

PHARMACY GUIDELINE – 21

Page 1 of 1

UNIVERSITY PHYSICIANS HEALTH PLANS

(Maricopa Health Plan)

PHARMACY REFERRAL GUIDELINE

LEUKOTRIENE INHIBITORS

- FDA Approved Indications
 - Chronic asthma (Montelukast - Singulair®; Zafirlukast - Accolate®)
 - Allergic rhinitis (Montelukast - Singulair®)
- Criteria for Use
 - Chronic asthma
 - Must be on inhaled corticosteroids with demonstrated compliance for at least three months (regular prescription refills documented in pharmacy profile).
 - Initial approval for three months. Must provide objective evidence of improvement for further authorization. Examples of supportive documentation include pulmonary function tests, spirometry, use of short-acting beta-agonist, asthma-related hospitalizations, and emergency department/urgent care visits for asthma.
 - Allergic rhinitis (Montelukast - Singulair® only)
 - Most have a documented trial of an antihistamine **and** a nasal steroid for at least three months with inadequate control.
 - Initial approval for three months. Must provide evidence of improvement for further authorization.

Approved by the Pharmacy and Therapeutics Committee 2/06; Revised and Approved by the Pharmacy and Therapeutics Committee 8/07; Reviewed 6/06, 1/08, 5/09