Mass General Brigham
Health Plan

Antihistamines
Effective 06/05/2023

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	Quzyttir®(cetirizine injection) is available through the medical benefit only.		

Overview

No PA	Drugs that require PA
First Generation (Nonselective) Antihistamines	
Benadryl® # (diphenhydramine)*	clemastine syrup ¶
carbinoxamine 4 mg tablet and solution	
chlorpheniramine*	Karbinal ER®(carbinoxamine extended-release)
clemastinetablet§	Ryclora®(dexchlorpheniramine) solution ‖
cyproheptadine	Ryvent® (carbinoxamine) 6 mg tablet ‖
hydroxyzine hydrochloride	
Phenergan® # (promethazine)	
Vistaril® # (hydroxyzine pamoate)	
Second Generation (Selective) Antihistamines	
fexofenadine tablet*	
fexofenadine/pseudoephedrine*	Alavert®(loratadine orally disintegrating tablet) †
cetirizine syrup, tablet*	
cetirizine/pseudoephedrine*	Allegra®(fexofenadine) orally disintegrating tablet, suspension †, tablets †
	Clarinex®(desloratadine) tablet ‡
	Clarinex-D®(desloratadine/pseudoephedrine)
loratadine tablet, solution*	Claritin®Chewtabs, Liqui-gel capsule, Reditabs(loratadine) chewable tablet, ODT †
loratadine/pseudoephedrine*	desloratadine orally disintegrating tablet
levocetirizine tablet§	levocetirizine solution ‡§
	Quzyttir®(cetirizine injection) ^ ¶

	Zyrtec®(cetirizine) chewable tablet†, Liquid Gels, orally disintegrating tablet †
Intranasal Antihistamines	
azelastine 137 mcg nasal spray	azelastine 0.15% nasal spray ††
	Patanase®(olopatadine nasal spray) ‡
Combination Agents	
Dymista®#(azelastine/fluticasone propionate)	

#This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule or liquid) does not have an FDA "A"-rated generic equivalent.
*The generic OTC and, if any, generic prescription versions of the drug are payable without prior authorization.
†Available OTC –both brand and generic OTC require PA.
‡A-rated generic available, both brand and A-rated generic require PA.
§Agent is available as an OTC product. The OTC product is not covered.
^ This drug is available through the health care professional who administer the drug.
‖Represents a branded-generic formulation
¶Agent does not participate in the federal rebate program
†† Brand-name Astepro products are available OTC. The OTC products are not covered.

Approval Diagnosis:

- **Perennial or seasonal allergic rhinitis:** All agents
- **Non-allergic rhinitis:** All agents
- **Chronic idiopathic urticaria:** Oral antihistamines only
- **Acute urticaria:** Quzyttir

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization will be granted when all the following criteria has been met, and documentation has been submitted:

Ryvent® (carbinoxamine) 6 mg tablet
Karbinal ER® (carbinoxamine extended-release)

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy) or adverse reaction to **ONE** or contraindication to **ALL** intranasal corticosteroid agents *
3. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy) or adverse reaction to **TWO** or contraindication to **ALL** nonselective antihistamines available without prior authorization
4. If request is for carbinoxamine 6 mg tablet, paid claims or physician documented of inadequate response or adverse reaction to carbinoxamine 4 mg tablet
5. If request is for Karbinal ER® (carbinoxamine extended-release),the member must meet the above low cost alternative (LCA) trials and provide an inadequate response (defined by 14 days of therapy) or adverse reaction to immediate-release carbinoxamine solution as evident by paid claims within the last 180 days or physician documentation.

**If the diagnosis is chronic idiopathic urticaria, then trial with intranasal corticosteroid agent is not required*

clemastine syrup
Ryclora® (dexchlorpheniramine) solution
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Inadequate response or adverse reaction to **TWO** antihistamine solutions that do not require prior authorization
3. If request is for clemastine syrup, member must meet the above criteria and the prescriber must submit documentation of trials of alternatives with rebate or clinical rationale for the use of a non-rebate product (as per the Non-FDA approved and Non-rebate Medications guideline)

Clarinex®(desloratadine) tablet
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy) or adverse reaction to **ONE** of the following or contraindication to **ALL** of the following:
    a. loratadine
    b. cetirizine
    c. levocetirizine
3. If request is for Brand Name agent, the member must meet the above LCA trials and provide medical records documenting an inadequate response or adverse reaction to the generic equivalent being requested (as per the Brand Name guideline).

Alavert® (loratadine ODT)
Allegra® (fexofenadine) ODT, suspension
desloratadine ODT
Claritin® (loratadine) Chewtabs, Liqui-gel capsule, Reditabs, ODT
levocetirizine solution
Zyrtec® (cetirizine) chewable tablet, Liquid Gels, ODT
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Medical necessity for use of requested agent as noted by **ONE** of the following:
    a. Member utilizes tube feeding (G-tube/J-tube)
    b. Member has a swallowing disorder or condition affecting ability to swallow
    c. Member is < 13 years of age
3. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy) or adverse reaction to **TWO** of the following or contraindication to **ALL** of the following*:
    a. loratadine
    b. cetirizine
    c. levocetirizine
4. If request is for Brand Name agent, the member must meet the above LCA trials and provide medical records documenting an inadequate response or adverse reaction to the generic equivalent being requested (as per the Brand Name guideline).

