# Clinical Policy: Cardiovascular Agents: Angina, Hypertension & Heart Failure

Reference Number: OH.PHAR.PPA.29
Effective Date: 01-2020
Last Review Date: 11.21
Line of Business: Medicaid

Coding Implications
*remove if no codes added*
Revision Log

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

**Description**
See **Appendix A** for list of preferred and non-preferred Cardiovascular Agents

**FDA Approved Indication(s):** Varies by drug product, please see package insert; clinical pharmacology or other appropriate clinical reference.

**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 Buckeye Health Plan® that Non-Preferred medication is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Prescribed medication requires prior authorization as noted in appendix A (must meet 1,2,3, and 4 OR 5)**

1. **Prescribed indication is FDA-approved or supported by standard pharmacopeias**
2. **Member must meet labeled age requirements for the medication**
3. **Member has failed therapeutic trials of no less than 30 days with TWO (2) preferred medications within the same class unless one of the following (a,b, or c)**
   a. Allergy to all medications not requiring prior approval
   b. Contraindication to all medications not requiring prior approval
   c. History of unacceptable/toxic side effects to medications not requiring prior approval
4. **The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated**
5. **If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication.** This medication should be reviewed for need at each request for reauthorization.

**Approval duration: 12 months**

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**II. Initial Approval Criteria if prescribed medication is Ivabradine (Corlanor)**

**A. Heart Failure (must meet all):**

1. Diagnosis of stable, symptomatic heart failure
2. Age ≥ 6 months;
3. **Baseline LVEF ≤ 35% for adults or ≤ 45% for pediatrics;**
4. Member is in sinus rhythm with a resting heart rate of 70 bpm or higher
5. Heart failure symptoms persisting with maximally tolerated doses of appropriate beta blockers recommended for heart failure, or patient has a contraindication to beta blocker therapy.

**Approval duration: 12 months**

**III. Initial Approval Criteria if prescribed medication is Valsartan/sacubitril (Entresto)**

**A. Diagnosis of chronic heart failure (NYHA Class II-IV)**

1. **Baseline Left ventricular ejection fraction less than or equal to 40%**
2. **Age ≥ 18 years;**
3. **At the time of request, member has none of the following contraindications:**
   a. Concomitant use with ACE inhibitors;
   b. If member has a diagnosis of diabetes, concomitant use with aliskiren;
4. Dose does not exceed sacubitril 194 mg/valsartan 206 mg (2 tablets) per day.

**Approval duration: 12 months**

**IV. Initial Approval Criteria if prescribed medication is <u>Verquvo</u>**

**A. Diagnosis of chronic heart failure (NYHA Class II-IV)**

1. Left ventricular ejection fraction less than 45%
2. Patient has been hospitalized for the treatment of heart failure within the previous 180 days or needs treatment with an outpatient intravenous diuretic within the previous 90 days
3. Patient must be treated with an agent from ALL the following medication classes unless contradicted: Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, or an angiotensin receptor neprilysin inhibitor; Beta-blocker; Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function

