Missouri Pharmacy Program – Preferred Drug List

Antihistamines - Intranasal

Effective 07/13/2013
Revised 07/11/2019

Preferred Agents

- Azelastine 0.1% Nasal (gen Astelin®)

Non-Preferred Agents

- Astepro®
- **Azelastine 0.15% Nasal (gen Astepro®)**
- Olopatadine
- Patanase®

Approval Criteria

- Appropriate ages per product
- Failure to achieve desired therapeutic outcomes with trial on 1 preferred agent
  - Documented trial period for preferred agents
  - Documented ADE/ADR to preferred agents

Denial Criteria

- Lack of adequate trial on required preferred agents
- Therapy will be denied if no approval criteria are met
- Drug Prior Authorization Hotline: (800) 392-8030