Select Inhaled Respiratory Agents

Policy #     00526
Original Effective Date: 01/01/2017
Current Effective Date: 06/19/2019

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Inhaled Corticosteroid Products

Based on review of available data, the Company may consider the inhaled corticosteroid products Aerospan®‡ (flunisolide), Alvesco®‡ (ciclesonide), Asmanex®‡ Twisthaler®‡ (mometasone furoate), Asmanex®‡ HFA (mometasone furoate), Pulmicort Flexhaler®‡ (budesonide), and Armonair™‡ Respiclick®‡ (fluticasone propionate) to be eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Aerospan (flunisolide), Alvesco (ciclesonide), Asmanex Twisthaler (mometasone furoate), Asmanex HFA (mometasone furoate), Pulmicort Flexhaler (budesonide), or Armonair Respiclick (fluticasone propionate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Arnuity™ Ellipta®‡ (fluticasone furoate), Flovent®‡ Diskus®‡ (fluticasone propionate), Flovent®‡ HFA (fluticasone propionate), or QVAR®‡ (beclomethasone dipropionate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Aerospan (flunisolide), Alvesco (ciclesonide), Asmanex Twisthaler (mometasone furoate), Asmanex HFA (mometasone furoate), Pulmicort Flexhaler (budesonide), or Armonair Respiclick (fluticasone propionate) WITHOUT clinical evidence or patient history that suggests the use of Arnuity Ellipta (fluticasone furoate),
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Flovent Diskus (fluticasone propionate), Flovent HFA (fluticasone propionate), or QVAR (beclomethasone propionate) will be/was ineffective or will/did cause an adverse reaction to the patient to be not medically necessary.**

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Inhaled Long Acting Beta Agonists (LABAs)

Based on review of available data, the Company may consider the inhaled long acting beta agonists Arcapta™ Neohaler™ (indacaterol) and Foradil® Aerolizer® (formoterol fumarate) to be eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Arcapta Neohaler (indacaterol) or Foradil Aerolizer (formoterol fumarate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Striverdi® Respimat® (olodaterol) or Serevent® Diskus (salmeterol xinafoate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Arcapta Neohaler (indacaterol) or Foradil Aerolizer (formoterol fumarate) WITHOUT clinical evidence or patient history that suggests the use of Striverdi Respimat (olodaterol) or Serevent Diskus (salmeterol xinafoate) will be/was ineffective or will/did cause an adverse reaction to the patient to be not medically necessary.**

When Services May Be Eligible for Coverage
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- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Nebulized Long Acting Chronic Obstructive Pulmonary Disease (COPD) Products

Based on review of available data, the Company may consider the nebulized long acting COPD products Brovana®† (arformoterol tartrate), Perforomist®† (formoterol fumarate), Lonhala™† Magnair™† (glycopyrrolate), and Yupelri®‡ (revefenacin) to be eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria

Coverage eligibility will be considered for Brovana (arformoterol tartrate), Perforomist (formoterol fumarate), Lonhala Magnair (glycopyrrolate), or Yupelri (revefenacin) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of TWO of the following preferred bronchodilating agents for COPD: Advair®‡ Diskus (fluticasone propionate/salmeterol, generics, Wixela™† Inhub), Serevent Diskus (salmeterol xinafoate), Spiriva®‡ Respimat®‡ (tiotropium bromide), Spiriva HandiHaler®‡ (tiotropium bromide), Anoro®‡ Ellipta (umeclidinium/vilanterol), Stiolo®‡ Respimat (tiotropium bromide/olodaterol), Striverdi Respimat (olodaterol), Incruse®‡ Ellipta (umeclidinium), or Symbicort®‡ (budesonide/formoterol fumarate dihydrate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Brovana (arformoterol tartrate), Perforomist (formoterol fumarate), Lonhala Magnair (glycopyrrolate), or Yupelri (revefenacin) WITHOUT clinical evidence or patient history that suggests the use of TWO of the following preferred bronchodilating agents for COPD: Advair Diskus (fluticasone propionate/salmeterol, generics, Wixela Inhub), Serevent Diskus (salmeterol xinafoate), Spiriva Respimat (tiotropium bromide), Spiriva HandiHaler (tiotropium bromide), Anoro Ellipta (umeclidinium/vilanterol), Stiolo Respimat (tiotropium bromide/olodaterol), Striverdi Respimat (olodaterol), Incruse Ellipta (umeclidinium), or Symbicort (budesonide/formoterol fumarate dihydrate) will be/was ineffective or will/did cause an adverse reaction to the patient to be not medically necessary.**
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When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

