

PRIOR AUTHORIZATION POLICY

- POLICY:** Pulmonary – Corticosteroid/Long-Acting Beta₂-Agonist Combination Inhalers Prior Authorization Policy
- Advair Diskus[®] (fluticasone propionate/salmeterol inhalation powder – GlaxoSmithKline, generic [including Wixela Inhub[®]])
 - Advair[®] HFA (fluticasone propionate/salmeterol inhalation aerosol – GlaxoSmithKline)
 - AirDuo[®] Digihaler[™] (fluticasone propionate/salmeterol inhalation powder – Teva)
 - AirDuo[®] RespiClick[®] (fluticasone propionate/salmeterol inhalation powder – Teva, generic)
 - Breo[®] Ellipta[®] (fluticasone furoate/vilanterol inhalation powder – GlaxoSmithKline; generic)
 - Dulera[®] (mometasone furoate/formoterol fumarate inhalation aerosol – Merck)
 - Symbicort[®] (budesonide/formoterol fumarate inhalation aerosol – AstraZeneca, generic)

REVIEW DATE: 07/27/2022

OVERVIEW

The corticosteroid/long-acting beta₂-agonist (LABA) combination inhalers are indicated for the treatment of asthma.¹⁻⁶ Age indications vary by agent. Fluticasone propionate and salmeterol inhalation powder (Advair Diskus, generics [including Wixela Inhub]), Breo Ellipta, and Symbicort are also indicated for the maintenance treatment of airflow obstruction and reducing exacerbations in patients with chronic obstructive lung disease (COPD), including chronic bronchitis and/or emphysema.^{1,3,5} Advair HFA and Dulera are not FDA-approved for the treatment of COPD; however, both products have been studied for this use.^{2,4,7-9} The AirDuo products also have not specifically been studied in patients with COPD. However, these agents were filed as a New Drug Application under Section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act.⁶ This approval pathway relies in part upon evidence not developed by the applicant. In the case of these agents, the literature and safety and effectiveness evidence supporting the approval and use of Advair Diskus (indicated in patients with COPD) are considered part of the evidence supporting the approval and use of the AirDuo products.

Guidelines

The 2022 Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for the diagnosis, management, and prevention of COPD support the use of combination inhaled corticosteroid (ICS)/LABA therapy in select highly symptomatic patients who are at high risk for COPD exacerbations.¹⁰ The ICS/LABAs are also featured prominently in the 2022 Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention. They are recommended as part of the step-wise treatment algorithm for patients ≥ 6 years of age.²⁹ European Respiratory Society (ERS) guidelines on the diagnosis and treatment of chronic cough in adults and children (2020) recommend a short-term trial (2 to 4 weeks) of ICS and long-acting bronchodilator (e.g. a LABA) combination in adults with chronic cough and fixed airflow obstruction.³⁰

Other Uses with Supportive Evidence

There are also data to support the use of ICS/LABA inhalers in patients with postinfectious cough. Subacute postinfectious cough may have multiple possible underlying etiologies, including asthma.^{11,12} The underlying cause of the cough must be determined before making therapeutic decisions. In this situation, ICS/LABA combination therapy may be used as diagnostic empiric therapy in determining the cause of cough (i.e., rule out asthma). When a patient with subacute cough presents with wheezes, rhonchi, or crackles with a normal chest radiograph, it may be a reasonable option to consider therapy with an inhaled bronchodilator and ICS. If cough following an upper respiratory tract infection persists for > 8 weeks, diagnoses other than postinfectious cough should be considered.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of the Corticosteroid/Long-Acting Beta₂-Agonist Inhalers. The purpose of this policy is to support the use of the corticosteroid/long-acting beta₂-agonist combination inhalers in chronic conditions where the products are indicated or their use is appropriate. All approvals are provided for the duration listed below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

Automation: Prescription claims (prior 130 days) for respiratory medications (e.g., leukotriene receptor antagonists; xanthines; inhaled mast cell stabilizers; oral and inhaled beta-agonists; inhaled corticosteroids, inhaled anticholinergic agents) are used as a surrogate marker for a diagnosis of asthma or chronic obstructive pulmonary disease (COPD). If use of these medications is not met at the point-of-service, coverage will be determined by prior authorization criteria. When available, the ICD-10 codes for asthma and COPD (including chronic bronchitis/emphysema) will also be used in automation to generate an approval of the requested medication (see Appendix A).

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of the Corticosteroid/Long-Acting Beta₂-Agonist Inhalers is recommended in those who meet one of the following criteria:

FDA-Approved Indications

- 1. Asthma/Reactive Airway Disease.** Approve for 1 year.
- 2. Chronic Obstructive Pulmonary Disease.** Approve for 1 year.
- 3. Chronic Bronchitis.** Approve for 1 year.
- 4. Emphysema.** Approve for 1 year.

Other Uses with Supportive Evidence

- 5. Postinfectious Cough.** Approve for 2 months.

