MEDICAL MUTUAL®

Drug Policy

Policy:	Epinephrine Auto-Injectors Preferred Step Therapy Policy	Annual Review Date: 07/20/2023 Last Revised Date: 09/21/2023

OVERVIEW

Anaphylaxis is an acute, serious life-threatening generalized or systemic hypersensitivity reaction. It is typically (but not always) mediated by an immunologic mechanism that involves a sudden systemic release of mast cells and basophil mediators. Anaphylaxis is highly likely when any one of the following three criteria is fulfilled: 1) the acute onset of a reaction (minutes to hours) with involvement of the skin, mucosal tissue, or both and at least one of the following: a) respiratory compromise or b) reduced blood pressure or symptoms of end-organ dysfunction; 2) two or more of the following that occur rapidly after exposure to a likely allergen for that patient – involvement of the skin/ mucosal tissue, respiratory compromise, reduced blood pressure or associated symptoms and/ or persistent gastrointestinal symptoms; or 3) reduced blood pressure after exposure to a known allergen.

Preferred Medications (Step 1)

- Generic epinephrine auto-injector
- Adrenaclick (epinephrine injection)
- Auvi-Q (epinephrine injection)

Non-preferred Medications (Step 2)

- Epipen (epinephrine injection)
- Epipen Jr. (epinephrine injection)

POLICY STATEMENT

A preferred step therapy program has been developed to encourage the use of a preferred product prior to the use of a non-preferred product. If the preferred step therapy rule is not met for a non-preferred agent at the point of service, coverage will be determined by the preferred step therapy criteria below. The medication may also require fulfillment of prior authorization criteria before approval. All approvals are provided for 12 months in duration.

PREFERRED STEP THERAPY CRITERIA

1. If the patient has tried a preferred medication (Step 1), then authorization for a non-preferred medication (Step 2) may be given.

Approval Duration

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Approval = 365 days (1 year)

Step Therapy Exception Criteria
In certain situations, the patient is not required to trial preferred agents. Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred agents. If so, please list diagnosis and/or patient characteristics [documentation required]; **OR**
B. The patient has a contraindication to all preferred agents. If so, please list the contraindications to each preferred agent [documentation required]; **OR**
C. The patient is continuing therapy with the requested non-preferred agent after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:
    1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred agent for 90 days within a 130-day look-back period AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product); OR
    2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred agent for 90 days AND that the patient has been receiving the requested non-preferred agent via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred agent) AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product).

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as [documentation required]. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

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