



SmartPA Criteria Proposal

Drug/Drug Class:	Antihistamines, Intranasal PDL Edit
First Implementation Date:	June 24, 2009
Revised Date:	September 1, 2022
Prepared For:	MO HealthNet
Prepared By:	MO HealthNet/Conduent
Criteria Status:	<input type="checkbox"/> Existing Criteria <input checked="" type="checkbox"/> Revision of Existing Criteria <input type="checkbox"/> New Criteria

Executive Summary

Purpose: The MO HealthNet Pharmacy Program will implement a state-specific preferred drug list.

Why Issue Selected: Intranasal antihistamines are FDA-approved for the relief of symptoms of seasonal allergic rhinitis. Contraindications, warnings, adverse drug events, and drug interactions are similar for all products and are considered class effects apart from use in children. Astepro® (0.1%) is approved for perennial allergic rhinitis in adults and children 6 months of age and older. Astelin® (0.1%) is approved for seasonal allergic rhinitis in adults and children 5 years of age and older. Patanase® is approved for adults and children 6 years of age and older.

Total program savings for the PDL classes will be regularly reviewed.

Program-Specific Information:	Preferred Agents	Non-Preferred Agents
	<ul style="list-style-type: none"> Azelastine 0.1% Nasal (Rx) 	<ul style="list-style-type: none"> Astepro (OTC) Astepro, Child (OTC) Azelastine 0.15% Nasal (Rx) Olopatadine Nasal Patanase® Nasal

Type of Criteria: Increased risk of ADE Preferred Drug List
 Appropriate Indications Clinical Edit

Data Sources: Only Administrative Databases Databases + Prescriber-Supplied

Setting & Population

- Drug class for review: Antihistamines, Intranasal
- Age range: 6 months to adult: Astepro®
- Age range: 5 years old to adult: Astelin®
- Age range: 6 years old to adult: Patanase®

Approval Criteria

- Participant is of appropriate ages per agent **AND**
- Failure to achieve desired therapeutic outcomes with trial on 1 preferred agent
 - Documented trial period of preferred agents **OR**
 - Documented ADE/ADR to preferred agents

Denial Criteria

- Lack of adequate trial on required preferred agents
- Therapy will be denied if all approval criteria are not met

Required Documentation

Laboratory Results:
MedWatch Form:

Progress Notes:
Other:

Disposition of Edit

Denial: Exception Code "0160" (Preferred Drug List)
Rule Type: PDL

Default Approval Period

1 year

References

- Evidence-Based Medicine and Fiscal Analysis: "Intranasal Antihistamines – Therapeutic Class Review", Conduent Business Services, L.L.C., Richmond, VA; January 2022.
- Evidence-Based Medicine Analysis: "Intranasal Antihistamines", UMKC-DIC; January 2022.
- USPDI, Micromedex; 2022.
- Facts and Comparisons eAnswers (online); 2022 Clinical Drug Information, LLC.