UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Ophthalmic Antihistamine

Program	Step Therapy
Medication	Azelastine Ophthalmic Solution, Olopatadine Ophthalmic Solution (Rx formulation)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New York, New York EPP, Rhode Island, Pennsylvania CHIP, New Jersey, South Carolina
Issue Date	12/2009
Pharmacy and Therapeutics Approval Date	10/2020
Effective Date	1/2021

1. Background:

Azelastine ophthalmic solution is indicated for the treatment of itching of the eye associated with allergic conjunctivitis.

Olopatadine ophthalmic solution is indicated for the treatment of the signs and symptoms of allergic conjunctivitis.

2. Coverage Criteria:

A. <u>Authorization Criteria</u>

1. **Azelastine Ophthalmic Solution** will be approved for patients who have a history of failure, contraindication, or intolerance to Pataday OTC.

Authorization will be issued for 12 months.

2. **Olopatadine Ophthalmic Solution (Rx formulation)** will be approved for patients who have **both** of the following:

   a. History of failure, contraindication, or intolerance to Pataday OTC

   -AND-

   b. History of failure, contraindication, or intolerance to **one** of the following
   - Azelastine ophthalmic solution

- Ketotifen
- Cromolyn

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Azelastine Ophthalmic Solution [package insert]. Bridgewater, NJ: Alembic Pharmaceuticals; March 2019.
2. Olopatadine Ophthalmic Solution [package insert]. Lake Forest, IL: Akorn Inc.; November 2017.

Program	Step Therapy –Ophthalmic Antihistamine
Change Control	
Date	Change
12/2009	Criteria were taken from the previously approved AmeriChoice policy. Policy was reformatted.
12/2010	Annual review, no change
3/2011	Annual review, no change
3/2012	Annual review, no change
3/2013	Annual review, no change
11/2016	Annual review, updated policy template and added standard authorization duration of 12 months
11/2017	Annual review. Updated references. Combined all requirements into one statement to align with standard language found in other policies.
11/2018	Annual review. Updated background and references.
12/2019	Annual review. Renamed policy from Optivar to Azelastine Ophthalmic Solution since only available as a generic. Updated criteria to remove automated step therapy language.
10/2020	Renamed policy from Azelastine Ophthalmic Solution to Opthalmic Antihistamine. Updated step for azelastine ophthalmic solution to step through Pataday OTC. Added olopatadine to

	policy and added step therapy criteria. Updated background and references.