Drug/Drug Class

Allergen Extracts

Clinical Information Included in this Document

Grastek (Timothy Grass Pollen Allergen Extract)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram:** a visual depiction of the clinical criteria logic
- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes)
- **References:** clinical publications and sources relevant to this clinical criteria

Note: Click the hyperlink to navigate directly to that section.

Odactra (House Dust Mite Allergen Extract)

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Oralair (Mixed Grass Pollens Allergen Extract)

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Palforzia (Peanut Allergen Powder)

- **Drugs requiring prior authorization**: the list of drugs requiring prior authorization for this clinical criteria
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Ragwitek (Short Ragweed Pollen Allergen Extract)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
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Revision Notes

Annual review by staff

Added criteria for Odactra

Updated age for Ragwitek to ≥ 5 years

Updated references

Grastek (Timothy Grass Pollen Allergen Extract)

Drugs Requiring Prior Authorization

Grastek	
Label Name	**GCN**
GRASTEK 2800 BAU SL TABLET	35777

Grastek (Timothy Grass Pollen Allergen Extract)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 5 years of age?
   [] Yes – Go to #2
   [] No – Deny

2. Is the client less than or equal to (≤) 65 years of age?
   [] Yes – Go to #3
   [] No – Deny

3. Does the client have a diagnosis of **allergic rhinitis** in the last 730 days?
   [] Yes – Go to #4
   [] No – Deny

4. Has the client had **hypersensitivity testing** in the last 5 years?
   [] Yes – Go to #5
   [] No - Deny

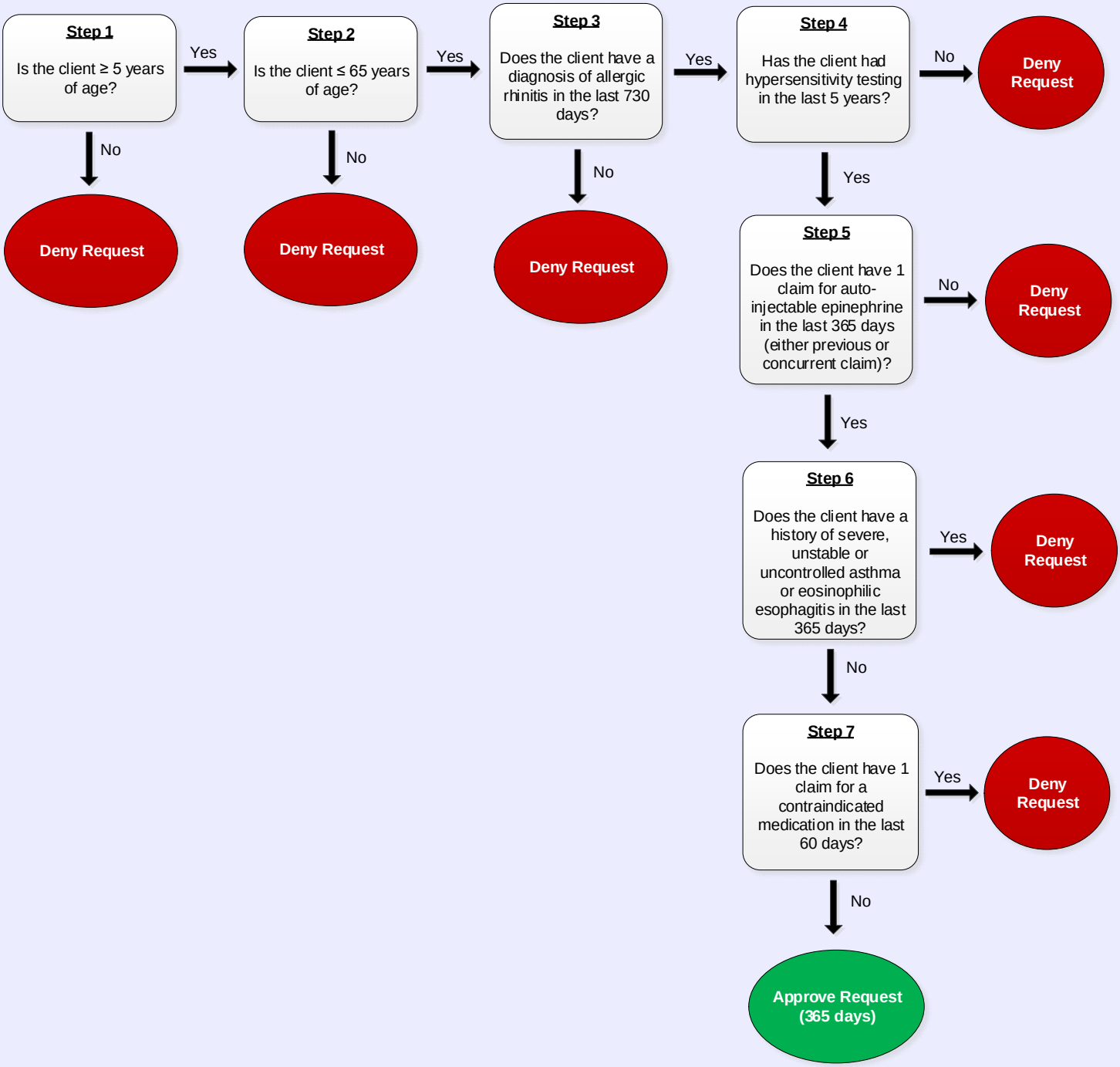
5. Does the client have 1 claim for **auto-injectable epinephrine** in the last 365 days or is the patient receiving auto-injectable epinephrine concurrently?
   [] Yes – Go to #6
   [] No - Deny

