr>
<th>Exceptions</th>
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**Overview**

Inhaled respiratory agents are used for disease states such as chronic obstructive pulmonary disease and asthma. These categories of medications include anticholinergics, inhaled corticosteroids, short acting beta agonists, and combination inhaled corticosteroid with a long acting beta agonist.

### No PA

<table>
<thead>
<tr>
<th>Anticholinergics</th>
<th>PA Required</th>
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<tbody>
<tr>
<td>Atrovent HFA® (ipratropium inhalation aerosol)</td>
<td>Lonhala® (glycopyrrolate inhalation solution)</td>
</tr>
<tr>
<td>Incruse® (umeclidinium)</td>
<td>Yupelri® (revefenacin)</td>
</tr>
<tr>
<td>ipratropium inhalation solution</td>
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<tr>
<td>Seebrì® (glycopyrrolate inhalation powder)</td>
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<tr>
<td>Spiriva HandiHaler® (tiotropium inhalation</td>
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</tr>
<tr>
<td>powder)</td>
<td></td>
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<tr>
<td>Spiriva Respimat® (tiotropium inhalation</td>
<td></td>
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<tr>
<td>solution)</td>
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<tr>
<td>Tudorza® (aclidinium)</td>
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</table>
This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* A-rated generic available, both brand and A-rated generic require PA.
† Authorized generic available, both brand and authorized generic require PA.
‡ Authorized generic available.
§ Brand Preferred over generic equivalents. A trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

## Coverage Guidelines

Authorizations requests will be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

### ProAir® Digihaler (albuterol inhalation powder)

Prescriber provides documentation of **ALL** of the following:

1. Member has a diagnosis of Asthma, chronic obstructive pulmonary disorder (COPD), or exercise-induced bronchospasm

2. Member meets **ONE** of the following:
   a. Physician documented inadequate response or adverse reaction to **TWO** albuterol inhalers (one must be ProAir HFA® or ProAir RespiClick®)
   b. Contraindication to **ALL** albuterol inhalers
Ventolin® (albuterol inhaler) \(^\dagger\) and albuterol inhaler
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of Asthma, chronic obstructive pulmonary disorder (COPD), OR exercise-induced bronchoconstriction
2. Physician documented inadequate response, adverse reaction or contraindication to albuterol inhalers (ProAir HFA\(^\dagger\), ProAir RespiClick\(^\dagger\), or Proventil\(^\dagger\))
3. If the request is for BRAND NAME Ventolin\(^\circ\), member must meet the above criteria and the prescriber must provide medical records documenting an inadequate response or adverse reaction to the therapeutically equivalent generic

Breo\(^\circ\) (fluticasone/vilanterol) for COPD
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of chronic obstructive pulmonary disorder (COPD)
2. Member \(\geq 18\) years of age
3. Paid claims or prescriber documented inadequate response, adverse reaction, or contraindication to budesonide/formoterol
4. Quantity limit of one inhaler per month

Breo\(^\circ\) (fluticasone/vilanterol) for Asthma
1. Member has a diagnosis of asthma
2. Member \(\geq 18\) years of age
3. Member meets ONE of the following:
   a. Paid claims or prescriber documented inadequate response, adverse reaction, or contraindication to Advair (fluticasone/salmeterol inhalation aerosol, powder) or budesonide/formoterol
   b. Contraindication to both Advair\(^\circ\) (fluticasone/salmeterol inhalation aerosol, powder) and budesonide/formoterol
4. Quantity limit of one inhaler per month

Airduo RespiClick® (fluticasone/salmeterol inhalation powder) \(^\dagger\)
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of asthma
2. Member meets ONE of the following:
   a. Provider documented inadequate response or adverse reaction to Advair\(^\circ\) (fluticasone/salmeterol inhalation aerosol, powder)
   b. Clinical rationale for necessity of lower dose of fluticasone/salmeterol
   c. Member is already receiving another RespiClick formulation
3. Quantity limit of one inhaler per month
4. If the request is for BRAND NAME AirDuo RespiClick\(^\circ\), member must meet the above criteria and the prescriber must provide medical records documenting an inadequate response or adverse reaction to the therapeutically equivalent generic

Lonhala® (glycopyrrolate inhalation solution) and Yupelri® (revefenacin inhalation solution)
Prescriber provides documentation of ALL of the following:
1. The member has a diagnosis of COPD
2. Member \(\geq 18\) years of age
3. Member meets ONE of the following:
a. Member has a claim for a nebulized respiratory product and no claims for inhalers within the last month
b. Clinical rationale for nebulized formulation (See Appendix I: Medical Necessity for Nebulized Formulations)

