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Pharmacy Policy

Beta Blockers

Policy Number: 9.602

Revision Number: R1

Version Effective Date: 1/1/2021

Product Applicability <input type="checkbox"/> All Plan+ Products	
Well Sense Health Plan <input checked="" type="checkbox"/> New Hampshire Medicaid <input type="checkbox"/> _____	Boston Medical Center HealthNet Plan <input type="checkbox"/> MassHealth - MCO <input type="checkbox"/> MassHealth - ACO <input type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct <input type="checkbox"/> Senior Care Options <input type="checkbox"/> _____

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

Prior Authorization Policy

Products Affected:

- **Hemangeol (propranolol)**
- **Sotylize (sotalol)**

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

Covered Us	All FDA approved indications unless otherwise excluded
Exclusion Criteria	<u>Hemangeol</u> <ol style="list-style-type: none"> 1. Premature infants with corrected age of less than 5 weeks 2. Member weighs less than 2 kilograms 3. Member has contraindications to treatment (e.g., history of pheochromocytoma, blood pressure less than 50/30 mmHg, etc.)

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Required Medical Information	<p>Hemangeol Documentation of the following:</p> <ol style="list-style-type: none"> 1. Diagnosis of proliferating infantile hemangioma requiring systemic therapy. <p>Sotylize Documentation of the following:</p> <ol style="list-style-type: none"> 1. A diagnosis of life-threatening ventricular arrhythmias or highly symptomatic atrial fibrillation or atrial flutter; AND 2. Inadequate response or intolerance to generic sotalol tablets; AND 3. Rationale for using liquid formulation. AND 4. Trial and Failure of 3 preferred products required (See Appendix A for list of Preferred Beta Blockers and Combinations).
Age Restrictions	Hemangeol: Member is between 5 weeks to 5 months
Prescriber Restriction	None
Coverage Duration	1 year
Other criteria	<p>Sotylize Reauthorization criteria:</p> <ol style="list-style-type: none"> 1. Continued inability to take an oral tablet or capsule due to difficulty swallowing

Appendix A:

Preferred BETA-BLOCKERS AND COMBINATION	
acebutolol (generic for Sectral®)	nadolol (generic for Corgard®)
atenolol/chlorthalidone (generic for Tenoretic®)	nadolol/bendroflumethiazide (generic for Corzide®)
betaxolol (generic for Kerlone®)	pindolol (generic for Visken®)
bisoprolol (generic for Zebeta®)	propranolol (generic for Inderal®)
bisoprolol /HCTZ (generic for Ziac®)	propranolol ER (generic for Inderal LA®)
carvedilol (generic for Coreg®)	propranolol/HCTZ (generic for Inderide®)
labetalol (generic for Normodyne® and Trandate®)	sotalol (generic for Betapace®)
metoprolol (generic for Lopressor®)	sotalol AF (generic for Betapace AF®)
metoprolol/HCTZ (generic for Lopressor HCT®)	Sorine®
metoprolol succinate ER/HCTZ (generic for Dutoprol®)	timolol (generic for Blocadren®)
metoprolol succinate (generic for Toprol XL®)	

Clinical Background Information and References

1. James PA. 2014 Evidence-based guidelines for the management of high blood pressure in adults. Report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014;311(5):507-520

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2. Yancy CW. 2013 ACCF/AHA guideline for the management of heart failure. *Circulation*. 2013;128(16);e240-e327
3. Product Information: Hemangeol™, propranolol oral solution. Pierre Fabre Pharmaceuticals, Inc, Parsippany, NJ, 2014
4. Product Information: Sotylize™, sotalol oral solution. Arbor Pharmaceuticals, Atlanta, GA, 2015.
5. Hogeling M, Adams S, Wargon O. A randomized controlled trial of propranolol for infantile hemangiomas. *Pediatrics*. 2011;128:e259-e266.
6. Metry DW. Management of infantile hemangiomas. UpToDate. Last updates March 9, 2015. Accessed April 16, 2015. Available at www.uptodate.com.

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

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date	Approved by
12/1/2020	Policy 9.164 Discontinued. Created separate policy for NH only. Criteria change to try 3 preferred products for Sotylize per NH PDL.	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.

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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.

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