Louisiana Medicaid
Asthma/COPD – Inhaled Glucocorticoids

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred inhaled glucocorticoids.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation ~~and Continuation~~ of Therapy

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy~~Duration of approval for initiation and continuation of therapy~~: 12 months

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Revision / Date	Implementation Date
Single PDL Implementation	May 2019
Separated "Select Therapeutic Classes Not Established" into individual therapeutic class documents / November 2019	January 2020
Added preferred brand wording for Advair Diskus® and Symbicort®, added references / November 2020	January 2021
Formatting changes, removed specific references / September 2021	January 2022
Added wording for use of Flovent® HFA / November 2022	January 2023
Added wording for use of Advair HFA®, removed wording for use of Flovent® HFA / October 2023	January 2024
Removed specific wording for use of Advair HFA®, Advair Diskus® and Symbicort®, formatting changes / April 2024	July 2024

Created separate 'Continuation of Therapy' criteria / March 2025	August 2025