6. Does the client have a history of severe, unstable or uncontrolled **asthma OR a history of eosinophilic esophagitis** in the last 365 days?
   [] Yes – Deny
   [] No – Go to #7

7. Does the client have 1 claim for a **medication not recommended to be taken** in conjunction with Grastek in the last 60 days?
   [] Yes – Deny
   [] No – Approve (365 days)

Grastek (Timothy Grass Pollen Allergen Extract)

Clinical Criteria Logic Diagram



Odactra (House Dust Mite Allergen Extract)

Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Label Name	GCN
ODACTRA 12 SQ-HDM SL TABLET	42527

Odactra (House Dust Mite Allergen Extract)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 12 years of age?
   [] Yes – Go to #2
   [] No – Deny

2. Is the client less than or equal to (≤) 65 years of age?
   [] Yes – Go to #3
   [] No – Deny

3. Does the client have a diagnosis of **allergic rhinitis** in the last 730 days?
   [] Yes – Go to #4
   [] No – Deny

4. Has the client had **hypersensitivity testing** in the last 5 years?
   [] Yes – Go to #5
   [] No – Deny

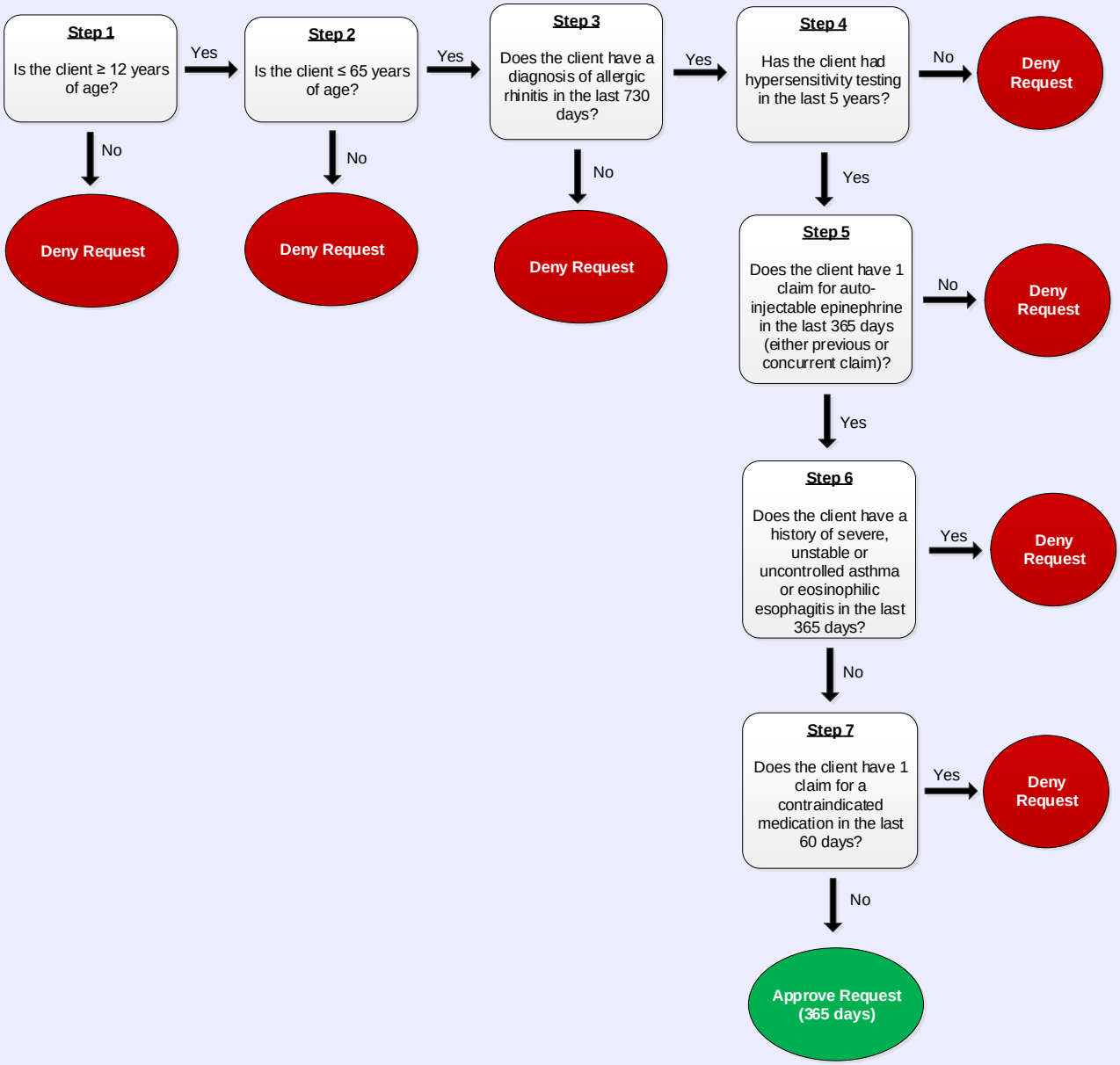
5. Does the client have 1 claim for **auto-injectable epinephrine** in the last 365 days or is the patient receiving auto-injectable epinephrine concurrently?
   [] Yes – Go to #6
   [] No - Deny

