Pharmacy Drug Policy & Procedure

Policy Name:	Non-Preferred ICS Inhalers	Policy #:	2386P

Purpose of the Policy

The purpose of this policy is to define the criteria for coverage of Arnuity Ellipta.

Statement of the Policy

Health Alliance Medical Plans will approve the use of Arnuity Ellipta when the following criteria have been met.

Criteria

1. Coverage Criteria

1.1 Documented diagnosis of asthma

1.2 Documentation of previous trial and subsequent failure, intolerance, or contraindication to Asmanex, and Pulmicort, and QVAR RediHaler

2. Approval Period

2.1 Initial Approval: 12 months

2.2 Subsequent Approvals: 2 years

CPT Codes

HCPCS Codes

References

1. Global Initiative for Asthma (GINA), Global Strategy for Asthma Management and Prevention, 2023. https://ginasthma.org/2023-gina-main-report/

Created Date: 10/07/15
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DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.