UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2214-5
Program	Prior Authorization/Medical Necessity
Medications	Albuterol tablets
P&T Approval Date	7/2020, 7/2021, 7/2022, 7/2023, 7/2024
Effective Date	10/1/2024

1. Background:

Albuterol tablets are indicated for the relief of bronchchospasm in adults and children 6 years of age and older with reversible obstructive airway disease. Guidelines do not recommend the use of albuterol tablets and note they have a higher risk of side-effects. In addition, guidelines note that there are no long-term safety studies that have been performed to assess the risk of severe exacerbations with albuterol tablets in patients not also taking an inhaled corticosteroid.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Albuterol tablets** will be approved based on **all** of the following criteria:

   a. Diagnosis of obstructive airway disease (e.g., asthma)

   -AND-

   b. Patient's obstructive airway disease is being managed with **both** of the following:

      1) **One** of the following controller medications:

         a) An inhaled corticosteroid (e.g., Arnuity Ellipta, QVAR RediHaler)
         b) An inhaled corticosteroid/long-acting beta-agonist [e.g., fluticasone/salmeterol (generic Advair Diskus), Advair HFA, Breo Ellipta, Symbicort)
         c) Spiriva HandiHaler/Respimat
         d) A long-acting muscarinic antagonist/long-acting beta-agonist (e.g., Anoro Ellipta, Bevespi Aerosphere)

      -AND-

      2) History of failure, contraindication or intolerance to an inhaled short-acting beta-agonist [e.g., albuterol HFA (generic ProAir HFA, generic Proventil HFA)]

      -AND-

   c. Prescriber attests that the benefits outweigh the risk

Authorization will be issued for 12 months.

B. Reauthorization

1. **Albuterol tablets** will be approved based on the following criterion:

    a. Documentation of positive clinical response to therapy

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4. References:

1. Albuterol tablets [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc: July 2014.
2. Asthma Management and Prevention. Global Initiative for Asthma (GINA). 2024.

Program	Prior Authorization/Medical Necessity – Albuterol tablets
Change Control	
7/2020	New program.
7/2021	Annual review. Updated the example used for the inhaled short-acting beta-agonist.
7/2022	Annual review. Updated references.
7/2023	Annual review. Updated references.
7/2024	Annual review. Updated medication examples in criteria.