GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ALISKIREN AND COMBINATIONS PA SUMMARY

Non-Preferred
Tekturna (aliskiren) Tekturna HCT (aliskiren/hydrochlorothiazide)

LENGTH OF AUTHORIZATION: 1 Year

PA CRITERIA:

Tekturna and Tekturna HCT

- Approvable for members with a diagnosis of hypertension that have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with an angiotensin-converting enzyme inhibitor or ACE inhibitor/diuretic, angiotensin receptor blocker (ARB) or ARB/diuretic AND at least one other antihypertensive medication (diuretic, beta blocker or calcium channel blocker).

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 www.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 current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.