Missouri Pharmacy Program – Preferred Drug List

Antihistamines – Intranasal

Effective 07/13/2013
Revised 07/12/2018

Preferred Agents

- Azelastine (generic Astelin®)
- Azelastine (generic Astepro®)

Non-Preferred Agents

- Astelin® (discontinued)
- Astepro®
- Olopatadine
- **Patanase®**

Approval Criteria

- Appropriate ages per product
- Failure to achieve desired therapeutic outcomes with **trial on 1 preferred** agents
    - Documented trial period for preferred agents
    - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen

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