



Missouri Pharmacy Program – Preferred Drug List



Intranasal Antihistamines

Effective 07/11/2013

Revised 07/09/2015

Preferred Agents

- Astelin®
- Astepro®
- Patanase®

Non-Preferred Agents

- Azelastine Nasal
- **Olopatadine**

<u>Approval Criteria</u>	<u>Denial Criteria</u>
<ul style="list-style-type: none"> • Failure to achieve desired therapeutic outcomes with trial on 3 or more preferred agents <ul style="list-style-type: none"> ○ Documented trial period for preferred agents ○ Documented ADE/ADR to preferred agents 	Lack of adequate trial on required preferred agents
<ul style="list-style-type: none"> • Documented compliance on current therapy regimen 	Therapy will be denied if no approval criteria are met
	Drug Prior Authorization Hotline: (800) 392-8030