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Inhaled Corticosteroid/Long Acting Beta Agonist Combination Products (ICS/LABAs)

Based on review of available data, the Company may consider the inhaled corticosteroid/long acting beta agonist combination product AirDuo™ Respiclick (fluticasone propionate/salmeterol) to be eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for AirDuo Respiclick (fluticasone propionate/salmeterol) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Advair Diskus (fluticasone propionate/salmeterol, generics, Wixela Inhub), Advair HFA (fluticasone propionate/salmeterol), Breo® Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/formoterol fumarate dihydrate), the branded generic Fluticasone Propionate/Salmeterol (branded generic of AirDuo Respiclick), or Dulera® (mometasone furoate/formoterol furoate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of AirDuo Respiclick (fluticasone propionate/salmeterol) WITHOUT clinical evidence or patient history that suggests the use of Advair Diskus (fluticasone propionate/salmeterol, generics, Wixela Inhub), Advair HFA (fluticasone propionate/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/formoterol fumarate dihydrate), the branded generic Fluticasone Propionate/Salmeterol (branded generic of AirDuo Respiclick), or Dulera (mometasone furoate/formoterol furoate) will be/was ineffective or will/did cause an adverse reaction to the patient to be not medically necessary.**
When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Inhaled Long Acting Antimuscarinic Agents (LAMAs)

Based on review of available data, the Company may consider the inhaled long acting antimuscarinic agents Tudorza® Pressair® (aclidinium bromide) and Seebri™ Neohaler (glycopyrrolate) to be eligible for coverage** when the below patient selection criterion is met:

Patient Selection Criteria
Coverage eligibility will be considered for Tudorza Pressair (aclidinium bromide) or Seebri Neohaler (glycopyrrolate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Spiriva Respimat (tiotropium bromide), Spiriva HandiHaler (tiotropium bromide), or Incruse Ellipta (umeclidinium) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Tudorza Pressair (aclidinium bromide) or Seebri Neohaler (glycopyrrolate) WITHOUT clinical evidence or patient history that suggests the use of Spiriva Respimat (tiotropium bromide), Spiriva HandiHaler (tiotropium bromide), or Incruse Ellipta (umeclidinium) will be/was ineffective or will/did cause an adverse reaction to the patient to be not medically necessary.**

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

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**Inhaled Long Acting Antimuscarinic Agent/Long Acting Beta Agonist Combination Products (LAMA/LABAs)**

Based on review of available data, the Company may consider the inhaled long acting antimuscarinic agent/long acting beta agonist combination products Bevespi Aerosphere™ (glycopyrrolate/formoterol fumarate) and Utibron™ Neohaler (indacaterol/glycopyrrolate) to be **eligible for coverage** when the below patient selection criterion is met:

**Patient Selection Criteria**
Coverage eligibility will be considered for Bevespi Aerosphere (glycopyrrolate/formoterol fumarate) or Utibron Neohaler (indacaterol/glycopyrrolate) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Anoro Ellipta (umeclidinium/vilanterol) or Stiolto Respimat (tiotropium bromide/olodaterol) will be/was ineffective or will/did cause an adverse reaction to the patient.

**When Services Are Considered Not Medically Necessary**
Based on review of available data, the Company considers the use of Bevespi Aerosphere (glycopyrrolate/formoterol fumarate) or Utibron Neohaler (indacaterol/glycopyrrolate) **WITHOUT** clinical evidence or patient history that suggests the use of Anoro Ellipta (umeclidinium/vilanterol) or Stiolto Respimat (tiotropium bromide/olodaterol) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary.**

