AllCare CCO - Prior Authorization Criteria Summary:

Criteria number: 019.2

Criteria title: Ipratropium

Date of origin: 11/16/2012

Classification: Drug Specific

Date of Last Review: 06/14/2022

Drug: Ipratropium (Atrovent)

Date of Next Review: 06/13/2024

References:

● Oregon Health Authority, Department of Medical Assistance, OAR 410-120-0250 (3):

● Oregon Medicaid Pharmaceutical Services Prior Authorization Criteria :

● Clinical Pharmacology [database online]. Ipratropium. Tampa, FL: Gold Standard, Inc.; 2019.● Global Initiative for Asthma (GINA). Global strategy for asthma management and prevention. Vancouver (WA): Global Initiative for Asthma (GINA); 2021:

● Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. Vancouver (WA): Global Initiative for Chronic Obstructive Lung Disease (GOLD); 2021:

FDA approved indication: For the treatment of bronchospasm due to chronic obstructive pulmonary disease (COPD), including chronic bronchitis or emphysema Off-label indication: For the treatment of acute bronchospasm (e.g., asthma exacerbation); For adjunctive exercise-induced bronchospasm prophylaxis

Purpose: To define the process and coverage for ipratropium inhalers and solution for inhalation.

Clinical Rationale: A systematic review of RCTs found that ipratropium alone provided small benefits over short-acting beta2-agonist in terms of lung function, health status and requirement for oral steroids for the treatment of COPD. Ipratropium may provide some additive benefit to inhaled beta-2-agonists when treating severe acute asthma exacerbations in the emergency department and, in some instances, during medical transport. Ipratropium has not demonstrated effectiveness in long-term management of asthma.

Policy: Cover ipratropium for members with COPD or asthma exacerbation who have a tried a short acting beta agonist. Quantity limits apply.

Approval Criteria for Ipratropium (Atrovent):		**Met**	**Not Met**
Criteria #1:	Does the member have a diagnosis of COPD	Approve x12 months with QL 2 per month	Go to #2
Criteria #2:	Is there documentation to support off-label diagnosis:	Asthma: Go to #3 Exercise-induced bronchospasm prophylaxis: Go to #4	Deny
Criteria #3:	Is the request for ipratropium nebulizer solution for acute asthma exacerbation	Approve x1 fill with QL of 1 box	Deny
Criteria #4:	Is the request for ipratropium HFA inhaler and is there documentation of continued symptoms despite use of SABA and ICS or leukotriene receptor antagonist	Approve x 12 months; QL 1 per month	Deny

Reviewed and approved by: Chief Medical Officer

Date: 01/18/2013