



**GEORGIA MEDICAID FEE-FOR-SERVICE
ANGIOTENSIN RECEPTOR BLOCKERS AND COMBINATIONS
PA SUMMARY**

Angiotensin Receptor Blockers (ARBs)

Preferred	Non-Preferred
Benicar (olmesartan) Irbesartan generic Losartan generic Micardis (telmisartan) Valsartan generic	Atacand (candesartan) Candesartan generic Edarbi (azilsartan) Eprosartan generic Telmisartan generic Teveten (eprosartan)

ARB Combinations

Preferred	Non-Preferred
Azor (amlodipine/olmesartan)* Benicar HCT (olmesartan/hydrochlorothiazide) Exforge (amlodipine/valsartan)* Exforge HCT (amlodipine/valsartan/hydrochlorothiazide)* Irbesartan/hydrochlorothiazide generic Losartan/hydrochlorothiazide generic Micardis HCT (telmisartan/hydrochlorothiazide) Tribenzor (olmesartan/amlodipine/hydrochlorothiazide)* Valsartan/hydrochlorothiazide generic	Amlodipine/valsartan generic Amlodipine/valsartan/hydrochlorothiazide generic Atacand HCT (candesartan/hydrochlorothiazide) Candesartan/hydrochlorothiazide generic Edarbyclor (azilsartan/chlorthalidone) Entresto (sacubitril/valsartan) Telmisartan/amlodipine generic Telmisartan/hydrochlorothiazide generic Teveten HCT (eprosartan/hydrochlorothiazide) Twynsta (telmisartan/amlodipine)

*Preferred agents that require PA.

LENGTH OF AUTHORIZATION: 1 Year

NOTES:

- ❖ If generic eprosartan is approved, the PA will be issued for brand Teveten.
- ❖ If generic candesartan is approved, the PA will be issued for brand Atacand.
- ❖ If generic candesartan/hydrochlorothiazide is approved, the PA will be issued for brand Atacand HCT.
- ❖ If generic telmisartan/amlodipine is approved, the PA will be issued for brand Twynsta.

PA CRITERIA:

For Atacand, Edarbi and Teveten

- ❖ Approvable for members that have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to two preferred ARB or ARB Combination products, one of which must be a losartan-containing product.



For Candesartan Generic

- ❖ In addition to meeting the criteria for brand Atacand, the prescriber must submit a written letter of medical necessity stating the reason(s) that brand Atacand is not appropriate for the member.

For Entresto

- ❖ Approvable for members 18 years or older with a diagnosis of chronic heart failure, including class II-IV or stage C-D and left ventricular ejection fraction $\leq 40\%$, that have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or intolerable side effects to angiotensin converting enzyme (ACE) inhibitor therapy and ineffectiveness to ARB therapy, including valsartan.
- ❖ In addition, member must take with beta blocker therapy for heart failure or be unable to take beta blocker therapy.

For Eprosartan Generic

- ❖ In addition to meeting the criteria for brand Teveten, the prescriber must submit a written letter of medical necessity stating the reason(s) that brand Teveten is not appropriate for the member.

For Telmisartan Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) that brand Micardis is not appropriate for the member.

For Azor and Exforge

- ❖ Approvable for members that have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to a losartan-containing product.

For Exforge HCT and Tribenzor

- ❖ Approvable for members that have experienced ineffectiveness with losartan/hydrochlorothiazide

OR

- ❖ Member must have experienced allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to losartan.

For Atacand HCT and Teveten HCT

- ❖ Approvable for members that have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to two preferred ARB/Diuretic Combination products, one of which must be losartan/hydrochlorothiazide.

For Candesartan/Hydrochlorothiazide Generic

- ❖ In addition to meeting the criteria for brand Atacand HCT, the prescriber must submit a written letter of medical necessity stating the reason(s) that brand Atacand HCT is not appropriate for the member.

For Edarbyclor

- ❖ Approvable for members that have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to two preferred ARB/Diuretic Combination products, one of which must be losartan/hydrochlorothiazide.



For Telmisartan/Amlodipine Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) generic amlodipine and brand Micardis as separate prescriptions as well as brand Twynsta are not appropriate for the member.

For Telmisartan/Hydrochlorothiazide Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) that brand Micardis HCT is not appropriate for the member.

For Twynsta

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) generic amlodipine and brand Micardis as separate prescriptions as are not appropriate for the member.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to <http://dch.georgia.gov/prior-authorization-process-and-criteria> and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the Quantity Level Limits (QLL), please go to <https://www.mmis.georgia.gov/portal>, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.