

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Angiotensin Modulator Combinations (formerly Angiotensin Modulator/Calcium Channel Blocker (CCB) Combination Drugs)**

A. Prescriptions That Require Prior Authorization

Prescriptions for Angiotensin Modulator Combinations that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Angiotensin Modulator Combination drug. See Preferred Drug List (PDL) for the list of preferred Angiotensin Modulator Combinations at:  
[www.providersynergies.com/services/documents/PAM\\_PDL.pdf](http://www.providersynergies.com/services/documents/PAM_PDL.pdf)
2. A prescription for a preferred Angiotensin Modulator Combination drug with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits at:  
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>
3. A prescription for an Angiotensin Modulator Combination drug when there is a record of a recent paid claim for a Calcium Channel Blocker, ACE Inhibitor, ARB, or another Angiotensin Modulator Combination in PROMISE, the Department's Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Angiotensin Modulator Combination drug, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For an initial request for approval of an Aliskiren Agent – Whether the recipient:
  - a. Is 18 years of age or older

**AND**

- b. Is not pregnant

**AND**

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- c. Has a documented diagnosis of uncontrolled hypertension despite treatment with the following drug classes at maximum tolerated FDA approved doses unless contraindicated: Calcium Channel Blockers, Beta Blockers, Diuretics, ACE Inhibitors, and ARBs

**AND**

- d. Is not taking Cyclosporine, Itraconazole, or high doses of diuretics

**AND**

- e. If diabetic, is not taking an ACE Inhibitor or an Angiotensin Receptor Blocker (ARB)

**AND**

- f. Was evaluated for secondary causes of hypertension (including renal artery stenosis, pheochromocytoma, hypercortisolism, and hyperaldosteronism)

**AND**

- g. Has baseline kidney function and electrolyte testing

**AND**

- h. Does not have a CrCl<30mL/minute

**OR**

- i. If taking an ACE Inhibitor or ARB, does not have a CrCl<60mL/minute

**AND**

- j. Does not have a history of allergy to ACE Inhibitors or ARBs
- 2. For a request for renewal of a prescription for an Aliskiren Agent – Whether the recipient:
    - a. Is not pregnant

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**AND**

- b. Is not taking Cyclosporine, Itraconazole, or high doses of diuretics

**AND**

- c. If diabetic, is not taking an ACE Inhibitor or an Angiotensin Receptor Blocker (ARB)

**AND**

- d. Has repeat kidney function and electrolyte testing showing that this agent is well tolerated

**AND**

- e. Does not have a CrCl<30mL/minute

**OR**

- f. If taking an ACE Inhibitor or ARB, does not have a CrCl <60mL/minute

- 3. For all other non-preferred Angiotensin Modulator Combinations, whether the recipient has a history of a contraindication, intolerance to, or therapeutic failure of the preferred Angiotensin Modulator Combination drugs.

**AND**

- 4. For therapeutic duplication, whether:
  - a. The recipient is being titrated to, or tapered from, a drug in the same class

**OR**

- b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested
- 5. In addition, if a prescription for either a preferred or non-preferred Angiotensin Modulator Combination is in a quantity that exceeds the quantity limit, the determination of whether

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the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

**OR**

6. The recipient does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for an Angiotensin Modulator Combination drug. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

**References:**

1. Amturnide package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012
2. Valturna package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. April 2012
3. Tekamlo package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012
4. <http://www.fda.gov/drugs/drugsafety/ucm300889.htm>, accessed May 2012