

## INTRANASAL ANTIHISTAMINES PA SUMMARY

<b>PREFERRED</b>	Astelin (brand), Astepro
<b>NON-PREFERRED</b>	Azelastine 0.1% nasal spray (generic), Patanase

**LENGTH OF AUTHORIZATION:** 1 Year

### PA CRITERIA:

*Patanase*

- ❖ Member must be 6 years of age or older with a diagnosis of seasonal allergic rhinitis

*AND*

- ❖ Submit documentation of current use, inadequate response, or intolerable side effects to a nasal steroid

*AND*

- ❖ Submit documentation of an inadequate response, allergies, contraindications, drug-to-drug interactions, or a history of intolerable side effects to Astelin nasal spray or Astepro nasal spray.

*For Azelastine 0.1% nasal spray (generic)*

- ❖ Submit a written letter of medical necessity stating the reason(s) brand Astelin nasal spray (preferred product) is not appropriate for the member..

### EXCEPTIONS:

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

### PA and Appeal Process:

- ❖ For online access to the PA process please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

### Quantity Level Limitations:

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