# Angiotensin II Receptor Blocker (ARB)
# June 19, 2019

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| **Plan** | ☒ MassHealth<br>☐Commercial/Exchange | **Program Type** | ☐ Prior Authorization<br>☐ Quantity Limit<br>☒ Step Therapy |
| **Benefit** | ☒ Pharmacy Benefit<br>☐ Medical Benefit (NLX) | | |
| **Specialty Limitations** | N/A | | |
| **Contact Information** | **Specialty Medications** | | |
| | All Plans | Phone: 866-814-5506 | Fax: 866-249-6155 |
| | **Non-Specialty Medications** | | |
| | MassHealth | Phone: 877-433-7643 | Fax: 866-255-7569 |
| | Commercial | Phone: 800-294-5979 | Fax: 888-836-0730 |
| | Exchange | Phone: 855-582-2022 | Fax: 855-245-2134 |
| | **Medical Specialty Medications (NLX)** | | |
| | All Plans | Phone: 844-345-2803 | Fax: 844-851-0882 |
| **Exceptions** | N/A | | |

## Overview

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:
**First-Line:** Medications listed on first-line are covered without prior-authorization.
**Second-Line:** Second-line medications will pay if the member has filled at least two different first-line medications or a second-line medication within the past 180 days.

## Coverage Guidelines

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member has had a documented inadequate response or side effect to at least two (2) different first-line medications.

| FIRST-LINE | SECOND-LINE |
|---|---|
| Generic ACE Inhibitors<br>losartan<br>losartan/HCTZ<br>irbesartan<br>irbesartan/HCTZ<br>valsartan<br>valsartan/HCTZ | candesartan<br>candesartan/HCTZ<br>olmesartan<br>olmesartan/amlodipine/HCTZ<br>Edarbi & Edarbyclor<br>telmisartan<br>telmisartan/HCTZ<br>eprosartan 600mg |

## Limitations
Approvals will be granted for 36 months.

## References
N/A

## Review History
06/27/05 – Reviewed
06/26/06 – Reviewed
04/23/07 – Updated
04/28/08 – Reviewed
04/27/09 – Updated
11/23/09 –Twynsta
04/26/10 – Reviewed
12/15/10 – Disclaimer
04/25/11 – Reviewed
09/02/11 – Added 2nd line agents pay if 3rd-line approved
02/03/12 – Eprosartan 600mg
03/19/12 – Edarbyclor
04/11/12 – Avapro/Avalide generics
04/23/12 – Reviewed
02/06/13 – Diovan HCT & Atacand HCT
04/22/13 – Updated
06/03/13 – April P&T updates & Atacand generic
04/28/14 – Reviewed
03/09/15 – Diovan generic
04/27/15 – Reviewed
06/27/16 – Updated
06/26/17 – Reviewed
06/25/18 – Updated
06/19/19 – Retired for CommExch

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