Pharmacy Medical Necessity Guidelines:
Nasal Corticosteroid Medications

Effective: September 9, 2025

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0939

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Beclomethasone:

- Beconase AQ is indicated for the relief of symptoms of seasonal or perennial allergic and nonallergic (vasomotor) rhinitis. It is also indicated for the prevention of recurrence of nasal polyps following surgical removal. The safety and effectiveness of Beconase AQ nasal spray have been established in children aged 6 years and older.
- Qnasl is indicated for the treatment of the nasal symptoms associated with seasonal and perennial allergic rhinitis in patients 4 years of age and older.

Budesonide intranasal is indicated for the management of nasal symptoms of seasonal or perennial allergic rhinitis in adults and children 6 years of age and older.

Ciclesonide:

Omnaris and Zetonna are indicated for the treatment of nasal symptoms associated with perennial allergic rhinitis in adults and adolescents 12 years and older, and for the treatment of nasal symptoms associated with seasonal allergic rhinitis in adults and children 6 years and older (Omnaris) or adults and adolescents 12 years and older (Zetonna).

Flunisolide intranasal (generic, Nasarel) is indicated for the relief and management of nasal symptoms of seasonal and perennial allergic rhinitis. It is not recommended for use in patients less than 6 years of age.

Fluticasone:

- Flonase (generic and Flonase Rx) is indicated for the management of the nasal symptoms of perennial nonallergic rhinitis in patients 4 years and older.
- Flonase OTC is indicated for the relief of hay fever or other upper respiratory allergies (e.g., itchy and watery eyes, nasal congestion, runny nose, sneezing, itchy nose) in patients 4 years and older.
- Flonase Sensimist is indicated for the relief of hay fever or other upper respiratory allergies (e.g., nasal congestion, runny nose, sneezing, itchy nose) in patients 2 years of age and older and itchy, watery eyes for patients 12 years of age and older.

Mometasone (Nasonex RX) is indicated for the treatment of nasal polyps in patients 18 years of age and older and for the prophylaxis of the nasal symptoms of for seasonal allergic rhinitis in adults and children 12 years of age and older.

Triamcinolone:

- Nasacort OTC is indicated for the relief of hay fever and other upper respiratory allergies (e.g., nasal congestion, runny nose, sneezing, itchy nose) in adults and children 2 years and older.

Tufts Health RITogether Preferred Drug List Status		
Brand Name	**Generic Name**	**Utilization Management (UM)**
Beclomethasone	Beconase AQ	PA
Rhinocort Aqua[1]	**Budesonide 32mcg***	**Covered**
Flunisolide (Nasarel)[1]	Flunisolide	PA
Fluticasone (Flonase)[1]	**Fluticasone propionate***	**Covered**
Nasonex[1]	Mometasone Furoate	PA

Omnaris	Ciclesonide	PA
Qnasl, Qnasl Childrens	Beclomethasone Dipropionate	PA
Triamcinolone (Nasacort AQ)[1]	**Triamcinolone acetonide***	**Covered**
Flonase Sensimist	Fluticasone Furoate	PA
Zetonna	Ciclesonide	PA

*** Preferred products are the generic formulations, budesonide, fluticasone, and OTC triamcinolone.**

[1] Brand name medications with AB-rated generics are non-covered. They are included in the table to serve as a reference. Requests for the brand-name products, with AB-rated generics, will also require review according to Brand Name criteria.

COVERAGE GUIDELINES

The plan may authorize coverage of a non-preferred nasal corticosteroid agent for Members when **ONE** of the following criterions is met and limitations do not apply:

1. The Member has had an inadequate response, adverse reaction, or contraindication to two of the preferred nasal corticosteroid agents: fluticasone (generic Flonase), budesonide (generic Rhinocort), and OTC triamcinolone (Nasacort)

OR

2. The Member is between 2 and 4 years of age with the diagnosis of allergic rhinitis and has had an inadequate response, adverse reaction, or contraindication to intranasal triamcinolone (Nasacort)

LIMITATIONS

1. Requests for brand-name products, with AB-rated generics, will also be reviewed according to Brand Name criteria.

CODES

None

REFERENCES

1. Beconase AQ (beclomethasone dipropionate monohydrate) [package insert]. Research Triangle Park, NC: GlaxoSmithKline; February 2021.
2. Flonase (fluticasone propionate) [package insert]. Research Triangle Park, NC: GlaxoSmithKline; January 2019.
3. Flonase Sensimist (fluticasone furoate) [package insert]. Warren, NJ: GlaxoSmithKline; October 2023 .
4. Flunisolide [package insert]. Bridgewater, NJ: Bausch + Lomb Inc; February 2024 .
5. Nasacort AQ (triamcinolone) [package insert]. Bridgewater, NJ: Aventis; 2002.
6. Nasonex (mometasone furoate) [package insert]. Jersey City, NJ: Organon & Co.; June 2022.
7. Omnaris (ciclesonide) [package insert]. Zug, Switzerland: Covis Pharma; May 2019.
8. Qnasl (beclomethasone dipropionate) [package insert]. Parsippany, NJ: Teva Respiratory; September 2022.
9. Rhinocort Aqua (budesonide) [package insert]. Wilmington, DE: AstraZeneca; February 2012.
10. Zetonna (ciclesonide) [package insert]. Zug, Switzerland: Covis Pharma; February 2023.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. September 12, 2023: Effective December 1, 2023, updated the previous trial language to "inadequate response, adverse reaction, or contraindication to."
2. September 10, 2024: Administrative change to fax number.
3. September 9, 2025: No changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity 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 service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical

Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

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.

Provider Services