GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
LEUKOTRIENE MODIFIERS PA SUMMARY

Preferred	Non-Preferred
Montelukast generic Zafirlukast generic	Zyflo (zileuton) Zyflo CR (zileuton extended-release)

LENGTH OF AUTHORIZATION: 1 Year

NOTE: All agents require prior authorization.

PA CRITERIA:

Montelukast Chewables/Tablets Generic

- Approvable for members 1 year of age or older with a diagnosis of asthma who have experienced ineffectiveness for at least 3 months with agent(s) from any of the following classes: xanthines, long-acting beta agonist, short acting beta agonist, oral or inhaled steroids, or a mast cell stabilizer.
- Approvable for members 2 years of age or older with a diagnosis of seasonal or perennial allergic rhinitis who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or a history of intolerable side effects to two of the following (cetirizine, desloratadine, levocetirizine, loratadine) and a nasal steroid.
- Approvable for members 6-23 months of age with a diagnosis of perennial allergic rhinitis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or a history of intolerable side effect to desloratadine.
- Approvable for members 6 years of age or older with a diagnosis of exercise-induced bronchoconstriction who have experienced ineffectiveness with a short-acting beta agonist and an inhaled corticosteroid.

Montelukast 4 mg Granule Packets Generic

- Approvable for members 12-23 months of age with a diagnosis of asthma who have experienced ineffectiveness for at least 3 months with agent(s) from any of the following classes: xanthines, long-acting beta agonist, short acting beta agonist, oral or inhaled steroids, or a mast cell stabilizer.
- Approvable for members 6-23 months of age with a diagnosis of perennial allergic rhinitis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or a history of intolerable side effect to desloratadine.

Zafirlukast Generic

- Approvable for members 5 years of age or older with a diagnosis of asthma who have experienced ineffectiveness for at least 3 months with agent(s) from any of the following classes: xanthines, long-acting beta agonist, short acting beta agonist, oral or inhaled steroids, or a mast cell stabilizer.

Zyflo or Zyflo CR

- Approvable for members 12 years of age or older with a diagnosis of asthma who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or a history of intolerable side effects to the preferred products, montelukast and zafirlukast.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.