

**UNIVERSITY PHYSICIANS HEALTH PLANS**  
(University Family Care)

**PHARMACY REFERRAL GUIDELINE**

**LEUKOTRIENE INHIBITORS**

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- FDA Approved Indications
  - Chronic asthma (Montelukast - Singulair®; Zafirlukast - Accolate®)
  - Allergic rhinitis (Montelukast - Singulair®)
- Criteria for Use
  - Chronic asthma
    - Must be on inhaled corticosteroids with demonstrated compliance for at least three months (regular prescription refills documented in pharmacy profile).
    - Initial approval for three months. Must provide objective evidence of improvement for further authorization. Examples of supportive documentation include pulmonary function tests, spirometry, use of short-acting beta-agonist, asthma-related hospitalizations, and emergency department/urgent care visits for asthma.
  - Allergic rhinitis (Montelukast - Singulair® only)
    - Most have a documented trial of an antihistamine **and** a nasal steroid for at least three months with inadequate control.
    - Initial approval for three months. Must provide evidence of improvement for further authorization.

*Approved by the Pharmacy and Therapeutics Committee 2/06; Revised and Approved by the Pharmacy and Therapeutics Committee 8/07; Reviewed 6/06, 1/08, 5/09*