Clinical Policy: Budesonide/Albuterol (Airsupra®)

Reference Number: AR.QC.CP.PMN.259
Effective Date: 01.01.27
Last Review Date: 10.26
Line of Business:QualChoice

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

- Budesonide/Albuterol (Airsupra®) is a combination ICS/SABA inhaler

FDA Approved Indication(s)

Airsupra is indicated for the treatment or prevention of a transient increase in bronchospasm (e.g., episodic wheezing) as asthma reliever therapy and to reduce the risk of asthma exacerbation

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that inhaled agents for asthma and COPD are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Relief of asthma symptoms and to reduce the risk of asthma exacerbation (must meet all)**:**

1. Diagnosis of asthma as FDA-approved for the requested agent
2. Age ≥ 18 years;
3. Failure of one generic albuterol sulfate HFA product in combination with one ICS (e.g., fluticasone propionate diskus/HFA) AND budesonide/formoterol (generic Symbicort) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated
4. Request does not exceed one of the following (a or b):
   a. The health plan quantity limit;
   b. The FDA-approved maximum dose for the relevant indication (see *Section V*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed

under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Relief of asthma symptoms and to reduce the risk of asthma exacerbation (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, request does not exceed one of the following (a or b):
   a. The health plan quantity limit;
   b. The FDA-approved maximum dose for the relevant indication (see *Section V*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

EIB: exercise-induced bronchospasm
FDA: Food and Drug Administration
LABA: long acting beta-2 agonist
FEV1: forced expiratory volume
FVC: forced vital capacity
ICS: inhaled corticosteroid
GINA: Global Initiative for Asthma

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
albuterol (Proventil HFA®, Ventolin HFA®)	*Metered-dose inhaler (MDI)*: 2 puffs every 4 to 6 hours as needed *Nebulization solution:* 2.5 mg via oral inhalation every 6 to 8 hours as needed	*MDI*: 12 puffs/day *Nebulization solution*: 4 doses/day or 10 mg/day Higher maximum dosages for inhalation products have been recommended in National Asthma Education and Prevention Program guidelines for acute exacerbations of asthma.
Arnuity Ellipta (fluticasone furoate)	Asthma: ≥ 12 years: 100-200 mcg inhaled QD 5-11 years: 50 mcg inhaled QD	Asthma: ≥ 12 years: 200 mcg/day 5-11 years: 50 mcg/day
budesonide/formoterol (Symbicort)	Asthma: 2 inhalations BID	Asthma: 160/4.5 mcg BID
fluticasone propionate (Flovent Diskus)	Asthma: 1 inhalation BID (starting dosage is based on asthma severity)	Asthma: 2,000 mcg/day
fluticasone propionate (Flovent HFA)	Asthma: 1 inhalation BID	Asthma: 1,760 mcg/day
fluticasone/salmeterol (Advair Diskus, Wixela Inhub)	Asthma: 1 inhalation BID (starting dosage is based on asthma severity	Asthma: 500/50 mcg BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Qvar RediHaler (beclomethasone)	Asthma: ≥ 12 years: 40 mcg, 80 mcg, 160 mcg, or 320 mcg inhaled BID 4-11 years: 40 mcg or 80 mcg inhaled BID	Asthma: ≥ 12 years: 640 mcg/day 4-11 years: 160 mcg/day
Serevent (salmeterol)	Asthma: 1 inhalation (50 mcg) BID	Asthma: 100 mcg/day
Asmanex HFA	Asthma: 2 inhalations BID (starting dosage is based on age and asthma severity)	800 mcg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - All agents: hypersensitivity to any component of the requested agent or the following as additionally specified:
    - Milk proteins
- Boxed warning(s): none reported

Appendix D: General Information

- Historical management of asthma has involved an as-needed short-acting beta agonist for reliever therapy, with stepwise approach to add on controller maintenance therapies such as inhaled corticosteroids and long-acting beta agonists. In 2019, the Global Initiative for Asthma (GINA) guidelines for asthma management and prevention began recommending that inhaled corticosteroids be initiated as soon as possible after diagnosis of asthma, including use as reliever therapy (to be administered as-needed alongside a short-acting beta agonist). The National Asthma Education and Prevention Program from the National Heart, Lung, and Blood Institute followed suit with their recommendations in 2020. GINA guidelines currently recommend budesonide/formoterol as the preferred anti-inflammatory reliever therapy for adults/adolescents while ICS + SABA is an alternative option.

I. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Airsupra	Asthma	2 inhalations prn for asthma symptoms	12 inhalations/24 hours

II. Product Availability

Drug Name	Availability
Airsupra	Inhalation aerosol: pressurized metered dose inhaler that delivers a combination of albuterol 90 mcg and budesonide 80 mcg per actuation

III. References

SABA

1. ProAir Digihaler Prescribing Information. Parsippany, NJ: Teva Pharmaceuticals USA, Inc; September 2020. Available at: https://www.proair.com/globalassets/proair/hfa/proair_digihaler_pil.pdf. Accessed October 27, 2025.
2. Nelson HS, Bensch G, Pleskow WW, et al. Improved bronchodilation with levalbuterol compared with racemic albuterol in patients with asthma. J Allergy Clin Immunol. 1998; 102: 943-952.
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ICS

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ICS/SABA
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy adapted from CP.PMN.259 for Arkansas QualChoice use	10.02.26	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent

judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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