Clinical Policy: Angiotensin Modulators

Reference Number: PHW.PDL.113
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 PA Health & Wellness® that Angiotensin Modulators are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Angiotensin Modulators

A. Prescriptions That Require Prior Authorization

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

1. A non-preferred Angiotensin Modulator, including an Angiotensin Modulator in combination with HCTZ.

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

3. An Angiotensin Modulator when there is a record of a recent paid claim for another Angiotensin Modulator or an Angiotensin Modulator Combination (therapeutic duplication).

B. Exemptions from Prior Authorization

The following are exempt from prior authorization:

1. Qbrelis (lisinopril oral solution) when prescribed for a child under 9 (nine) years of age.

2. Epaned (enalapril oral solution) when prescribed for a child under 9 (nine) years of age.

C. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Angiotensin Modulator, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For an aliskiren agent, **both** of the following:

a. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

b. Has a documented diagnosis of uncontrolled hypertension despite treatment with the following drug classes at maximum tolerated Food and Drug Administration (FDA)-approved doses unless contraindicated: calcium channel blockers, beta blockers, diuretics, ACE inhibitors, and ARBs;

AND

2. For all other non-preferred Angiotensin Modulators, has a history of therapeutic failure, contraindication, or intolerance of the preferred Angiotensin Modulators;

AND

3. For therapeutic duplication, **one** of the following:

   a. Is being titrated to or tapered from another Angiotensin Modulator or Angiotensin Modulator Combination
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

AND

4. If a prescription for an Angiotensin Modulator 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 member does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section C. above to assess the medical necessity of a prescription for an Angiotensin Modulator. If the guidelines in Section C. 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 member.

E. **Approval Duration: 12 months**

F. References

1. Colucci, W.S. Overview of the therapy of heart failure with reduced ejection fraction. UpToDate, accessed August 23, 2018.
2. Drazner, M. Use of angiotensin II receptor blocker and neprilysin inhibitor in heart failure with reduced ejection fraction. UpToDate, accessed August 23, 2018.
3. Entresto prescribing information. Novartis November 2017.
4. http://www.fda.gov/drugs/drugsafety/ucm300889.htm, accessed May 2012.
5. Mandrola, J. The Benefits of Slow Medicine Apply to Entresto. Medscape, July 16, 2015.
6. Practice Changing Updates. Cardiovascular Medicine (July 2015) Angiotensin receptor-neprilysin inhibitor for heart failure. UpToDate, accessed August 7, 2015.
7. Stiles, S. After Sinking in, PARADIGM-HF Critiqued at HFSA Sessions. Medscape September 25, 2014.
8. Tekturna package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. November 2017.
9. Tekturna HCT package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. November 2016.
10. Yancy C.W., et al. 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. J Am Coll Cardiol 2017; Volume 70, Issue 6:776-803.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026 annual review: no changes.	11/2025