Clinical Policy: Mometasone (Nasonex)
Reference Number: HIM.PA.93
Effective Date: 12/14
Last Review Date: 08/17
Line of Business: Health Insurance Marketplace

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Mometasone (Nasonex®) is a corticosteroid.

FDA approved indication
Nasonex is indicated:

- For the treatment of the nasal symptoms of seasonal allergic and perennial allergic rhinitis, in adults and pediatric patients 2 years of age and older
- For the relief of nasal congestion associated with seasonal allergic rhinitis, in adults and pediatric patients 2 years of age and older
- For the prophylaxis of the nasal symptoms of seasonal allergic rhinitis in adult and adolescent patients 12 years and older
- For the treatment of nasal polyps in patients 18 years of age and older

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. Allergic Rhinitis or Nasal Polyps (must meet all)**:**

1. Diagnosis of allergic rhinitis or nasal polyps;
2. Failure of two formulary intranasal steroids (e.g., flunisolide, fluticasone propionate, budesonide) unless all are contraindicated or clinically significant adverse effects are experienced;
3. Dose does not exceed 400 mcg/day (8 sprays/day, or 2 bottles/30 days).

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Allergic Rhinitis or Nasal Polyps (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy;
3. If request is for a dose increase, new dose does not exceed 400 mcg/day (8 sprays/day, or 2 bottles/30 days).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to HIM.PA.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation Key
FDA: Food and Drug Administration

V. References

1. Nasonex Prescribing Information. Whitehouse Station, NJ: Merck Sharp & Dohme Corp.; March 2013. Available at: https://www.merck.com/product/usa/pi_circulars/n/nasonex/nasonex_pi.pdf. Accessed April 17, 2017.
2. Jankowski R, Klossek JM, Attali V, Coste A, Serrano E. Long-term study of fluticasone propionate aqueous nasal spray in acute and maintenance therapy of nasal polyposis. Allergy. 2009 Jun;64(6):944-50.
3. Stjärne P, Blomgren K, Cayé-Thomasen P, Salo S, Søderstrøm T. The efficacy and safety of once-daily mometasone furoate nasal spray in nasal polyposis: a randomized, double-blind, placebo-controlled study. Acta Otolaryngol. 2006 Jun;126(6):606-12.
4. Filiaci F, Passali D, Puxeddu R, Schrewelius C. A randomized controlled trial showing efficacy of once daily intranasal budesonide in nasal polyposis. Rhinology. 2000 Dec;38(4):185-90.
5. Lund VJ, Flood J, Sykes AP, Richards DH. Effect of fluticasone in severe polyposis. Arch Otolaryngol Head Neck Surg. 1998 May;124(5):513-8.
6. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed January 24, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Reformatted guideline to new format. Added Workflow reference document.	12/15	12/15
Expanded approval to all FDA approved indications. Removed workflow document. Updated referenced to reflect current literature search.	08/16	08/16
Converted to new template. Updated policy name from “Nasal Steroids” to mometasone	04/17	08/17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
(Nasonex) since generic budesonide (Rhinocort Aqua) no longer requires a PA per formulary; added max dose. Updated references.		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.