



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

Preferred	Non-Preferred
Angiotensin Receptor Blockers (ARBs)	
Irbesartan generic Losartan generic Olmesartan generic Telmisartan generic Valsartan generic	Candesartan generic Edarbi (azilsartan)
ARB Combinations	
Amlodipine/valsartan generic* Entresto (sacubitril/valsartan)* Irbesartan/hydrochlorothiazide generic Losartan/hydrochlorothiazide generic Olmesartan/hydrochlorothiazide generic Valsartan/hydrochlorothiazide generic	Amlodipine/olmesartan generic Candesartan/hydrochlorothiazide generic Edarbyclor (azilsartan/chlorthalidone) Exforge HCT (amlodipine/valsartan/hydrochlorothiazide) Micardis HCT (telmisartan/hydrochlorothiazide) Telmisartan/amlodipine generic Telmisartan/hydrochlorothiazide generic Tribenzor (olmesartan/amlodipine/hydrochlorothiazide) Twynsta (telmisartan/amlodipine)

*Preferred agents that require PA; HCT, HCTZ=hydrochlorothiazide

LENGTH OF AUTHORIZATION: 1 year

NOTES:

- Amlodipine/valsartan generic and Entresto are preferred but require prior authorization.
- If generic telmisartan/hydrochlorothiazide is approved, the PA will be issued for brand Micardis HCT. If generic telmisartan/amlodipine is approved, the PA will be issued for brand Twynsta.

PA CRITERIA:

Candesartan Generic and Edarbi

- ❖ Approvable for members who have experienced an inadequate response, allergies, contraindications, drug-drug interaction, or intolerable side effects to at least two preferred ARB or ARB Combination products (excludes Entresto), one of which must be a losartan-containing product.

Amlodipine/Valsartan Generic

- ❖ Approvable for members who have experienced an inadequate response, allergy, contraindication, drug-drug interactions, or intolerable side effect to a losartan-containing product.

Candesartan/HCTZ Generic, Edarbyclor, Micardis HCT and Telmisartan/HCTZ Generic

- ❖ Approvable for members who have experienced an inadequate response with at least two preferred ARB/Diuretic Combination products, one of which must be



losartan/hydrochlorothiazide, or who have experienced allergies, contraindications, drug-drug interactions, or intolerable side effects to at least two preferred ARB/Diuretic Combinations products, one of which must be a losartan-containing product.

Entresto

- ❖ Approvable for members 1 year of age and older with a diagnosis of heart failure.

Amlodipine/Olmesartan Generic, Exforge HCT, Telmisartan/Amlodipine Generic, Tribenzor and Twynsta

- ❖ Approvable for members who have experienced an inadequate response with losartan/hydrochlorothiazide and amlodipine/valsartan or who have experienced allergies, contraindications, drug-drug interactions or intolerable side effects to losartan and valsartan.

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 Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL list.