GENERIC STEP THERAPY PLANS (GSTP)

DRUG CLASS **ANGIOTENSIN II RECEPTOR ANTAGONISTS (ARBs)**
DIRECT RENIN INHIBITORS

PGST SSB – Ref# 366-D: Edarbi

HPGST SSB – Ref# 399-D: Edarbi, Tekturna

TGST SSB – Ref# 376-D: Edarbi, Tekturna

Status: CVS Caremark Criteria
Type: Initial Step Therapy; Post Step Therapy Prior Authorization

INITIAL STEP THERAPY
If the patient has filled a prescription for at least a 30 day supply of a generic ACE, ACE/HCTZ combination, ARB, or ARB/HCTZ combination product or generic ACE/CCB combination product within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA
Branded ARBs will be covered with post step therapy prior authorization when the following criteria are met:

- Patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one generic ACE, ACE/HCTZ combination, ARB, or ARB/HCTZ combination product or generic ACE/CCB combination product.

RATIONALE
If the patient has filled a prescription for at least a 30 day supply of a generic ACE, ACE/HCTZ combination, ARB, or ARB/HCTZ combination product or generic ACE/CCB combination product within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit.

If the patient does not meet the initial step therapy criteria, then prior authorization is required.

If the patient has a documented contraindication to or a potential drug interaction with a generic drug, then the requested brand drug will be covered. If the patient is intolerant to at least one of the generic drugs, then the requested brand drug will be covered. If the patient has tried one of the generic drugs for at least 30 days and had an inadequate treatment response, then the requested brand drug will be covered. If these requirements are met, then the approval duration is 24 months.

REFERENCES
N/A

Written by:	UM Development
Date Written:	04/2009
Revised:	09/2009, 10/2009, 04/2010, 07/2010, 10/2010, 03/2011, 05/2011, 09/2011, 01/2012 (removed Teveten), 03/2012 (removed Avapro), 07/2012 (removed Diovan), 09/2012 (updated formatting and documentation & removed Atacand), 10/2012 (removed documentation), 09/2013 (updated grids, re-worded question 2, removed Micardis), 05/2014 (reordered questions), 08/2014 (removed Teveten 400mg), 04/2015, 04/2016 (removed Benicar), 04/2017 (no clinical changes),(SF) 04/2018 (no clinical changes)
Reviewed:	Medical Affairs, 05/2009, 09/2009, 10/2009, 07/2010, 10/2010, 03/2011, 09/2011, 01/2012, 03/2012, (KP) 07/2012; (DC) 09/2012, 09/2013, (DC) 05/2014, (LB) 04/2015
External Review:	05/2009, 12/2009, 03/2011, 12/2011, 12/2012, 12/2013, 08/2014, 08/2015, 08/2016, 08/2017, 08/2018

CRITERIA FOR APPROVAL

1	Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of a generic ACE, ACE/HCTZ, ARB, ARB/HCTZ, or ACE/CCB combination product? [If yes, then no further questions.]	Yes	No
2	Does the patient have a documented contraindication to or a potential drug interaction with a generic ACE, ACE/HCTZ, ARB, ARB/HCTZ, or ACE/CCB combination product? [If yes, then no further questions.]	Yes	No
3	Has the patient had a trial and was intolerant to at least one generic ACE, ACE/HCTZ, ARB, ARB/HCTZ, or ACE/CCB combination product?	Yes	No

Guidelines for Approval					
Duration of Approval		24 Months			
Set 1 - Failed Trial		Set 2 – Contraindication		Set 3 – Intolerance	
Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)
1	None	2	1	3	1
					2

Mapping Instructions		
	Yes	No
1	Approve, 24 months	Go to 2
2	Approve, 24 months	Go to 3
3	Approve, 24 months	Deny