UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Cough and Cold Medications- TEXAS

Program	Prior Authorization
Medication	Cough and Cold Medications
Markets in Scope	Texas

1. Background:

Drugs Requiring Prior Authorization: Age and PDL Related Rejections

ALAHIST CF TABLET	ED A-HIST DM TABLET
ALAHIST DM LIQUID	ED A-HIST LIQUID
ALA-HIST DM LIQUID	ED BRON GP LIQUID
ALA-HIST PE TABLET	ED CHLORPED D PEDIATRIC DROPS
ALLFEN DM TABLET	ED-A-HIST 4 MG-10 MG TABLET
AP-HIST DM LIQUID	ED-A-HIST DM LIQUID
APRODINE TABLET	ED-A-HIST PSE TABLET
BENZONATATE 100 MG CAPSULE	ENDACOF-DM LIQUID
BENZONATATE 150 MG CAPSULE	EXTRA ACTION COUGH SYRUP
BENZONATATE 200 MG CAPSULE	GUAIFENESIN 100 MG/5 ML SYRUP
BROMFED DM COUGH SYRUP	GUAIFENESIN ER 1,200 MG TABLET
BROMPHENIR-PSEUDOEPHED-DM SYR	GUAIFENESIN/PSE ER 600-60 MG
BROTAPP DM LIQUID	HISTEX-DM SYRUP
BROTAPP LIQUID	HISTEX-PE SYRUP
CHEST CONGESTION RELIEF PE	IOPHEN DM-NR LIQUID
CHEST CONGESTION RELIEF TABLET	IOPHEN NR LIQUID
CHILD DELSYM COUGH 30 MG/5 ML	KIDKARE COUGH & COLD LIQUID
CHILD DELSYM COUGH+CHEST DM LQ	KID'S MUCINEX MINI-MELTS PACK
CHILD MUCINEX CONGEST-COUGH LQ	LODRANE D CAPSULE
CHILD MUCINEX MULTI-SYMPTOM LQ	LOHIST-D LIQUID
CHILDREN COLD & COUGH DM ELIXI	LOHIST-DM SYRUP
CHILDREN'S MUCINEX COUGH LIQ	LORTUSS DM LIQUID
CHL MUCINEX CHEST CONGEST LIQ	LORTUSS LQ LIQUID
CHLD MUCINEX STUFFY NOSE-COLD	MAXIPHEN DM TABLET
CHLO TUSS LIQUID	MAXIPHEN TABLET
COUGH DM 30 MG/5 ML SUSPENSION	M-END DMX LIQUID
COUGH SYRUP 200 MG/10 ML	M-HIST DM LIQUID
DALLERGY 1-2.5 MG/ML DROPS	MUCINEX COUGH MINI-MELT PACK
DALLERGY 1-5 MG TABLET	MUCINEX D ER 1,200-120 MG TABLET
DECONEX DMX TABLET	MUCINEX D ER 600-60 MG TABLET
DECONEX IR TABLET	MUCINEX DM ER 1,200-60 MG TAB
DELSYM 30 MG/5 ML SUSPENSION	MUCINEX DM ER 600-30 MG TABLET
DELSYM COUGH + CHEST CONGST DM LQ	MUCINEX ER 1,200 MG TABLET
DEXTROMETHORPHAN ER 30 MG/5 ML	MUCINEX ER 600 MG TABLET
DIMAPHEN DM ELIXIR	MUCINEX FAST-MAX CONGEST-COUGH
DIMAPHEN ELIXIR	MUCINEX FAST-MAX DM MAX LIQUID