6. Does the client have a history of severe, unstable or uncontrolled **asthma OR a history of eosinophilic esophagitis** in the last 365 days?
   [] Yes – Deny
   [] No – Go to #7

7. Does the client have 1 claim for a **medication not recommended** to be taken in conjunction with Odactra in the last 60 days?
   [] Yes – Deny
   [] No – Approve (365 days)

Odactra (House Dust Mite Allergen Extract)

Clinical Criteria Logic Diagram



Oralair (Grass Pollen Allergen Extract)

Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Oralair	
Label Name	**GCN**
ORALAIR 300 IR SUBLINGUAL TABLET	33970

Oralair (Grass Pollen Allergen Extract)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 5 years of age?
   [] Yes – Go to #2
   [] No – Deny

2. Is the client less than or equal to (≤) 65 years of age?
   [] Yes – Go to #3
   [] No – Deny

3. Does the client have a diagnosis of **allergic rhinitis** in the last 730 days?
   [] Yes – Go to #4
   [] No – Deny

4. Has the client had **hypersensitivity testing** in the last 5 years?
   [] Yes – Go to #5
   [] No - Deny

5. Does the client have 1 claim for **auto-injectable epinephrine** in the last 365 days or is the patient receiving auto-injectable epinephrine concurrently?
   [] Yes – Go to #6
   [] No – Deny

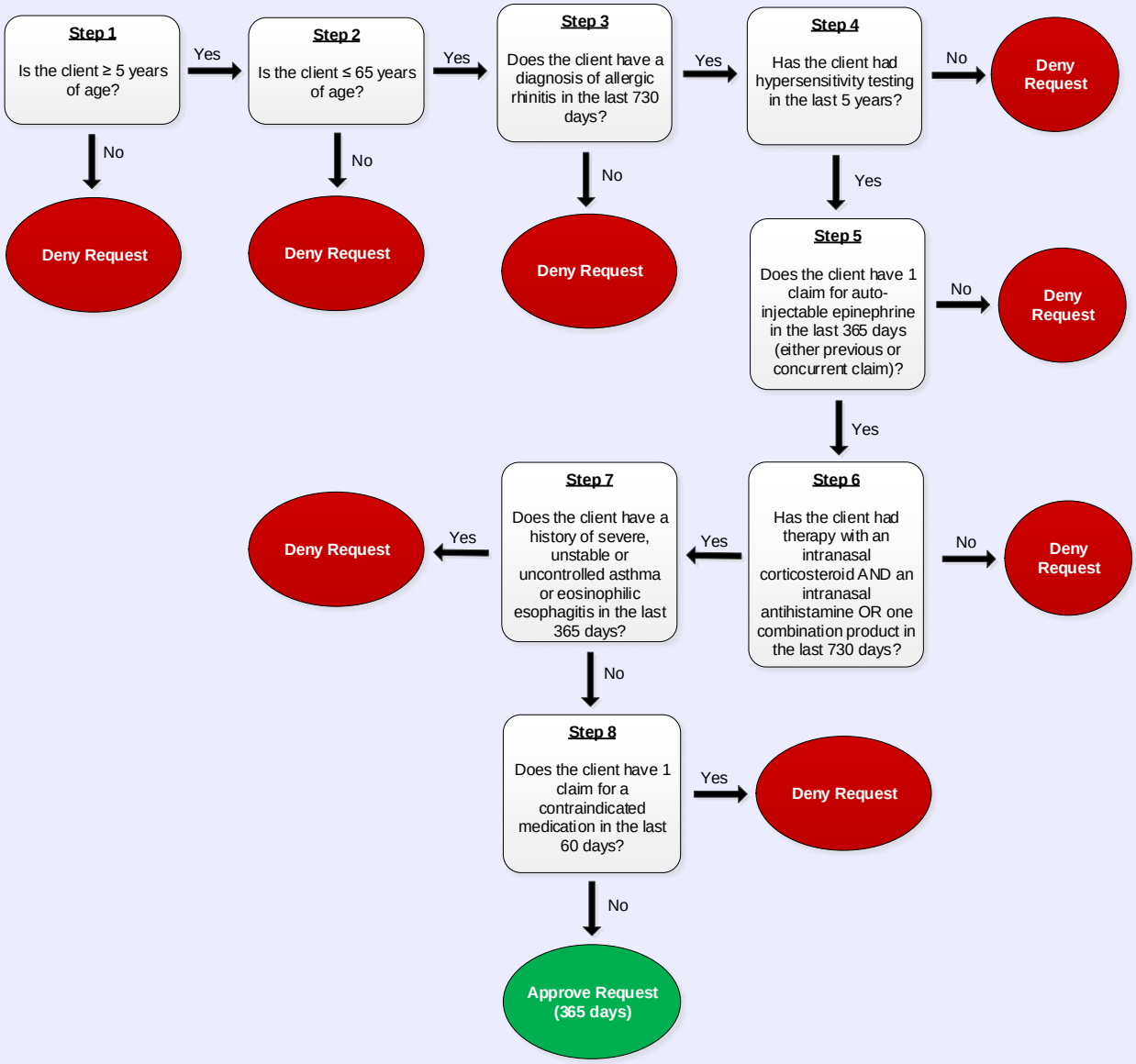
6. Has the client had therapy with an **intranasal corticosteroid** AND an **intranasal antihistamine** OR one **combination intranasal corticosteroid and intranasal antihistamine product** in the last 730 days?
   [] Yes – Go to #7
   [] No - Deny