**When Services May Be Eligible for Coverage**
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

**Inhaled Short Acting Beta Agonists (SABAs)**

Based on review of available data, the Company may consider the short acting beta agonists Proventil® HFA (albuterol sulfate), Xopenex® HFA (levalbuterol tartrate), and branded generic Albuterol HFA to be **eligible for coverage** when the below patient selection criterion is met:
Patient Selection Criteria
Coverage eligibility will be considered for Proventil HFA (albuterol sulfate), Xopenex HFA (levalbuterol tartrate), or branded generic Albuterol HFA when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of ProAir® RespiClick (albuterol sulfate), ProAir HFA (albuterol sulfate) or Ventolin® HFA (albuterol sulfate) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary
Based on review of available data, the Company considers the use of Proventil HFA (albuterol sulfate), Xopenex HFA (levalbuterol tartrate), or branded generic Albuterol HFA WITHOUT clinical evidence or patient history that suggests the use of ProAir RespiClick (albuterol sulfate), ProAir HFA (albuterol sulfate), or Ventolin HFA (albuterol sulfate) will be/was ineffective or will/did cause an adverse reaction to the patient to be not medically necessary.**

<table>
<thead>
<tr>
<th>Class</th>
<th>Non-Preferred Products</th>
<th>Preferred Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaled Corticosteroids (ICS)</td>
<td>Aerospan, Alvesco, Asmanex Twisthaler, Asmanex HFA, Pulmicort Flexhaler, Armonair Respiclick</td>
<td>Arnuity Ellipta, Flovent Diskus, Flovent HFA, QVAR</td>
</tr>
<tr>
<td>Inhaled Long Acting Beta Agonists (LABAs)</td>
<td>Arcapta Neohaler, Foradil Aerolizer</td>
<td>Striverdi Respimat, Serevent Diskus</td>
</tr>
<tr>
<td>Nebulized Long Acting COPD Products</td>
<td>Brovana, Perforimist, Lonhala Magnair, Yupelri</td>
<td>Advair Diskus (e.g. generics, Wixela Inhub), Serevent Diskus, Spiriva Respimat, Spiriva HandiHaler, Anoro Ellipta, Stiolo Respimat, Striverdi Respimat, Incruse Ellipta</td>
</tr>
</tbody>
</table>
### Background/Overview

The various products mentioned in this policy are approved for use in COPD and/or asthma patients, depending on the particular product.

### Rationale/Source

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests the preferred products listed in this policy will be ineffective or cause an adverse reaction to the patient. Based on a review of the available data and in the absence of any

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of the caveats mentioned, there is no advantage of using the non-preferred agents mentioned in this policy over the preferred agents mentioned in this policy.

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**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/08/2016</td>
<td>Medical Policy Committee review</td>
</tr>
<tr>
<td>09/21/2016</td>
<td>Medical Policy Implementation Committee approval. New policy.</td>
</tr>
<tr>
<td>08/03/2017</td>
<td>Medical Policy Committee review</td>
</tr>
<tr>
<td>08/23/2017</td>
<td>Medical Policy Implementation Committee approval. Moved Stiolto Respimat to a preferred agent. New drug (AirDuo) placed in the non-preferred position. Branded generic of AirDuo (fluticasone/salmeterol) place in preferred position. Adjust existing criteria based on these changes.</td>
</tr>
<tr>
<td>01/04/2018</td>
<td>Medical Policy Committee review</td>
</tr>
<tr>
<td>01/17/2018</td>
<td>Medical Policy Implementation Committee approval. Placed new drug, Armonair Respliclick, in the non-preferred column for ICS products. Added a new section for new drug class (LAMA/ICS/LABA) and placed Trelegy Ellipta in the preferred column.</td>
</tr>
<tr>
<td>06/07/2018</td>
<td>Medical Policy Committee review</td>
</tr>
<tr>
<td>06/20/2018</td>
<td>Medical Policy Implementation Committee approval. Switched Dulera to a preferred product. Added Lonhala Magnair to the policy. Changed nebulized long acting beta agonists to nebulized long acting COPD products. Added Advair Diskus and Symbicort as preferred options prior to Brovana, Perforomist, and Lonhala Magnair.</td>
</tr>
<tr>
<td>06/06/2019</td>
<td>Medical Policy Committee review</td>
</tr>
<tr>
<td>06/19/2019</td>
<td>Medical Policy Implementation Committee approval. Added the branded generic Albuterol HFA as a non-preferred option. Added the generics for Advair Diskus (generic, Wixela Inhub) as preferred options for therapy. Added a new product, Yupelri, to the policy in a non-preferred position.</td>
</tr>
</tbody>
</table>

Next Scheduled Review Date: 06/2020

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

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A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
   1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
   2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
   3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
   A. In accordance with nationally accepted standards of medical practice;
   B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
   C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.
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NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.