

## **Program: Leukotriene modifiers**

### **DESCRIPTION**

The purpose of this document is to provide approval criteria and guidelines for prior authorization of benefits for Leukotriene modifier medications. Claims submitted without obtaining prior authorization of benefits will reject on the pharmacy claim system.

### **Applicable lines of business**

RlteCare and Managed Pharmacy

### **Impacted Formulary Medications**

Singulair (montelukast) 4mg, 5mg Chew Tabs, 4mg Packets, 10mg Tablets

### **APPROVAL DURATION AND QUANTITY LIMITS**

Approval Duration: Lifetime

### **APPROVAL CRITERIA:**

For Singulair (montelukast), those patients that are under 5 years of age, or 5 years of age and over **AND** on either an inhaled corticosteroid (ICS) or B-agonist agent are exempt from this program.

I. Requests for Singulair (montelukast) may be approved if:

- A. The patient is under 5 years of age; **OR**
- B. The patient has a diagnosis of asthma; **OR**
- C. The patient has been on Singulair in the previous 180 days; **OR**
- D. The patient is being treated for allergic rhinitis; **AND**
- E. Documentation is provided for a treatment failure with one of the following:
  - 1. Intranasal steroid
  - 2. Prescription OR OTC less sedating/non-sedating antihistamine
  - 3. Astelin Nasal Spray

### **Look Back Criteria in Claims System**

Look back 180 days for asthma related medications including beta-agonists, inhaled corticosteroid, if yes, approve, if no, see additional look back below  
Look back 180 days for NSA OR intranasal steroid OR Astelin Nasal Spray, if yes approve, if no reject for PA