7. Does the client have a history of severe, unstable or uncontrolled **asthma OR a history of eosinophilic esophagitis** in the last 365 days?
   [] Yes – Deny
   [] No – Go to #8

8. Does the client have 1 claim for a **medication not recommended** to be taken in conjunction with Oralair in the last 60 days?
   [] Yes – Deny
   [] No – Approve (365 days)

Oralair (Grass Pollen Allergen Extract)

Clinical Criteria Logic Diagram



Palforzia (Peanut Allergen Powder)

Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
PALFORZIA INITIAL DOSE PACK	47639
PALFORZIA 12 MG (LEVEL 3)	47654
PALFORZIA 120 MG (LEVEL 7)	47659
PALFORZIA 160 MG (LEVEL 8)	47664
PALFORZIA 20 MG (LEVEL 4)	47655
PALFORZIA 200 MG (LEVEL 9)	47649
PALFORZIA 240 MG (LEVEL 10)	47652
PALFORZIA 3 MG (LEVEL 1)	47647
PALFORZIA 300 MG (MAINTENANCE)	47653
PALFORZIA 300 MG (LEVEL 11)	47653
PALFORZIA 40 MG (LEVEL 5)	47656
PALFORZIA 6 MG (LEVEL 2)	47648
PALFORZIA 80 MG (LEVEL 6)	47658

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Palforzia (Peanut Allergen Powder)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 4 years of age?
   [ ] Yes (Go to #2)
   [ ] No (Deny)

2. Has the client had at least 1 paid claim for the requested agent in the last 60 days?
   [ ] Yes, (Go to #4)
   [ ] No, and the client is 4 – 17 years of age (Go to #3)
   [ ] No, and the client is ≥ 18 years of age (Deny)

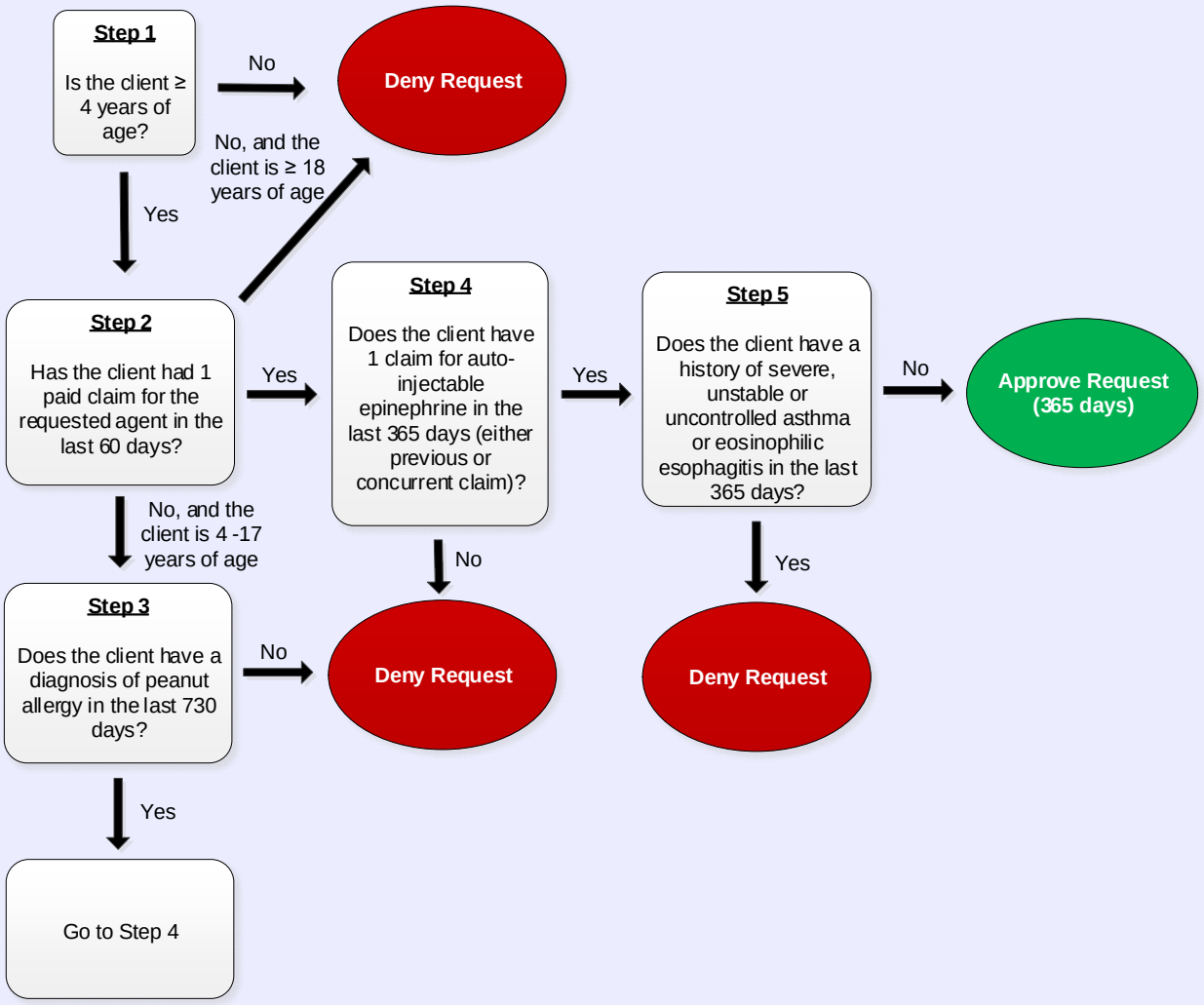
3. Does the client have a diagnosis of **peanut allergy** in the last 730 days?
   [ ] Yes (Go to #4)
   [ ] No (Deny)

