Non-Sedating Antihistamines
Cetirizine (Cetirizine Rx), Desloratadine (Clarinex), Levocetirizine (Xyzal)

Effective: 7/1/15

<table>
<thead>
<tr>
<th>Clinical Documentation and Prior Authorization Required</th>
<th>Type of Review – Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Covered</td>
<td>✓ Type of Review – Clinical Review</td>
</tr>
<tr>
<td></td>
<td>Fax: 617-673-0988</td>
</tr>
<tr>
<td>Pharmacy (RX) or Medical (MED) Benefit</td>
<td>✓ RX Department to Review</td>
</tr>
</tbody>
</table>

OVERVIEW

FDA-APPROVED INDICATIONS
Cetirizine is indicated for the temporary relief of symptoms associated with upper respiratory allergies, and for the relief of itching due to urticaria.

Desloratadine is indicated for the relief of the nasal and non-nasal symptoms of perennial allergic rhinitis in patients 6 months of age and older, for the relief of the nasal and non-nasal symptoms of seasonal allergic rhinitis in patients 2 years of age and older, and for the symptomatic relief of pruritus and reduction in the number and size of hives in patients 6 months of age and older.

Levocetirizine is indicated for the relief of symptoms associated with perennial allergic rhinitis in patients 6 months of age and older, for the relief of symptoms of seasonal allergic rhinitis in patients 2 years of age and older, and for the treatment of uncomplicated skin manifestations of chronic idiopathic urticarial in patients 6 months of age and older.

PHARMACY COVERAGE GUIDELINES
Tufts Health Plan – Network Health may authorize coverage of a non-preferred non-sedating antihistamine for members when one of the following criterions is met and limitations do not apply:

Desloratadine (Clarinex), levocetirizine (Xyzal)
- The member tried and failed therapy with, or the provider indicates clinical inappropriateness of therapy with both a loratadine- and a cetirizine-containing agent OR
- The member is between 6 months and 2 years of age and has tried and failed therapy with, or the provider indicates clinical inappropriateness of therapy with a cetirizine-containing agent.

Cetirizine oral syrup or solution (Rx)
- The member tried and failed therapy with, or the provider indicates clinical inappropriateness of therapy with over-the-counter (OTC) cetirizine syrup or solution.

Upon renewal,
- The member has had an office visit and has been re-assessed for this condition within the past year, and continued therapy with this medication is considered medically necessary.

LIMITATIONS
- Approval will be limited to one year.
- Requests for brand-name products, with AB-rated generics, will be reviewed according to Brand Name criteria.

CODES
None

REFERENCES
Pharmacy Medical Necessity Guidelines

Non-Sedating Antihistamines


7. Clarinex (desloratadine) [prescribing information]. Whitehouse Station, NJ: Merck & Co, Inc; April 2014.

APPROVAL HISTORY

- 2/10/15: Reviewed by the Pharmacy and Therapeutics Committee; approval duration is limited to one year; criteria for prescription cetirizine modified to a single trial with OTC cetirizine.

BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION

Pharmacy Medication Request Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medication Request Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medication Request Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medication Request Guidelines apply to all insured offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable Preferred Drug List (formulary) in the pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to the Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.