Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.017	**Effective Date: 01/01/2020** **Revision Date: 07/2020**
Policy Name: Angiotensin Modulator Combinations	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q3 2020 annual review: no changes.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:**

Clinical Policy: Angiotensin Modulator Combinations

Reference Number: PHW.PDL.017
Effective Date: 01/01/2020
Last Review Date: 07/2020

Revision Log

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 PA Health and Wellness® that Angiotensin Modulator Combinations are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Angiotensin Modulator Combinations

A. Prescriptions That Require Prior Authorization

Prescriptions for Angiotensin Modulator Combinations that meet any of the following conditions must be prior authorized:

1. A non-preferred Angiotensin Modulator Combination drug.

2. An Angiotensin Modulator Combination drug with a prescribed quantity that exceeds the quantity limit.

3. An Angiotensin Modulator Combination drug when there is a record of a recent paid claim for a Calcium Channel Blocker, ACE Inhibitor, Angiotensin Receptor Blocker (ARB), or another Angiotensin Modulator Combination (Therapeutic Duplication)

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Angiotensin Modulator Combination drug, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For a non-preferred Angiotensin Modulator Combination drug, whether the beneficiary has a history of a contraindication, intolerance to, or therapeutic failure of the preferred Angiotensin Modulator Combination drugs

AND

2. For therapeutic duplication, whether:

   a. The beneficiary is being titrated to, or tapered from, a drug in the same class

OR

b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

AND

3. If a prescription for an Angiotensin Modulator Combination is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Angiotensin Modulator Combination drug. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. **Approval Duration: 12 months**

E. References

1. Amturnide package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012.
2. http://www.fda.gov/drugs/drugsafety/ucm300889.htm, accessed May 2012.
3. Tekamlo package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012.
4. Valturna package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. April 2012.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020