4. Does the client have 1 claim for **auto-injectable epinephrine** in the last 365 days or is the patient receiving auto-injectable epinephrine concurrently?
   [ ] Yes (Go to #5)
   [ ] No (Deny)

5. Does the client have a history of severe, unstable or uncontrolled **asthma OR a history of eosinophilic esophagitis** in the last 365 days?
   [ ] Yes (Deny)
   [ ] No (Approve – 365 days)

Palforzia (Peanut Allergen Powder)

Clinical Criteria Logic Diagram



Ragwitek (Short Ragweed Pollen Allergen Extract)

Drugs Requiring Prior Authorization

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Label Name	GCN
RAGWITEK SUBLINGUAL TABLET	36402

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Ragwitek (Short Ragweed Pollen Allergen Extract)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 5 years of age?
   [] Yes – Go to #2
   [] No – Deny

2. Is the client less than or equal to (≤) 65 years of age?
   [] Yes – Go to #3
   [] No – Deny

3. Does the client have a diagnosis of **allergic rhinitis** in the last 730 days?
   [] Yes – Go to #4
   [] No – Deny

4. Has the client had **hypersensitivity testing** in the last 5 years?
   [] Yes – Go to #5
   [] No – Deny

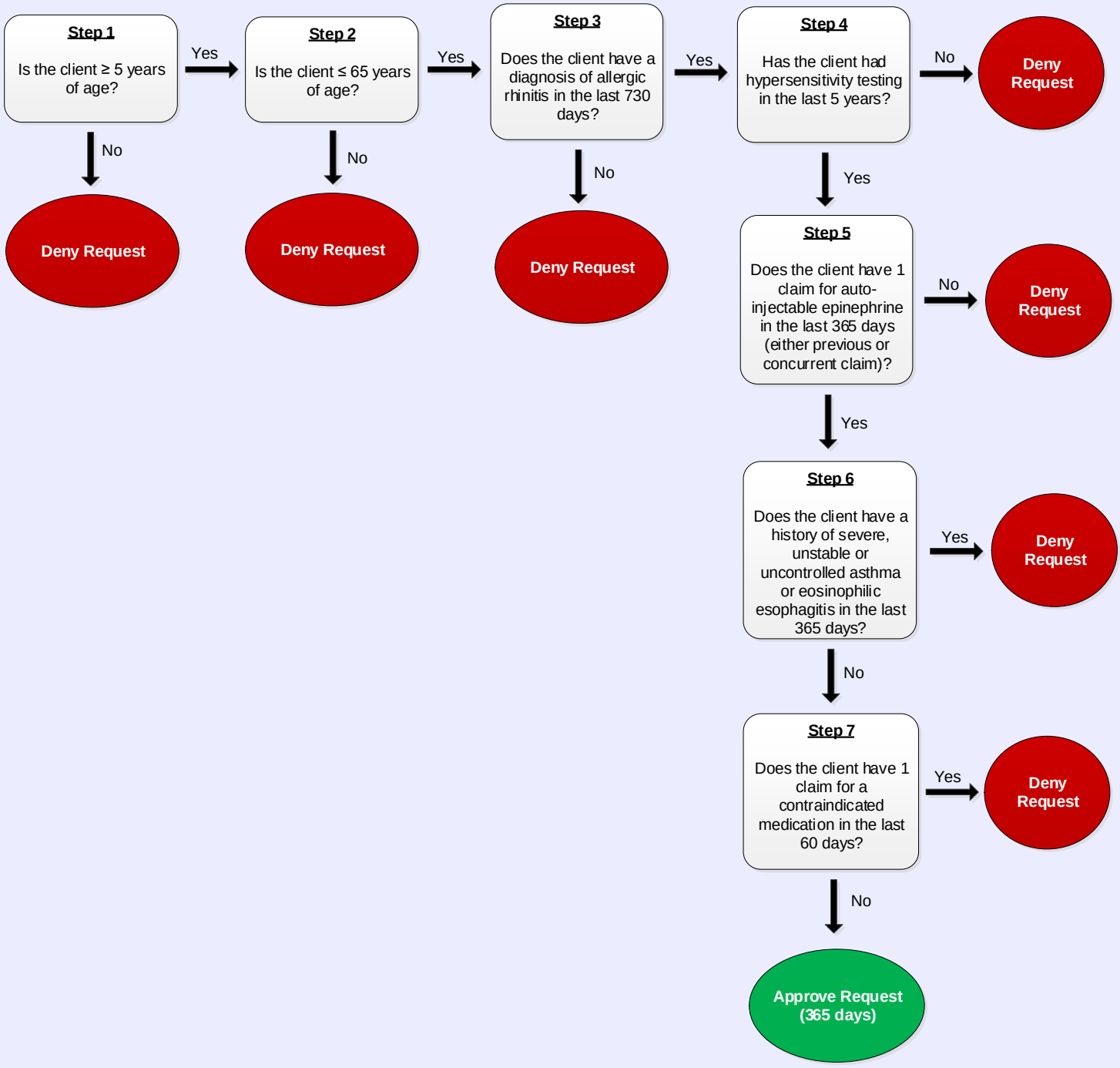
5. Does the client have 1 claim for **auto-injectable epinephrine** in the last 365 days or is the patient receiving auto-injectable epinephrine concurrently?
   [] Yes – Go to #6
   [] No - Deny

