UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1423-4
Program	Non-Formulary
Medication	Fluticasone propionate HFA*
P&T Approval Date	12/2023, 3/2024, 3/2025, 4/2026
Effective Date	7/1/2026

1. Background:

Fluticasone propionate HFA* is indicated for the maintenance treatment of asthma as prophylactic therapy in adults and pediatric patients. Guidelines recommend the use of a spacer device based on child's age and capability. The preferred device in patients < 3 years of age is a spacer with face mask and for children aged 3-5 the preferred device is a spacer with mouthpiece. In addition, spacers remain essential for some elderly patients who are unable to utilize devices correctly.

Guidelines from the American College of Gastroenterology and consensus recommendations from the American Gastroenterological Association (AGA) Institute/North American Society of Pediatric Gastroenterology, Hepatology, and Nutrition on the management of eosinophilic esophagitis recommend oral administration of inhalational corticosteroids (e.g., fluticasone, budesonide) as first-line therapy in adults and children with eosinophilic esophagitis.

Claims for patients less than 6 years of age will process automatically.

2. Coverage Criteria:

Authorization

A. Asthma

1. **Fluticasone propionate HFA*** will be approved based on **both** of the following criteria:

   a. Diagnosis of asthma

   -AND-

   b. One of the following:

      1) Submission of medical of records (e.g. chart notes) documenting a history of failure, contraindication or intolerance to **both** of the following:

         a) Arnuity™ Ellipta®
         b) QVAR RediHaler®

      -OR-

      2) Patient requires a metered dose inhaler used with a spacer device due to **one** of the following:

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a) Physical dexterity
b) Inspiratory flow
c) Cognitive status

Authorization will be issued for 12 months

B. **Eosinophilic Esophagitis**

1. Diagnosis of Eosinophilic Esophagitis

Authorization will be issued for 12 months

*Fluticasone propionate HFA is typically excluded from coverage

3. Additional Clinical Rules:

- 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. Fluticasone HFA [package insert]. Mason, OH: Prasco Laboratories; May 2023
2. Global Strategy for Asthma Management and Prevention. Global Initiative for Asthma (GINA). 2025.

Program	Non-Formulary – Fluticasone propionate HFA
Change Control	
Date	Change
12/2023	New program.
3/2024	Added eosinophilic esophagitis to criteria.
3/2025	Annual review. Updated references.
4/2026	Annual review. Added medical record requirement.

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