

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
GLUCOCORTICOIDS, INHALED

Proposed Effective Date: January 5, 2026

Revisions are noted with a ~~strike through~~ for deletions and **bold and underline** for additions.

I. Requirements for Prior Authorization of Glucocorticoids, Inhaled

A. Prescriptions That Require Prior Authorization

Prescriptions for Glucocorticoids, Inhaled that meet any of the following conditions must be prior authorized:

1. A non-preferred Glucocorticoid, Inhaled. See the Preferred Drug List (PDL) for the list of preferred Glucocorticoids, Inhaled at: <https://papdl.com/preferred-drug-list>.
2. A Glucocorticoid, Inhaled with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html>.
3. A Glucocorticoid, Inhaled when there is a record of a recent paid claim for another agent that contains an inhaled glucocorticoid in the point-of-sale on-line claims adjudication system (therapeutic duplication).
4. An inhaled long-acting anticholinergic when there is a record of a recent paid claim for another inhaled long-acting anticholinergic in the point-of-sale on-line claims adjudication system (therapeutic duplication).
5. An inhaled long-acting beta agonist when there is a record of a recent paid claim for another agent that contains an inhaled long-acting beta agonist in the point-of-sale on-line claims adjudication system (therapeutic duplication).

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Glucocorticoid, Inhaled, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred single-ingredient Glucocorticoid, Inhaled (i.e., a product that contains only one active ingredient), has history of therapeutic failure of or a contraindication or an intolerance to the preferred single-ingredient Glucocorticoids, Inhaled **approved or medically accepted for the beneficiary's diagnosis**; **AND**
2. For a non-preferred Glucocorticoid, Inhaled combination agent (i.e., a product that contains more than one active ingredient), has history of therapeutic failure of or a contraindication

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or an intolerance to the preferred Glucocorticoid, Inhaled combination agents **approved or medically accepted for the beneficiary's diagnosis**; **AND**

3. For therapeutic duplication, **one** of the following:
- a. For an inhaled glucocorticoid, is being titrated to or tapered from another inhaled glucocorticoid,
 - b. For an inhaled long-acting anticholinergic, is being titrated to or tapered from another inhaled long-acting anticholinergic,
 - c. For an inhaled long-acting beta agonist, is being titrated to or tapered from another inhaled long-acting beta agonist,
 - d. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

AND

4. If a prescription for a Glucocorticoid, Inhaled is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **one** of the following:
- a. The guidelines set forth in the Quantity Limits Chapter
 - b. For a ~~formoterol-containing~~ Glucocorticoid, Inhaled **containing a beta agonist** for the treatment of asthma, **both** of the following:
 - i. The beneficiary is using the requested drug as part of a therapy that is supported by consensus treatment guidelines [e.g., Single Maintenance and Reliever Therapy (SMART)]
 - ii. The prescribed dose is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Glucocorticoid, Inhaled. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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D. References

1. ~~Expert Panel Working Group of the National Heart, Lung, and Blood Institute (NHLBI) administered and coordinated National Asthma Education and Prevention Program Coordinating Committee (NAEPPCC), Cloutier MM, Baptist AP, Blake KV, Brooks EG, Bryant-Stephens T, DiMango E, Dixon AE, Elward KS, Hartert T, Krishnan JA, Lemanske RF Jr, Ouellette DR, Pace WD, Schatz M, Skolnik NS, Stout JW, Teach SJ, Umscheid CA, Walsh CG. 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group. J Allergy Clin Immunol. 2020 Dec;146(6):1217-1270. doi: 10.1016/j.jaci.2020.10.003. Erratum in: J Allergy Clin Immunol. 2021 Apr;147(4):1528-1530. PMID: 33280709; PMCID: PMC7924476.~~
2. ~~Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention: 2022 update. <https://ginasthma.org/wp-content/uploads/2022/07/GINA-Main-Report-2022-FINAL-22-07-01-WMS.pdf>. (Accessed July 25, 2022).~~
3. **Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention: 2024 update. Online. Accessed July 31, 2025.**