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Pharmacy Policy

Exforge/ Exforge HCT

Policy Number: 9.623
Revision Number: R0
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☒ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☐ MassHealth - MCO ☐ MassHealth - ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Exforge (amlodipine/valsartan)**
- **Exforge HCT (amlodipine/valsartan/hydrochlorothiazide)**

***Generic equivalents covered without prior authorization**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications unless otherwise excluded
Exclusion	None

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Criteria	
Required Medical Information	1. Diagnosis of Hypertension; AND 2. Trial and Failure of 2 preferred Angiotensin II Receptor Blockers and Combinations (See Appendix A); OR 3. Trial and Failure of 3 preferred Calcium Channel Blockers and Combinations (See Appendix B)
Age Restrictions	None
Prescriber Restriction	None
Coverage Duration	1 year
Other criteria	Reauthorization: 1. Currently receiving medication via Well Sense benefit or member has previously met initial approval criteria; **AND** 2. Attestation of continued efficacy, monitoring and appropriateness of therapy.

Appendix A: Angiotensin II Receptor Blockers/Combinations

PREFERRED Products	
amlodipine/olmesartan (generic for Azor®)	Trial and failure of **2** Preferred products required prior to Non-Preferred products
amlodipine/olmesartan/HCTZ (generic for Tribenzor®)	
amlodipine/valsartan (generic for Exforge®)	
amlodipine/valsartan/HCTZ	
candesartan (generic for Atacand®)	
candesartan/HCTZ (generic for Atacand HCT®)	
Diovan®	
Entresto®	
eprosartan (generic for Teveten®)	
irbesartan (generic for Avapro®)	
irbesartan/HCTZ (generic for Avalide®)	
losartan (generic for Cozaar®)	
losartan/HCTZ (generic for Hyzaar®)	
olmesartan (generic for Benicar®)	
olmesartan/HCTZ (generic for Benicar HCT®)	
telmisartan (generic for Micardis®)	
telmisartan/amlodipine (generic for Twynsta)	
telmisartan /HCTZ (generic for Micardis HCT®)	
valsartan (generic for Diovan®)	

valsartan/HCTZ (generic for Diovan HCT®)	

Appendix B: Calcium Channel Blockers/Combinations

PREFERRED Products	
afeditab CR® (generic for Adalat CC®)	Trial and failure of **3** Preferred products required prior to Non-Preferred products
amlodipine (generic for Norvasc®)	
amlodipine/benazepril (generic for Lotrel®)	
felodipine ER (generic for Plendil®)	
isradipine (generic for Dynacirc®)	
nicardipine (generic for Cardene®)	
nifediac CC (generic for Adalat CC®)	
nifedical XL (generic for Procardia XL®)	
nifedipine IR (generic for Procardia®)	
nifedipine SA/ER/XL (generic for Procardia XL®)	
nimodipine (generic for Nimotop®)	
nisoldipine	

Clinical Background Information and References

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	P&T Committee, NH DHHS

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	New Policy created for NH	1/1/2021	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.