**Approval duration: 12 months**

**<u>**Please see preferred and non-preferred charts below in Appendix A**</u>**

## Appendix A

| Cardiovascular Agents: Angina, Hypertension and Heart Failure | |
|---|---|
| **Preferred** | **Non-Preferred** |
| Acebutolol | Aliskiren |
| Amlodipine | Candesartan |
| Amlodipine Valsartan | Candesartan/Hydrochlorothiazide |
| Amlodipine/Benazepril | Carospir |
| Amlodipine/Olmesartan | Carvedilol ER |
| Amlodipine/Valsartan/Hydrochlorothiazide | Corlanor |
| Atenolol | Edarbi |
| Atenolol/Chlorthalidone | Diltiazem 24HR ER tabs |
| Benazepril | Edarbyclor |
| Benazepril/Hydrochlorothiazide | Enalapril Sol |
| Betaxolol | Hydralazine/Hydrochlorothiazide |
| Bisoprolol | Innopran XL |
| Bisoprolol/Hydrochlorothiazide | Isradipine |
| Bystolic | Kapspargo |
| Captopril | Katerzia |
| Captopril/Hydrochlorothiazide | Nebivolol |
| Cartia XT | Nimodipine |
| Carvedilol | Nisoldipine |
| Clonidine | Nymalize |
| Diltiazem | Qbrelis |
| Diltiazem 12HR ER caps | Sotylize |
| Diltiazem 24HR ER caps | Tekturna/HCT |
| Doxazosin | Telmisartan |
| Dutoprol | Telmisartan/Hydrochlorothiazide |
| Enalapril | Verapamil 200, 300mg ER 24HR |
| Enalapril/Hydrochlorothiazide | Verquvo |
| Entresto **PA** | |
| Epaned **BvD** | |
| Eplerenone | |
| Felodipine ER | |
| Fosinopril | |
| Fosinopril/Hydrochlorothiazide | |
| Guanfacine | |
| Hemangeol **AR** | |
| Hydralazine | |
| Irbesartan | |
| Irbesartan/Hydrochlorothiazide | |
| Labetalol | |
| Lisinopril | |
| Lisinopril/Hydrochlorothiazide | |
| Losartan | |
| Losartan/Hydrochlorothiazide | |
| Olmesartan | |
| Olmesartan/Amlodipine/ Hydrochlorothiazide | |
| Olmesartan/Hydrochlorothiazide | |
| Methyldopa | |
| Methyldopa/Hydrochlorothiazide | |

| | |
|---|---|
| Metoprolol Succinate ER<br>Metoprolol Tartrate<br>Metoprolol/Hydrochlorothiazide<br>Minoxidil<br>Moexipril<br>Nadolol<br>Nadolol/Bendroflumethiazide<br>Nicardipine<br>Nifedipine<br>Perindopril<br>Pindolol<br>Prazosin<br>Propranolol<br>Propranolol/Hydrochlorothiazide<br>Quinapril<br>Quinapril/Hydrochlorothiazide<br>Ramipril<br>Ranolazine<br>Sotalol<br>Spironolactone<br>Spironolactone/Hydrochlorothiazide<br>Telmisartan/Amlodipine<br>Terazosin<br>Timolol<br>Trandolapril<br>Trandolapril/Verapamil<br>Valsartan<br>Valsartan/Hydrochlorothiazide<br>Verapamil<br>Verapamil SR | |

* Note: Clinical criteria must be met

*** Note: nimodipine only approvable for 21 days after subarachnoid hemorrhage.**

*** AR - Hemangeol oral solution: a PA is required for patients over 2 years old**

## V. Diagnoses/Indications for which coverage is NOT authorized:

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.

## VI. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

PA: Prior Authorization

ER: Extended Release

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*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.*

*****See above tables for preferred alternatives***** *Dosing varies by drug product. See FDA approved dosing and administration.*
*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*

- *See package insert; clinical pharmacology or other appropriate clinical reference.*

**VII. Dosage and Administration:** varies by drug product. See package insert; clinical pharmacology or other appropriate clinical reference for FDA approved dosing and administration

**VIII. Product Availability:** See package insert; clinical pharmacology or other appropriate clinical reference for product availability

**VII. References.** Refer to package insert.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| New policy created. | 10.19 | |
| Added Katerzia oral suspension as a non-preferred calcium channel blocker | 03.20 | |
| Changed criteria point 3 for ranolazine to: 3. Member has had a therapeutic failure to no less than a 30 day trial of a beta blocker, a diltiazem product, **or** a nitrate (excluding sublingual nitroglycerin), or contraindications to these agents exist; indicating that a patient only needs to try/fail just one of the three preferred agents rather than try/fail all three. | 06.20 | |
| Ranolazine (generic Ranexa) changed to preferred, no PA required. | 11.20 | |
| Annual review: updated the preferred and non-preferred list; also added Hemangeol oral solution: a PA is required for patients over 2 years old | 10.21 | |
| Added: Section IV Verquvo - updated preferred- non-preferred chart | 11.21 | |

**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.

**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.