MEDICAL MUTUAL®

Drug Policy

Policy:	**Angiotensin Receptor Blocker (ARB)** **Preferred Step Therapy**	**Annual Review Date: 08/20/2020** **Last Revised Date: 08/20/2020**
Impacted Drugs:	Atacand® (candesartan tablets) Atacand HCT® (candesartan/hydrochlorothiazide tablets) Avalide® (irbesartan/hydrochlorothiazide tablets) Avapro® (irbesartan tablets) Azor® (olmesartan/amlodipine tablets) Benicar® (olmesartan tablets) Benicar HCT® , (olmesartan/hydrochlorothiazide tablets) Cozaar® (losartan tablets) Diovan® (valsartan tablets) Diovan HCT® (valsartan/hydrochlorothiazide tablets) Edarbi® (azilsartan tablets) Edarbyclor® (azilsartan/chlorthalidone tablets) Exforge® (valsartan/amlodipine tablets) Exforge HCT® (valsartan/amlodipine/hydrochlorothiazide tablets) Hyzaar® (losartan/hydrochlorothiazide tablets) Micardis® (telmisartan tablets) Micardis® HCT (telmisartan/hydrochlorothiazide tablets) Prexxartan® (valsartan oral solution – BioRamo)Tribenzor® (olmesartan/amlodipine/hydrochlorothiazide tablets) Twynsta® (telmisartan/amlodipine tablets)	

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OVERVIEW

Angiotensin receptor blockers (ARBs) (also known as angiotensin II receptor antagonists) are all indicated for adults with hypertension. Some ARBs have other indications as well. Several ARBs are also available generically including losartan, losartan plus hydrochlorothiazide (HCTZ), candesartan, candesartan plus HCTZ, irbesartan, irbesartan plus HCTZ, olmesartan, olmesartan/HCTZ, Olmesartan/amlodipine/HCTZ, telmisartan, telmisartan plus amlodipine, telmisartan/HCTZ, valsartan, valsartan plus HCTZ, valsartan plus amlodipine, the combination of valsartan/amlodipine/HCTZ and telmisartan plus amlodipine.

POLICY STATEMENT

A preferred step therapy program has been developed to encourage the use of a preferred product prior to the use of a non-preferred product. If the preferred step therapy rule is not met for a non-preferred agent at the point of service, coverage will be determined by the preferred step therapy criteria below. All approvals are provided for 1 year in duration.

Automation: Patients with a history of one Step 1 drug within the 130-day look-back period are excluded from step therapy.

Preferred Medications

- Candesartan and candesartan/HCTZ
- Irbesartan, and irbesartan/HCTZ
- Losartan and losartan/HCTZ
- Olmesartan
- Olmesartan/HCTZ
- Olmesartan and amlodipine
- Olmesartan/amlodipine/hydrochlorothiazide tablets
- Telmisartan and telmisartan/ amlodipine and telmisartan/HCTZ,
- Valsartan and valsartan/amlodipine and valsartan/HCTZ and valsartan/amlodipine/hydrochlorothiazide

Non-Preferred Medications

- Atacand® (candesartan tablets)
- Atacand HCT® (candesartan/hydrochlorothiazide tablets)
- Avalide® (irbesartan/hydrochlorothiazide tablets)
- Avapro® (irbesartan tablets)
- Azor® (olmesartan/amlodipine tablets)
- Benicar® (olmesartan tablets)
- Benicar HCT® , (olmesartan/hydrochlorothiazide tablets)
- Cozaar® (losartan tablets)

- Diovan® (valsartan tablets)
- Diovan HCT® (valsartan/hydrochlorothiazide tablets)
- Edarbi® (azilsartan tablets)
- Edarbyclor® (azilsartan/chlorthalidone tablets)
- Exforge® (valsartan/amlodipine tablets)
- Exforge HCT® (valsartan/amlodipine/hydrochlorothiazide tablets)
- Hyzaar® (losartan/hydrochlorothiazide tablets)
- Micardis® (telmisartan tablets)
- Micardis® HCT (telmisartan/hydrochlorothiazide tablets)
- Prexxartan® (valsartan oral solution – BioRamo)
- Tribenzor® (olmesartan/amlodipine/hydrochlorothiazide tablets)
- Twynsta® (telmisartan/amlodipine tablets)

PREFERRED STEP THERAPY CRITERIA

1. Coverage is provided for the non-preferred medication in situations where the patient has had an inadequate response, experienced intolerance, OR has a contraindication to at least two preferred angiotensin receptor blockers.
2. Authorization may be given for Prexxartan if the patient has difficulty swallowing tablets.

Initial Approval/ Extended Approval.
A) *Initial Approval:* 365 days
B) *Extended Approval:* 365 days

Preferred Step Therapy Exception Criteria
In certain situations, the patient is not required to trial preferred agents. Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred agents. If so, please list specific diagnosis and/or specific patient characteristics [documentation required]; **OR**
B. The patient has a contraindication to all preferred agents. If so, please list the specific contraindications to each preferred agent [documentation required]; **OR**
C. The patient is continuing therapy with the requested non-preferred agent after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:

1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred agent for 90 days within a 130-day look-back period; OR
2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred agent for 90 days AND that the patient has been receiving the requested non-preferred agent via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred agent); OR
3. There are no generic alternatives to the requested non-preferred agent [NOTE: ESI reviewer to list generic alternatives for requested non-preferred medication and confirm accuracy of physician response]

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as [documentation required]. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.**REFERENCES**

- Diovan® tablets [prescribing information]. East Hanover, NJ: Novartis Pharmaceutical Corporation; February 2017.
- Avapro® tablets [prescribing information]. Bridgewater, NJ: sanofi-aventis; February 2016.
- Cozaar® tablets [prescribing information]. Whitehouse Station, NJ: Merck & Co., Inc.; December 2015.
- Atacand® tablets [prescribing information]. Wilmington, DE: AstraZeneca; July 2016.
- Micardis® tablets [prescribing information]. Ridgefield, CT: Boehringer Ingelheim; December 2014.
- Benicar® tablets [prescribing information]. Parsippany, NJ: Daiichi Sankyo Pharma; November 2016.
- Edarbi® tablets [prescribing information]. Osaka, Japan and Atlanta, GA: Takeda and Arbor Pharmaceuticals; October 2016.
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- Edarbyclor® tablets [prescribing information]. Osaka, Japan and Atlanta, GA: Takeda and Arbor Pharmaceuticals; October 2016.
- Exforge® tablets [prescribing information]. East Hanover, NJ: Novartis; August 2015.
- Exforge® HCT tablets [prescribing information]. East Hanover, NJ: Novartis; July 2015.

- Azor® tablets [prescribing information]. Parsippany, NJ: Daiichi Sankyo, Inc; January 2017.
- Twynsta® tablets [prescribing information]. Ridgefield, CT: Boehringer Ingelheim; January 2016.
- Tribenzor® tablets [prescribing information]. Parsippany, NJ: Daiichi Sankyo; January 2017.
- Prexxartan® oral solution [prescribing information]. Fort Lauderdale, FL: BioRamo; December 2017.