



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Trelegy

Page: 1 of 2

Effective Date: 2/1/2024

Last Review Date: 1/2024

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

**Intent:**

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Trelegy under the patient’s prescription drug benefit.

**Description:**

This program applies to the triple inhaler products (ICS-LABA-LAMA) specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

**Applicable Drug List:**

**Table. Drug Class/Therapeutic Category**

	Product(s)
<b>Preferred*</b>	• <b>Breztri (budesonide-glycopyrrolate-formoterol)</b>
<b>Targeted</b>	• <b>Trelegy (fluticasone-umeclidinium-vilanterol)</b>

\*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

**Policy/Guideline:**

**Criteria for Approval:**

Coverage for the targeted product is provided when any of the following criteria are met:

A. Member has a diagnosis of asthma that is persistently uncontrolled despite use of a medium to high potency ICS-LABA

**OR**

B. Member has a documented inadequate response, intolerable adverse event, or contraindication with any of the preferred products.

**Approval Duration and Quantity Restrictions:**

**Approval:** 12 months



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**References:**

1. Trelegy (fluticasone-umeclidinium-vilanterol) [package insert]. Durham, NC: GlaxoSmithKline; June 2023.
2. Breztri (budesonide-glycopyrrolate-formoterol) [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; January 2022.
3. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2023. Updated July 2023. Available from: [www.ginasthma.org](http://www.ginasthma.org)