

Title: Progressive Medication Program for Angiotensin II Receptor Antagonists

Origination: 05/25/11	Revised: 11/11/11	Annual Review: 12/15/11
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Purpose:

To provide guidelines and criteria for the review and decision determination of requests for medications that requires prior authorization.

Background Information:

Medication Summary

- Angiotensin II receptor antagonists (ARBs) are a class of medications used in the treatment of hypertension. All available agents have an FDA-approved indication for hypertension. However, only two (2) medications, candesartan and valsartan are FDA-approved for the treatment of heart failure.
- Angiotensin II receptor antagonists block the AT receptors thereby blocking angiotensin II, the primary vasoactive hormone in the rennin-angiotensin system. By blocking angiotensin II, ARBs decrease systemic vascular resistance without a marked change in heart rate.
- ARBs have been recommended in patients who cannot tolerate angiotensin converting enzyme (ACE) inhibitors due to cough or angioedema.
- The following ARBs (with HCTZ) are currently available in the marketplace as individual products or in combination with diuretics, calcium channel blockers and direct renin inhibitors: azilsartan (Edarbi), candesartan (Atacand/HCT), eprosartan (Teveten/HCT), irbesartan (Avapro/Avalide), losartan (Cozaar/Hyzaar), olmesartan (Benicar/HCT), amlodipine/olmesartan (Azor/Tribenzor), telmisartan (Micardis/HCT), and valsartan (Diovan/HCT), amlodipine/valsartan (Exforge/HCT), and aliskiren/valsartan (Valturna).

Reference Statement

- Guidelines are compiled from available US Food and Drug Administration (FDA) approved indications, general practice guidelines, and/or evidence-based uses established through phase III clinical studies without published conflicting data. Only clinical studies published in their entirety in reputable peer-reviewed journals will be evaluated.

Eligibility Criteria

- Member must be eligible and have applicable benefit coverage.
- Prior authorization requests that do not meet clinical criteria in this Procedure will be forwarded to a Clinical Pharmacist for review.

Exclusion criteria

- Member must not be pregnant.

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Procedure:

- 1.0 Request for *initial therapy* with losartan or losartan/hctz requires documentation from the Member's medical records maintained by the requesting independent practitioner's office verifying the following:
 - 1.1 Member is new Member to AvMed (eligibility within the past 120 days) and has been on targeted medication prior to joining AvMed (evidenced by progress notes from prescriber indicating use or documented previous fill history with pharmacy);
 - OR**
 - 1.1 Member has tried and failed one (1) ACE inhibitor (amlodipine/benazepril, benazepril/HCT, captopril/HCT, enalapril/HCT, enalapril/felodipine, fosinopril/HCT, lisinopril/HCT, moexipril/HCT, perindolapril, quinapril/HCT, ramipril, trandolapril/HCT, or any brand name ARB listed in the medication summary above;
 - 1.2 If all criteria are met, request may be approved for one (1) month with quantity limit of 30 tablets for 30 days. Refills should continue to process every month thereafter.
- 2.0 Request for *initial therapy* with Exforge, Exforge HCT, Diovan, Diovan HCT or Valturna requires documentation from the Member's medical records maintained by the requesting independent practitioner's office verifying the following:
 - 2.1 Member is new Member to AvMed (eligibility within the past 120 days) and has been on targeted medication prior to joining AvMed (evidenced by progress notes from prescriber indicating use or documented previous fill history with pharmacy);
 - OR**
 - 2.1 Member has tried and failed one (1) ACE inhibitor (amlodipine/benazepril, benazepril/HCT, captopril/HCT, enalapril/HCT, enalapril/felodipine, fosinopril/HCT, lisinopril/HCT, moexipril/HCT, perindolapril, quinapril/HCT, ramipril, trandolapril/HCT);
 - 2.2 If all criteria are met, request may be approved for one (1) month with quantity limit of 30 tablets for 30 days. Refills should continue to process every month thereafter.

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Procedure, continued:

- 3.0 Request for *initial therapy* with Atacand, Atacand HCT, Avapro, Avalide, Azor, Benicar, Benicar HCT, Edarbi, Micardis, Micardis HCT, or Tribenzor requires documentation from the Member's medical records maintained by the requesting independent practitioner's office verifying the following:
- 3.1 Member is new Member to AvMed (eligibility within the past 120 days) and has been on targeted medication prior to joining AvMed (evidenced by progress notes from prescriber indicating use or documented previous fill history with pharmacy); **OR**
 - 3.1 Member has tried and failed one (1) product in each of the following medication categories:
 - 3.1.1 ACE Inhibitor (identified in 1.2 above); **AND**
 - 3.1.2 Losartan, losartan hct, Cozaar, or Hyzaar; **AND**
 - 3.1.3 Exforge, Exforge HCT, Diovan, Diovan HCT, or Valtorna; **AND**
 - 3.2 If all criteria are met, request may be approved for one (1) month with quantity limit of 30 tablets for 30 days. Refills should continue to process every month thereafter.

References:

1. DRUGDEX[®] System (electronic version). Thomson MICROMEDEX, Greenwood Village, Colorado, USA. Available at: <http://csi.micromedex.com>
2. Lexi-Comp Online (electronic version) Lexi-Comp Inc. 1978-2010, Hudson, Ohio, USA. Available at: <http://online.lexi.com/crlsql/servlet/crlonline>

Disclaimer Information:

Prior Authorization criteria are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions based on the Member's benefit plan contract and these criteria. This guideline sets forth concise clinical coverage criteria which have been developed from a review of current literature, policies of the FDA and other government agencies, and other appropriate references, in consultation and with approval from practicing physicians who are members of AvMed's Pharmacy and Therapeutic committee. Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change. The use of these criteria is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.