Note: Postinfectious cough is cough that persists after an acute respiratory infection has resolved.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of the Corticosteroid/Long-Acting Beta₂-Agonist Inhalers is not recommended in the following situations:

- 1. Acute Cough Associated with the Common Cold.** Note: This includes symptoms associated with a current rhinovirus infection.
There are no data to support the use of ICS/LABA combination therapy in treating this condition. American College of Chest Physicians (ACCP) guidelines for the treatment of acute cough associated with the common cold do not recommend using an ICS or a bronchodilator in treating this condition.^{11,26}
- 2. Chronic Cough due to Gastroesophageal Reflux Disease (GERD).** There are no data to support the use of ICS/LABA combination therapy in treating this condition. The ACCP guidelines for the management of chronic cough due to GERD recommend treatment of the underlying condition and do not mention the use of any inhaled therapies.^{13,24}
- 3. Acute Cough due to an Acute Respiratory Infection.** Note: Examples of an acute respiratory infection are acute bronchitis, sinusitis, influenza, or pneumonia. An acute exacerbation of chronic bronchitis is not the same as acute bronchitis.
ACCP guidelines for the management of acute cough due to acute bronchitis in immunocompetent adult outpatients do not recommend routine use of inhaled corticosteroids and inhaled beta-agonists.¹⁴ Current evidence is not sufficient to prove that these therapies are safe and effective at reducing the severity and duration of cough in this setting. Bronchodilators are also not a recommended therapeutic option in treating cough associated with acute bacterial sinusitis.¹² Additional ACCP guidelines for the management of acute cough due to suspected pneumonia or influenza state that there is insufficient evidence on the use of nonantibiotic symptomatic therapies such as ICSs or bronchodilators.²⁶ There are no data to support the use of ICS/LABA combination therapy in treating these conditions.
- 4. Chronic Cough due to Non-Asthmatic Eosinophilic Bronchitis (NAEB).** There are no data to support the use of ICS/LABA combination therapy in treating this condition. Per the guidelines for the management of chronic cough due to NAEB from ACCP ICSs are the recommended first-line treatment.^{11,23} One of the clinical characteristics of NAEB is chronic cough without evidence of variable airflow obstruction or airway hyperresponsiveness. As a result, a beta-agonist bronchodilator would not be expected to be useful in treating this condition.
- 5. Chronic Cough due to Bronchiolitis.** The ACCP guidelines do not recommend bronchodilators as a therapeutic option in treating bronchiolitis.^{11,15} Use of asthma medications is discouraged unless other evidence of asthma is present. Guidelines from the American Academy of Pediatrics regarding the diagnosis and management of bronchiolitis (2014) also do not recommend inhaled corticosteroids or bronchodilators be routinely used in the management of bronchiolitis.¹⁶
- 6. Chronic Cough due to Bronchiectasis.** Limited data are available with budesonide/formoterol (foreign formulation of Symbicort) for the treatment of non-cystic fibrosis (CF) bronchiectasis.^{17,18} ACCP guidelines note that in patients with bronchiectasis due to CF or other causes, treatment of respiratory infections and airway clearance techniques are the mainstays of management.²⁷ In patients with airflow obstruction and/or bronchial hyperreactivity (e.g., asthma and/or COPD), bronchodilators may be of benefit.^{11,19} However, the ACCP guidelines and the British Thoracic Society (BTS) guidelines do not recommend treatment with ICSs. Bronchiectasis guidelines from the European Respiratory Society also recommend against offering ICSs to adult patients with bronchiectasis.²⁰

There may be a role for combination ICS/LABA therapy in patients with coexisting asthma or COPD, but there is no evidence to support this therapy in patients without these concomitant conditions.^{19,20}

7. **Whooping Cough/Pertussis.** There are no data to support the use of ICS/LABA combination therapy in treating this condition. According to the ACCP guidelines, LABAs and corticosteroids should not be offered to patients with whooping cough as there is no evidence to suggest benefit.¹¹ Although short-acting beta-agonists (SABA) [along with other treatments] have been proposed as standard treatment for whooping cough, one review article reported that treatment with the SABA salbutamol resulted in no change in coughing.²¹
8. **Angiotensin-Converting Enzyme (ACE) Inhibitor-Induced Cough.** There are no data to support the use of ICS/LABA combination therapy in treating this condition. Discontinuation of the ACE inhibitor is the only uniformly effective treatment for ACE inhibitor-induced cough. In those patients in whom the ACE inhibitor cannot be discontinued, pharmacologic therapy aimed at suppressing cough should be attempted. ICSs and beta-agonists are not recommended therapeutic options.¹¹
9. **Psychogenic Cough/Habit Cough/Tic Cough.** There are no data to support the use of ICS/LABA combination therapy in treating these conditions. Non-pharmacological therapies, such as behavior modification, hypnosis and psychiatric therapy are the mainstays of treatment.^{11,22}
10. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

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APPENDIX A

ICD-10 Codes Automated for Asthma and COPD

ICD-10 Codes	Code Description
J41*	Simple and mucopurulent chronic bronchitis
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43*	Emphysema
J43.0	Unilateral pulmonary emphysema (MacLeod's syndrome)
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified
J44*	Other chronic obstructive pulmonary disease
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J45*	Asthma
J45.2*	Mild intermittent asthma
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma with (acute) exacerbation
J45.22	Mild intermittent asthma with status asthmaticus
J45.3*	Mild persistent asthma
J45.30	Mild persistent asthma, uncomplicated
J45.31	Mild persistent asthma with (acute) exacerbation
J45.32	Mild persistent asthma with status asthmaticus
J45.4*	Moderate persistent asthma
J45.40	Moderate persistent asthma, uncomplicated
J45.41	Moderate persistent asthma with (acute) exacerbation
J45.42	Moderate persistent asthma with status asthmaticus
J45.5*	Severe persistent asthma
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J45.9*	Other and unspecified asthma
J45.90*	Unspecified asthma
J45.901	Unspecified asthma with (acute) exacerbation
J45.902	Unspecified asthma with status asthmaticus
J45.909	Unspecified asthma, uncomplicated
J45.99*	Other asthma
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma

COPD – Chronic obstructive pulmonary disease; * Indicates the inclusion of subheadings.