



ARB-COMBINATIONS PA SUMMARY

PREFERRED	Avalide (brand), Benicar HCT, Diovan HCT (brand), Exforge, Exforge HCT, Losartan HCT, Micardis HCT
NON-PREFERRED	Atacand HCT (brand), Candesartan/Hydrochlorothiazide (generic), Edarbyclor, Irbesartan/Hydrochlorothiazide (generic), Teveten HCT, Valsartan/Hydrochlorothiazide (generic)

LENGTH OF AUTHORIZATION: 1 Year

NOTE: *Preferred (except Losartan HCT) and non-preferred agents require prior authorization. If generic candesartan/hydrochlorothiazide is approved, the PA will be issued for brand-name Atacand HCT. Physicians discharging a member from an inpatient facility stable and responding to a non-preferred agent should request prior authorization as part of the patient’s discharge planning.*

PA CRITERIA:

For Preferred Agent Exforge

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

For Preferred Agents Avalide (brand), Benicar HCT, Diovan HCT (brand), Exforge HCT, Micardis HCT

- ❖ Member must have failed a trial of generic losartan HCT
- OR
- ❖ Member must have experienced allergies, contraindications, drug-to-drug interactions, or intolerable side effects to losartan.

For Non-Preferred Agents Atacand HCT (brand or generic candesartan/hydrochlorothiazide), Teveten HCT

- ❖ Member must have failed a trial two preferred ARB-diuretic products, one of which must be generic losartan HCT
- OR
- ❖ Member must have experienced allergies, contraindications, drug-to-drug interactions, intolerable side effects to two preferred ARB-diuretic products, one of which must be generic losartan HCT.

For Non-Preferred Agent Edarbyclor

- ❖ Member must have failed a trial two preferred ARB-diuretic products, one of which must be generic losartan HCT
- OR
- ❖ Member must have experienced allergies, contraindications, drug-to-drug interactions, or intolerable side effects to two preferred ARB-diuretic products, one of which must be generic losartan HCT.

AND



- ❖ Physician should submit a written letter of medical necessity stating the reason(s) the two separate products, Edarbi and chlorthalidone, are not appropriate for the member.

For Non-Preferred Agents Irbesartan/Hydrochlorothiazide and Valsartan/Hydrochlorothiazide

- ❖ Physician should submit a written letter of medical necessity stating the reason(s) that the equivalent brand-name product, Avalide or Diovan HCT, is not appropriate for the member. Member must also meet all criteria for the brand-name product.

EXCEPTIONS:

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

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.