MUCINEX SINUS-MAX NASAL SPRAY	ROBAFEN COUGH 15 MG LIQUIDGEL
MUCUS RELIEF 400 MG TABLET	ROBAFEN DM CGH-CHEST CONG SYRUP
MUCUS RELIEF SINUS TABLET	ROBAFEN DM COUGH LIQUID
NASAL DECONGESTANT 0.05% SPRAY	ROBAFEN-DM SYRUP
NASOPEN PE LIQUID	RU-HIST D 10-4 MG TABLET
NINJACOF LIQUID	RYMED TABLET
NOHIST-DM LIQUID	RYNEX DM LIQUID
NOHIST-LQ LIQUID	RYNEX PE LIQUID
NOSE DROPS	RYNEX PSE LIQUID
ORGAN-I NR 200 MG TABLET	SILTUSSIN DM COUGH SYRUP
PEDIATRIC COUGH-COLD LIQUID	SILTUSSIN DM DAS LIQUID
PHENYLEPHRINE-PYRILAMINE 10-25	SILTUSSIN SA 100 MG/5 ML SYR
POLY HIST FORTE TABLET	SM NASAL SPRAY 0.05%
POLY-HIST DM LIQUID	SM TUSSIN DM LIQUID
POLY-HIST PD LIQUID	SM TUSSIN DM SYRUP
POLY-VENT DM TABLET	STAHIST AD LIQUID
POLY-VENT IR TABLET	STAHIST AD TABLET
	SUDOGEST SINUS & ALLERGY TAB
	TUSSIN 100 MG/5 ML SYRUP
Q-TUSSIN 100 MG/5 ML SOLUTION	TUSSIN DM CLEAR LIQUID
Q-TUSSIN DM SYRUP	TUSSIN DM LIQUID
RESCON TABLET	TUSSIN DM SYRUP
RESCON-DM LIQUID	VANACOF DM LIQUID
RESCON-GG LIQUID	VANACOF LIQUID
RESPAIRE-30 CAPSULE	VANACOF-8 LIQUID
ROBAFEN 100 MG/5 ML SYRUP	VANATAB AC CAPLET
ROBAFEN CF LIQUID	VANATAB DM CAPLET

Opioid Containing Cough and Cold Products

HYDROCODONE W/ HOMATROPINE TAB 5-1.5 MG
HYDROCODONE W/ HOMATROPINE SYRUP 5-1.5 MG/5ML
PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML
PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML
PSEUDOEPH-CHLORPHEN W/ HYDROCODONE SOLN 60-4-5 MG/5ML
GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML
GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML
HYDROCODONE-GUAIFENESIN SOLN 2.5-200 MG/5ML
PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-100 MG/5ML
PSEUDOEPHEDRINE W/ COD-GG SOLN 30-10-100 MG/5ML
PSEUDOEPHEDRINE W/ HYDROCODONE-GG SOLN 30-2.5-200 MG/5ML
HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML

2. Coverage Criteria:

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A. <u>Authorization Criteria- Age and PDL Related Rejections for Non-Opioid Containing Products</u>

1. The patient is at least 2 years of age.

-AND-

2. If the request is for a non-preferred medication the patient must have a history of failure, contraindication or intolerance to a trial of at least **<u>one</u>** preferred product within the past 180 days.

Authorization will be issued for 30 days.

B. <u>Opioid Containing Cough and Cold Products</u>

Quantity Limit Rules:

- **120mL/fill**
- **360mL/30 days**

1. Criteria for Morphine Equivalent Dosing (MED) Reviews

a. Doses exceeding the cumulative MED of 90 mg will be approved up to the requested amount if the prescriber attests they are aware of patient's current opioid therapy and MED dose and feels the treatment with the requested product is medically necessary.

Authorization will be issued for up to 30 days for cough and cold related treatment. The authorization should be entered for the MED requested.

2. Criteria for Requests Exceeding the Quantity Limit

a. Requests exceeding the quantity limit will be approved based on **<u>both</u>** of the following:

i. Doses exceeding the quantity limit will be approved up to the requested amount if the prescriber attests that a larger quantity is medically necessary.

-AND-

ii. The requested dose is within FDA maximum dose per day, where an FDA maximum dose per day exists.

Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.

3. <u>Criteria- Age and PDL Related Rejections for Opioid Containing Products</u>

a. The patient is at least 18 years of age.

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-AND-

b. If the request is for a non-preferred medication the patient must have a history of failure, contraindication or intolerance to a trial of at least one preferred cough and cold product within the last 180 days.

Authorization will be issued for 30 days.

Program	Program type – Prior Authorization
Change Control	
Date	Change
8/2016	New program
10/2017	Added criteria for opioid containing cough and cold products to align with opioid products criteria. Added non-preferred criteria.
5/2018	Added quantity limit criteria to opioid containing cough and cold section. Updated applicable drugs which this policy applies to. Go live 7/1/18.
6/2019	Removed non opioid containing promethazine products