HIGHMARK HEALTH OPTIONS

Updated: 06/2022
DMMA Approved: 06/2022

Request for Prior Authorization for Inhaled Corticosteroid Long Acting Beta Agonist Combination Medications
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Inhaled Corticosteroid Long Acting Beta Agonist Combination Medications require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Inhaled Corticosteroid Long Acting Beta Agonist Combination Medication Prior Authorization Criteria:

For all requests for Inhaled Corticosteroid Long Acting Beta Agonist Combination Medications the following criteria must be met in addition to diagnosis specific criteria below:

- If the request is for a non-preferred medication, must have trial and failure of or intolerance to the preferred medication(s) in the corresponding class.

Coverage may be provided with a diagnosis of **COPD** and the following criteria is met:

- Claims will pay at the point of sale when a diagnosis of COPD is entered and historical pharmacy claims data shows the member has tried a long-acting muscarinic antagonist (LAMA) or long-acting beta-2 agonist (LABA) within the past 180 days.
- For claims that do not pay at point of sale, must provide documentation showing the member has tried and failed or had an intolerance or contraindication to a long-acting muscarinic antagonist (LAMA) or a long-acting beta-2 agonist (LABA)

Coverage may be provided for a diagnosis of **mild asthma** when the following criteria is met:

- Claims will pay at the point of sale when a diagnosis of mild asthma is entered and historical pharmacy claims data shows the member has tried an inhaled corticosteroid (ICS) within the past 180 days.
- For claims that do not pay at point of sale, must provide documentation showing the member has tried and failed or had an intolerance or contraindication to an inhaled corticosteroid (ICS)

Coverage may be provided for a diagnosis of **moderate to severe asthma** when the following criteria is met:

- Claims will pay at the point of sale when a diagnosis of moderate to severe asthma is entered
- For claims that do not pay at the point of sale, coverage may be provided for a diagnosis of moderate to severe asthma.

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the member has at least one paid

prescription for an inhaled corticosteroid long acting beta agonist combination within the past 180 days
- For members who do not meet the automatic coverage criteria documentation is required indicating therapy is ongoing

➢ **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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INHALED CORTICOSTEROID/LONG ACTING BETA AGONIST COMBINATION MEDS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

For **Asthma:** What is the severity?
- ☐ **Mild Asthma:** Has the patient tried and failed an inhaled corticosteroid? ☐ Yes (please list below) ☐ No
- ☐ **Moderate/Severe Asthma**

For **COPD:** Has a long-acting beta-2 agonist (LABA) or long acting muscarinic antagonists (LAMA) been tried?
- ☐ Yes (please list below) ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date