

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Angiotensin Modulators (Formerly referred to as ACE Inhibitors)

A. Prescriptions That Require Prior Authorization

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

1. A prescription for a non-preferred Angiotensin Modulator, including Angiotensin Modulators in combination with HCTZ, regardless of the quantity prescribed. See Preferred Drug List (PDL) for the list of preferred Angiotensin Modulators at:
www.providersynergies.com/services/documents/PAM_PDL.pdf
2. A prescription for a preferred Angiotensin Modulator 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 ACE Inhibitor when there is a record of a recent paid claim for another ACE Inhibitor, an ARB, or an Angiotensin Modulator Combination in PROMISE, the Department's Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication)
4. A prescription for an ARB when there is a record of a recent paid claim for another ARB, an ACE Inhibitor, or an 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, 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

November 18, 2013
(Replacing November 13, 2012)

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

AND

- b. Is not pregnant

AND

- c. Has a documented diagnosis of uncontrolled hypertension despite treatment with the following drug classes at maximum tolerated Food and Drug Administration (FDA) approved doses unless contraindicated: Calcium Channel blockers, Beta Blockers, Diuretics, ACE Inhibitors, and Angiotensin Receptor Blockers (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 ARB

AND

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

AND

- g. Has baseline kidney function and electrolyte testing

AND

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

OR

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

AND

- j. Does not have a history of allergy to ACE Inhibitors or ARBs

November 18, 2013
(Replacing November 13, 2012)

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

2. For a request for a renewal of a prescription for an Aliskiren Agent
– Whether the recipient:

a. Is not pregnant

AND

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

AND

c. If diabetic, is not taking an ACE Inhibitor or an ARB

AND

d. Has repeat kidney function and electrolyte testing

AND

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

OR

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

3. For all other non-preferred Angiotensin Modulators - Whether the recipient has a history of therapeutic failure or intolerance of the preferred Angiotensin Modulators.

4. For therapeutic duplication, whether:

a. For an ACE Inhibitor, the recipient is being titrated to, or tapered from, another ACE Inhibitor, an ARB, or an Angiotensin Modulator Combination

b. For an ARB, the recipient is being titrated to, or tapered from, another ARB, an ACE Inhibitor, or an Angiotensin Modulator Combination

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November 18, 2013
(Replacing November 13, 2012)

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

- c. 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 is in a quantity that exceeds the quantity limit, the determination of whether 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. 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. Tekturna package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012
2. Tekturna HCT package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012
3. <http://www.fda.gov/drugs/drugsafety/ucm300889.htm>, accessed May 2012

November 18, 2013
(Replacing November 13, 2012)