**If the request is for desloratadine ODT and the member's age is between 6 months and 2 years, then cetirizine is the only LCA trial required (as it is also approved for children 6 months of age and older).*

Clarinex-D® (desloratadine/pseudoephedrine)
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy) or adverse reaction to **ONE** or contraindication to **ALL** intranasal corticosteroid agents *
3. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy), adverse reaction or contraindication to **BOTH** of the following:
    a. loratadine/pseudoephedrine
    b. cetirizine/pseudoephedrine

**If the diagnosis is chronic idiopathic urticaria, then trial with intranasal corticosteroid agent is not required.*

azelastine 0.15% nasal spray
Patanase® (olopatadine nasal spray)
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy) or adverse reaction to **ONE** or contraindication to **ALL** intranasal corticosteroid agents
3. Paid claims within the last 180 days or physician documented of inadequate response (defined by 14 days of therapy), adverse reaction or contraindication to azelastine 137 mcg nasal spray
4. For quantities greater than 1 bottle/month, prescriber must also provide documentation of an inadequate response to the manufacturer's recommended dosing.
5. If request is for Brand Name agent, the member must meet the above LCA trials and provide medical records documenting an inadequate response or adverse reaction to the generic equivalent being requested (as per the Brand Name guideline)

Quzyttir® (cetirizine injection)
Prescriber provides documentation of **ALL** of the following:

1. Diagnosis of acute urticaria
2. Physician documented of inadequate response, adverse reaction or contraindication to IM/IV diphenhydramine
3. Member must meet the above criteria and the prescriber must submit documentation of trials of alternatives with rebate or clinical rationale for the use of a non-rebate product (as per the Non-FDA approved and Non-rebate Medications guideline)

Continuation of Therapy
Reauthorization by physician will infer a positive response to therapy.

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.
2. The following quantity limits apply:

azelastine 0.15% nasal spray	1 bottle per 30 days
Patanase® (olopatadine nasal spray)	1 bottle per 30 days

Appendix

FDA-Approved Ages and Pregnancy Categories – Antihistamines and Intranasal Corticosteroids

Drug	FDA-Approved Age	Pregnancy Category/Breastfeeding*
Allegra® (fexofenadine)	Adults and children ≥ 6 months old	AAP: Maternal medication usually compatible with breastfeeding; infant risk is minimal
Astepro® (azelastine 0.15%)	Adults and children ≥ 6 years old	Pregnancy: MDX-fetal risk cannot be ruled out; breastfeeding: infant risk cannot be ruled out
azelastine 137 mcg nasal spray	Adults and children ≥ 6 months old	
Beconase® AQ (beclomethasone)	Adults and children ≥ 6 years old	
dexchlorpheniramine maleate	Adults and children ≥ 2 years old	
budesonide OTC nasal spray	Adults and children ≥ 6 years old	
Claritin® (loratadine)	Adults and children ≥ 2 years old	Pregnancy: MDX-fetal risk cannot be ruled out; breastfeeding: AAP: Maternal medication usually compatible with breastfeeding; infant risk is minimal
Clarinex® (desloratadine)	Adults and children ≥ 6 months old	Pregnancy: MDX-fetal risk cannot be ruled out; breastfeeding: infant risk cannot be ruled out
Flonase® (fluticasone)	Adults and children ≥ 4 years old	
Flonase® Sensimist (fluticasone furoate)	Adults and children ≥ 2 years old	
flunisolide nasal spray	Adults and children ≥ 6 years old	
fluticasone/ azelastine	Adults and children ≥ 6 years old	
Nasacort® Allergy 24HR OTC	Adults and children ≥ 2 years old	
Nasonex® (mometasone)	Adults and children ≥ 2 years old	
Omnaris® (ciclesonide)	Adults and children ≥ 6 years old	
Patanase® (olopatadine)	Adults and children ≥ 6 years old	
Qnasl® (beclomethasone) 80 µg	Adults and children ≥ 12 years old	
Qnasl® (beclomethasone) 40 µg	Children 4 to 11 years of age	

Rhinocort® Aqua (budesonide)	Adults and children ≥ 6 years old	
Sinuva® (mometasone furoate)	Adults ≥ 18 years old	
triamcinolone nasal spray	Adults and children ≥ 2 years old	
Veramyst® (fluticasone furoate)	Adults and children ≥ 2 years old	
Xhance® (fluticasone propionate)	Adults ≥ 18 years old	
Xyzal® (levocetirizine)	Adults and children ≥ 6 months old	
Zetonna® (ciclesonide)	Adults and children ≥ 12 years old	Pregnancy: MDX-fetal risk cannot be ruled out; breastfeeding: infant risk cannot be ruled out
Zyrtec® (cetirizine)	Adults and children ≥ 6 months old	

*Information obtained from Micromedex

References

N/A

Review History

02/08/2023 - Reviewed and created for Feb P&T; matched MH UPPL. Effective 4/1/23.
05/10/23 – Reviewed and updated for P&T. Added criteria for swallowing disorders. Updated language to require one or contraindication to all trial agents. Fexofenadine 60mg and 180mg tablets no longer require PA. Effective 6/5/23