4. Physician documented inadequate response, adverse reaction or contraindication to ipratropium inhalation nebulizer solution

5. ONE of the following:
   a. If request is for Lonhala Magnair® (glycopyrrolate) quantity limit of 60 mL per month
   b. If request is for Yupelri® (revefenacin), quantity limit of 90 mL per month

Alvesco® (ciclesonide inhaler), Arnunity® (fluticasone furoate inhalation powder) and Qvar RediHaler® (beclomethasone inhaler)
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of asthma
2. The member meets ONE of the following:
   a. Inadequate response or adverse reaction to ONE inhaled corticosteroid that does not require a prior authorization
   b. Contraindication to ALL inhaled corticosteroids that do not require a prior authorization

   Note: Requests citing drug interactions with HIV antiretrovirals – See Appendix II

Asmanex Twisthaler® (mometasone inhalation powder) 110 µg members ≥12 years of age
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of asthma
2. Clinical rationale for use of 110 µg strength in members ≥12 years of age years of age (see Appendix IV)

Asmanex Twisthaler® (mometasone inhalation powder) 220 µg members <12 years of age
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of asthma
2. Clinical rationale for use of 220 µg strength in members <12 years of age (see Appendix IV)

Pulmicort® (budesonide inhalation suspension) ≥ 13 years of age
Prescriber provides documentation of ALL of the following:
1. Member has a diagnosis of asthma
2. The member meets ONE of the following:
   a. Member < 13 years of age
   b. Member has a claim for a nebulized respiratory product and no claims for inhalers within the last month
   c. Clinical rationale for nebulized formulation (See Appendix I: Medical Necessity for Nebulized Formulations)

3. If the request is for BRAND NAME Pulmicort® inhalation suspension, member must meet the above criteria and the prescriber must also provide medical records documenting an inadequate response or adverse reaction to the generic budesonide respules

Continuation criteria:
Reauthorization requires physician documentation of continuation of therapy and positive response to therapy. Claims history should demonstrate utilization of the medication.
Limitations
1. Approvals and reauthorizations will be granted for 12 months.
2. The following quantity limits apply:

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Quantity Limit</th>
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<tbody>
<tr>
<td>Airduo RespiClick®</td>
<td>1 inhaler per 30 days</td>
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<tr>
<td>Breo® (fluticasone/vilanterol)</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Lonhala® (umeclidinium)</td>
<td>60mL per 30 days</td>
</tr>
<tr>
<td>Yupelri® (revefenacin)</td>
<td>90mL per 30 days</td>
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§Brand preferred over generic equivalent:
A trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.
- albuterol inhaler (ProAir)
- levalbuterol inhaler
- budesonide/formoterol
- fluticasone/salmeterol powder and Wixela

Appendix I: Medical Necessity for Nebulized Formulations
- Manual dexterity issues preventing the use of an inhaler formulation.
- Member has tried inhaled formulations with an inadequate response that had resulted in the member being hospitalized.
- Difficulty manipulating inhaler in the setting of tracheostomy.
- Difficulty manipulating inhaler during severe, acute asthma attacks.

Appendix II: Drug Interactions with HIV Antiretrovirals
Co-administration of several inhaled corticosteroids (e.g., budesonide, ciclesonide, fluticasone, and mometasone) with HIV protease inhibitors (e.g., atazanavir, darunavir) or elvitegravir/cobicistat can result in adrenal insufficiency and Cushing’s syndrome from increased concentration of glucocorticoid. In contrast, co-administration of beclomethasone (e.g., Qvar®) is considered safe.

Requests for Qvar® (beclomethasone) noting concomitant use of HIV protease inhibitors or elvitegravir/cobicistat can be approved without trials of less costly alternatives. Recertifications are contingent on members continuing on the interacting HIV antiretrovirals.

References
N/A

Review History
04/24/2017 – Reviewed
11/07/2020 – Retired ST for COPD; switched to PA for Inhaled Respiratory Agents; Effective 1/1/21
Updated to be in compliance with the Masshealth partial unified formulary requirements; Added QL
03/17/2021 – Updated and reviewed; Updated to be in compliance with MassHealth Unified Pharmacy Product List (UPPL). Previously called MH Partial unified formulary (PUF). QL requirements removed for Incruse, Seebri, Spiriva and Tudorza, UM requirements removed for Advair, Dulara and Symbicort. Effective 05/01/21.

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