6. Does the client have a history of severe, unstable or uncontrolled **asthma OR a history of eosinophilic esophagitis** in the last 365 days?
   [] Yes – Deny
   [] No – Go to #7

7. Does the client have 1 claim for a **medication not recommended** to be taken in conjunction with Ragwitek in the last 60 days?
   [] Yes – Deny
   [] No – Approve (365 days)

Ragwitek (Short Ragweed Pollen Allergen Extract)

Clinical Criteria Logic Diagram



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Allergen Extracts

Clinical Criteria Supporting Tables

Allergic Rhinitis	
ICD-10 Code	**Description**
J301	ALLERGIC RHINITIS DUE TO POLLEN

Peanut Allergy	
ICD-10 Code	**Description**
T7801XA	ANAPHYLACTIC REACTION DUE TO PEANUTS INITIAL ENCOUNTER
T7801XD	ANAPHYLACTIC REACTION DUE TO PEANUTS SUBSEQUENT ENCOUNTER
T7801XS	ANAPHYLACTIC REACTION DUE TO PEANUTS SEQUELA
Z91010	ALLERGY TO PEANUTS

Hypersensitivity Testing	
CPT Code/ ICD-10 Code	**Description**
86003	ALLERGEN SPECIFIC IGE; QUANTITATIVE OR SEMIQUANTITATIVE, EACH ALLERGEN
86005	ALLERGEN SPECIFIC IGE; QUALITATIVE, MULTIALLERGEN SCREEN
82785	TOTAL QUANTITATIVE IGE
83518	TOTAL QUALITATIVE IGE
95004	PERCUTANEOUS TESTS WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT
95024	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT
95027	INTRACUTANEOUS (INTRADERMAL) TESTS, SEQUENTIAL AND INCREMENTAL, WITH ALLERGENIC EXTRACTS FOR AIRBORNE ALLERGENS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT
95028	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, DELAYED TYPE REACTION, INCLUDING READING
Z0182	ENCOUNTER FOR ALLERGY TESTING

Auto-Injectable Epinephrine	
GCN	**Description**
44487	AUVI-Q 1MG AUTO-INJECTOR
28038	AUVI-Q 0.15MG AUTO-INJECTOR
19862	AUVI-Q 0.3MG AUTO-INJECTOR
28038	EPINEPHRINE 0.15MG AUTO-INJECTOR
19861	EPINEPHRINE 0.15MG AUTO-INJCT
19862	EPINEPHRINE 0.3MG AUTO-INJECTOR
19862	EPIPEN 0.3MG AUTO-INJECTOR
19861	EPIPEN JR 0.15MG AUTO-INJECTOR
46623	SYMJEPI 0.15MG/0.3ML SYRINGE
22547	SYMJEPI 0.3MG/0.3ML SYRINGE

Intranasal Corticosteroid	
GCN	**Description**
32099	AZELASTIN-FLUTIC 137-50MCG SPR
92231	BUDESONIDE 32MCG NASAL SPRAY
40708	BUDESONIDE 32 MCG NASAL SPRAY
34280	FLUNISOLIDE 0.025% SPRAY
62263	FLUTICASONE PROP 50 MCG SPRAY
37683	FLUTICASONE PROP 50 MCG SPRAY
71431	MOMETASONE FUROATE 50MCG SPRY
97453	OMNARIS 50 MCG NASAL SPRAY
31769	QNASL 80MCG NASAL SPRAY
37654	QNASL CHILDRENS 40MCG SPRAY
49205	RYALTRIS 665-25MCG SPRAY
36145	TRIAMCINOLONE 55MCG NASAL SPRAY
43878	XHANCE 93MCG NASAL SPRAY

Intranasal Antihistamine	
GCN	**Description**
60544	AZELASTINE 0.1% (137 MCG) SPRY
27584	AZELASTINE 0.15% NASAL SPRAY
99602	OLOPATADINE 665 MCG NASAL SPRY

Intranasal Corticosteroid/Intranasal Antihistamine Combination Product	
GCN	**Description**
32099	AZELASTIN-FLUTIC 137-50 MCG SPR
32099	DYMISTA NASAL SPRAY

Asthma or Eosinophilic Esophagitis	
ICD-10 Code	**Description**
J4550	SEVERE PERSISTENT ASTHMA, UNCOMPLICATED
J4551	SEVERE PERSISTENT ASTHMA, WITH (ACUTE) EXACERBATION
J4552	SEVERE PERSISTENT ASTHMA, WITH STATUS ASTHMATICUS
J45901	UNSPECIFIED ASTHMA, WITH (ACUTE) EXACERBATION
J45902	UNSPECIFIED ASTHMA, WITH STATUS ASTHMATICUS
K200	EOSINOPHILIC ESOPHAGITIS

