



# Missouri Pharmacy Program – Preferred Drug List



## ***Intranasal Antihistamines***

**Effective 06/24/2009**

Revised 06/21/2011

### **Preferred Agents**

- Patanase®
- Astepro®

### **Non-Preferred Agents**

- Azelastine Nasal
- Astelin®

<b><u>Approval Criteria</u></b>	<b><u>Denial Criteria</u></b>
Appropriate ages per product <b>Age range: 5 years old to adult: Astelin®</b> <b>Age range: 12 years old to adult: Patanase®</b>	Failure to meet approval criteria
Failure to achieve desired therapeutic outcomes with trial on 2 preferred agents	
Documented trial period for preferred agents	
Documented ADE/ADR to preferred agents	
Documented compliance on current therapy regimen	Drug Prior Authorization Hotline: (800) 392-8030