

Effective: October 8, 2024

<b>Guideline Type</b>	<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Non-Formulary <input checked="" type="checkbox"/> Step-Therapy <input type="checkbox"/> Administrative
<b>Applies to:</b> <b>Commercial Products</b> <input checked="" type="checkbox"/> Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988 <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617-673-0988 CareLink <sup>SM</sup> – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization  <b>Public Plans Products</b> <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988	

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

## Overview

### Food and Drug Administration – Approved Indications

**Asmanex (mometasone furoate)** is a corticosteroid indicated for maintenance treatment of asthma as prophylactic therapy.

## Clinical Guideline Coverage Criteria

**Note:** Prescriptions that meet the initial step therapy requirements will adjudicate **automatically** at the point of service. If the patient does not meet the initial step therapy criteria, the prescription will deny at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit PA requests to the plan for patients who do not meet the step therapy criteria at the point of service.

Please refer to the table below for medications subject to this policy:

Drug	
Step-1	
Arnuity Ellipta	Covered
Pulmicort Flexhaler (budesonide inhalation)	
Qvar RediHaler	
Step-2	
Asmanex HFA	Requires prior use of a drug on Step-1
Asmanex Twisthaler	

### Automated Step Therapy Coverage Criteria

The following stepped approach applies to coverage of the Step-2 medications by the plan:

**Step 1:** Medications on Step-1 are covered without prior authorization.

**Step 2:** The plan may cover medications on Step-2 if the following criteria are met:

1. The patient has had a trial of one Step-1 medication as evidenced by a paid claim under the prescription benefit administered by the plan.

## **Coverage Criteria for Patients not meeting the Automated Step Therapy Coverage Criteria at the Point of Sale**

The following stepped approach applies to Step – 2 medications covered by the plan:

**Step 2:** The plan may cover Step-2 medications if the following criteria are met:

1. The patient has had a trial of a Step-1 as evidenced by physician documented use, excluding the use of samples
- OR**
2. Requesting physician has documented that the patient has a contraindication to or is unable to tolerate medications on Step-1

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## **Limitations**

- Previous use of samples or vouchers/coupons for brand name medications will not be considered for authorization.
- Step therapy point of service coding does not apply to any non-formulary medications. For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

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## **Codes**

None

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## **References**

1. Asmanex HFA (mometasone furoate) [prescribing information]. Whitehouse Station, NJ: Merck & Co; June 2021.
2. Asmanex Twisthaler (mometasone furoate) [prescribing information]. Jersey City, NJ: Organon LLC; June 2021.

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## **Approval And Revision History**

September 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- October 10, 2023: Effective 1/1/2024, Flovent Diskus and Flovent HFA removed from step 1 drug.
- October 8, 2024: No changes.

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## **Background, Product and Disclaimer Information**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.