Non-Recommended Medication	
GCN	**Description**
26460	ACEBUTOLOL 200MG CAPSULE
26461	ACEBUTOLOL 400MG CAPSULE
20660	ATENOLOL 100MG TABLET
20662	ATENOLOL 25MG TABLET
20661	ATENOLOL 50MG TABLET
66991	ATENOLOL-CHLORTHAL 100-25MG TAB
66990	ATENOLOL-CHLORTHAL 50-25MG TAB
92024	ALFUZOSIN HCL ER 10MG TABLET
12791	BETAXOLOL 10MG TABLET
12792	BETAXOLOL 20MG TABLET
63820	BISOPROLOL FUMARATE 10MG TABLET
63821	BISOPROLOL FUMARATE 5MG TABLET
45063	BISOPROLOL-HCTZ 10-6.25MG TABLET
45061	BISOPROLOL-HCTZ 2.5-6.25MG TABLET
45062	BISOPROLOL-HCTZ 5-6.25MG TABLET
99236	BYSTOLIC 10MG TABLET
99235	BYSTOLIC 2.5MG TABLET
18703	BYSTOLIC 20MG TABLET
07055	BYSTOLIC 5MG TABLET
33431	CARDURA 1MG TABLET
33432	CARDURA 2MG TABLET

Non-Recommended Medication	
GCN	**Description**
33433	CARDURA 4MG TABLET
33434	CARDURA 8MG TABLET
01552	CARVEDILOL 12.5MG TABLET
01551	CARVEDILOL 25MG TABLET
01553	CARVEDILOL 3.125MG TABLET
01554	CARVEDILOL 6.25MG TABLET
97596	CARVEDILOL ER 10MG CAPSULE
97597	CARVEDILOL ER 20MG CAPSULE
97598	CARVEDILOL ER 40MG CAPSULE
97599	CARVEDILOL ER 80MG CAPSULE
01552	COREG 12.5MG TABLET
01551	COREG 25MG TABLET
01553	COREG 3.125MG TABLET
01554	COREG 6.25MG TABLET
97596	COREG CR 10MG CAPSULE
97597	COREG CR 20MG CAPSULE
97598	COREG CR 40MG CAPSULE
97599	COREG CR 80MG CAPSULE
52060	CORZIDE 40-5 TABLET
52061	CORZIDE 80-5 TABLET
01590	D.H.E. 45 1MG/ML AMPULE
01590	DIHYDROERGOTAMINE 1MG/ML AMPULE
33431	DOXAZOSIN MESYLATE 1MG TABLET
33432	DOXAZOSIN MESYLATE 2MG TABLET
33433	DOXAZOSIN MESYLATE 4MG TABLET
33434	DOXAZOSIN MESYLATE 8MG TABLET
28596	DUTASTERIDE-TAMSULOSIN 0.5-0.4
02213	ERGOLOID MESYLATES 1MG TABLET
48191	FLOMAX 0.4MG CAPSULE
36526	HEMANGEOL 4.28MG/ML ORAL SOLN
03231	INDERAL LA 120MG CAPSULE
03232	INDERAL LA 160MG CAPSULE
03233	INDERAL LA 60MG CAPSULE
03230	INDERAL LA 80MG CAPSULE
19359	INDERAL XL 120 MG CAPSULE
20621	INDERAL XL 80 MG CAPSULE
19359	INNOPRAN XL 120MG CAPSULE
20621	INNOPRAN XL 80MG CAPSULE
28596	JALYN 0.5-0.4MG CAPSULE

Non-Recommended Medication	
GCN	**Description**
10342	LABETALOL HCL 100MG TABLET
10341	LABETALOL HCL 200MG TABLET
10340	LABETALOL HCL 300MG TABLET
11340	METHERGINE 0.2MG/ML AMPULE
11350	METHYLERGONOVINE 0.2MG TABLET
20742	METOPROLOL SUCC ER 100MG TABLET
20743	METOPROLOL SUCC ER 200MG TABLET
12947	METOPROLOL SUCC ER 25MG TABLET
20741	METOPROLOL SUCC ER 50MG TABLET
20641	METOPROLOL TARTRATE 100MG TABLET
17734	METOPROLOL TARTRATE 25MG TABLET
37653	METOPROLOL TARTRATE 37.5MG TB
20642	METOPROLOL TARTRATE 50MG TABLET
37656	METOPROLOL TARTRATE 75MG TABLET
51551	METOPROLOL-HCTZ 100-25MG TAB
51552	METOPROLOL-HCTZ 100-50MG TAB
51550	METOPROLOL-HCTZ 50-25MG TAB
01250	MINIPRESS 1MG CAPSULE
01251	MINIPRESS 2MG CAPSULE
01252	MINIPRESS 5MG CAPSULE
20654	NADOLOL 20MG TABLET
20652	NADOLOL 40MG TABLET
20653	NADOLOL 80MG TABLET
52060	NADOLOL-BENDROFLU 40-5MG TABLET
52061	NADOLOL-BENDROFLU 80-5MG TABLET
99236	NEBIVOLOL 10 MG TABLET
18703	NEBIVOLOL 20 MG TABLET
99235	NEBIVOLOL 2.5 MG TABLET
07055	NEBIVOLOL 5 MG TABLET
20680	PINDOLOL 10MG TABLET
20681	PINDOLOL 5MG TABLET
01250	PRAZOSIN 1MG CAPSULE
01251	PRAZOSIN 2MG CAPSULE
01252	PRAZOSIN 5MG CAPSULE
20630	PROPRANOLOL 10MG TABLET
20631	PROPRANOLOL 20MG TABLET
45260	PROPRANOLOL 20MG/5ML SOLUTION
45261	PROPRANOLOL 40MG/5ML SOLUTION
20632	PROPRANOLOL 40MG TABLET

