BlueCross BlueShield of Louisiana

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# Nasal Allergy Medications

**Policy #** 00301
Original Effective Date: 05/22/2013
Current Effective Date: 06/18/2014

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

**When Services May Be Eligible for Coverage**
*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider brand name nasal allergy medications including, but not limited to Nasonex®‡ (mometasone), Omnaris®‡ (ciclesonide), Veramyst®‡ (fluticasone furoate), Rhinocort Aqua®‡ (budesonide), Flonase®‡ (fluticasone propionate), Beconase®‡ AQ (beclomethasone), Astelin®‡ (azelastine), Astepro®‡ (azelastine), Patanase®‡ (olopatadine), and Dymista®‡ (azelastine/fluticasone propionate) to be **eligible for coverage** when one of the below patient selection criteria is met:

Patient Selection Criteria
Coverage eligibility will be considered for brand name nasal allergy medications when one of the following criteria is met:

- For all brand name nasal allergy medications: the patient has tried and failed one prescription generic nasal allergy medication (e.g. flunisolide, fluticasone, triamcinolone, or azelastine nasal sprays); or
- For Rhinocort AQ: the patient is pregnant; or
- There is clinical evidence or patient history that suggests the generically available products will be ineffective or cause an adverse reaction to the patient.

**When Services Are Considered Not Medically Necessary**
Based on review of available data, the Company considers the use of brand name nasal allergy medications when patient selection criteria are not met or for usage not included in the above patient selection criteria to be **not medically necessary.****

## Background/Overview

Nasal allergy medications include those that are steroid based and those that are relatively selective histamine (H)-1 receptor antagonists. These drugs are approved for various indications such as seasonal allergic rhinitis and perennial allergic rhinitis. Rhinocort AQ is pregnancy category B, while the other medications are pregnancy category C.

## Rationale/Source

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests the available generic nasal allergy medications will be ineffective or cause an adverse reaction to the patient. This policy also takes into consideration whether or not the patient is pregnant. Based on a review of the data, in the absence of the above mentioned caveats, there is no advantage of

using a brand name nasal allergy medication over the available generic nasal allergy medications. Generic drugs are considered to have equal bioavailability and efficacy in comparison to brand name drugs.

## References

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30. Dymista™ Nasal Spray [package insert]. Somerset, New Jersey: MEDA; April 2012.

## Policy History

Original Effective Date: 05/22/2013
Current Effective Date: 06/18/2014
05/02/2013 Medical Policy Committee review
05/22/2013 Medical Policy Implementation Committee approval. New policy.
06/05/2014 Medical Policy Committee review
06/18/2014 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
Next Scheduled Review Date: 06/2015

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. in accordance with nationally accepted standards of medical practice;
B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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