

Market Applicability/Effective Date														
Market	FL & FHK	FL MMA	FL LTC	GA	KS	KY	LA	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	NA	NA	X	NA	X	X	X	X	X	X	NA	NA	X

Medication	Quantity Limits
Alamast (pemirolast potassium)	10mL/30 days
Alocril (nedocromil sodium)	5mL/30 days
Alomide (Iodoxamide tromethamine)	10mL/30 days
Bepreve (bepotastine besilate)	10mL/30 days
Emadine (emedstine difumarate)	5mL/30 days
Lastacaft (alcaftadine)	3mL/30 days
Pataday (olopatadine hydrochloride)	2.5mL/30 days
Patanol (olopatadine hydrochloride)	5mL/30 days
Pazeo (oloptadine hydrochloride)	2.5mL/30 days

OVERRIDE(S)

Prior Authorization of Benefits
Quantity Supply for Plans with Quantity Limits

APPROVAL DURATION

1 Year

APPROVAL CRITERIA

Requests for non-preferred ophthalmic allergy product may be approved for individuals who meet the following criteria:

- I. Documentation is provided for trial of ALL preferred ophthalmic allergy products;
 - A. Cromolyn;
 - B. Ketotifen;
 - C. Azelastine;
 - D. Epinastine;
 - E. Allergy Eye;
 - F. Eye Itch Relief;
 - G. Itchy Eye;

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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-AND-

II. Individuals' symptoms continue despite treatment with the preferred ophthalmic allergy products.

Note: Zaditor (ketotifen) is available only as an OTC product and could be considered as a first line product prior to trial of prescription products.

May approve additional bottle(s) when quantity limit will NOT be sufficient for a 30 day period. Ask for dosage and quantity needed. Note: Drop sizes may vary, more than one eye may be affected and drops may be wasted due to difficulty in administration.

Requests for additional increased quantities will be reviewed on a case by case basis.

Documentation includes, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

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