Non-Recommended Medication	
GCN	**Description**
20633	PROPRANOLOL 60MG TABLET
20634	PROPRANOLOL 80MG TABLET
03231	PROPRANOLOL ER 120MG CAPSULE
03232	PROPRANOLOL ER 160MG CAPSULE
03233	PROPRANOLOL ER 60MG CAPSULE
03230	PROPRANOLOL ER 80MG CAPSULE
52030	PROPRANOLOL-HCTZ 40-25MG TABLET
52031	PROPRANOLOL-HCTZ 80-25MG TABLET
16857	RAPAFLO 4MG CAPSULE
16858	RAPAFLO 8MG CAPSULE
16857	SILODOSIN 4MG CAPSULE
16858	SILODOSIN 8MG CAPSULE
39516	SORINE 120MG TABLET
39511	SORINE 160MG TABLET
39513	SORINE 240MG TABLET
39512	SORINE 80MG TABLET
39516	SOTALOL 120MG TABLET
39511	SOTALOL 160MG TABLET
39513	SOTALOL 240MG TABLET
39512	SOTALOL 80MG TABLET
37877	SOTYLIZE 5MG/ML ORAL SOLUTION
48191	TAMSULOSIN HCL 0.4MG CAPSULE
66991	TENORETIC 100 TABLET
66990	TENORETIC 50 TABLET
20660	TENORMIN 100MG TABLET
20662	TENORMIN 25MG TABLET
20661	TENORMIN 50MG TABLET
47127	TERAZOSIN 10MG CAPSULE
47124	TERAZOSIN 1MG CAPSULE
47125	TERAZOSIN 2MG CAPSULE
47126	TERAZOSIN 5MG CAPSULE
20670	TIMOLOL MALEATE 10MG TABLET
20671	TIMOLOL MALEATE 20MG TABLET
20672	TIMOLOL MALEATE 5MG TABLET
20742	TOPROL XL 100MG TABLET
20743	TOPROL XL 200MG TABLET
12947	TOPROL XL 25MG TABLET
20741	TOPROL XL 50MG TABLET
45063	ZIAC 10-6.25MG TABLET

Non-Recommended Medication	
GCN	**Description**
45061	ZIAC 2.5-6.25MG TABLET
45062	ZIAC 5-6.25MG TABLET

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Allergen Extracts

Clinical Criteria References

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9. Dykewicz MS, Wallace DV, Baroody F, et al. Treatment of seasonal allergic rhinitis. An evidence-based focused 2017 guideline update. Ann Allergy Asthma Immunol 2017;1-23.

10. Grastek Prescribing Information. Horsholm, Denmark. ALK-Abello Inc. December 2019.

11. Palforzia Prescribing Information. Brisbane, CA. Aimmune Therapeutics. July 2022.

12. Ragwitek Prescribing Information. Horsholm, Denmark. ALK-Abello Inc. April 2021.

13. Odactra Prescribing Information. Horsholm, Denmark. ALK-Abello Inc. January 2023

Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
01/29/2015	Presented to the DUR Board
02/27/2015	Initial publication and posting to website
07/31/2015	Review of ICD-9 and ICD-10 codes
08/01/2018	Annual review by staff Removed ICD-9 codes Updated Table 7, pages 8-11 Added GCN for Odactra, page 17 Updated references, page 22
11/09/2018	Removed criteria for Grastek – drug is not currently on formulary Removed GCN for Odactra, page 12
03/21/2019	Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each 'Drug Requiring PA' table
07/15/2019	Annual review by staff Removed criteria for Ragwitek – drug is no longer on formulary Updated Table 5, page 6 Updated Table 7, pages 7-10 Updated references, page 11
12/10/2019	Updated age to 5 years for Oralair on criteria logic and diagram, pages 3 and 4 Updated Table 6, page 6
07/22/2022	Revised diagnoses to include only allergic rhinitis due to pollen (J301) Updated criteria to require trial of an intranasal corticosteroid and an intranasal antihistamine Added GCNs for metoprolol (37653, 37656) and nebivolol (99236, 18703, 99235, 07055)
07/25/2022	Updated lookback for epinephrine and prior therapy to 730 days as requested by the DUR Board Updated prior therapy to include approval if a trial of a combination intranasal corticosteroid/intranasal antihistamine agent is found
12/01/2022	Annual review by staff Added GCNs for budesonide (40708) and fluticasone (37683) Updated references

Publication Date	Notes
03/23/2023	Added Palforzia criteria to Allergen Extracts guide Added additional ICD-10 codes for peanut allergy (T7801XA, T7801XD, T7801XS)
08/31/2023	Added criteria for Grastek and Ragwitek (previously approved by the DUR Board)
09/20/2023	Updated lookback for auto-injectable epinephrine for Oralair to 365 days
01/09/2024	Annual review by staff Added GCNs for Auvi-Q (44487, 28038, 19862), Dymista (32099), and Ryaltris (49205) Removed GCNs for Beconase AQ (47100), Nasonex (71431), and Patanase (99602)
05/30/2024	Removed GCNs for Dymista (32099) from intranasal corticosteroid table
08/31/2024	Annual review by staff Added criteria for Odactra Updated age to ≥ 5 years for Ragwitek Updated references