BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Step Therapy Policy - Antihypertensive Agents

Policy Number: 9.615
Version Number: 2
Version Effective Date: 3/1/2022

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan	**Boston Medical Center Healthnet Plan**
☐ New Hampshire Medicaid	☒ Masshealth - MCO
	☒ Masshealth - ACO
	☐ Qualified Health Plans
	☐ Senior Care Options

Note: Disclaimer and Audit Information Is Located At the End of This Document.

Prior Authorization Policy

POLICY STATEMENT:
A step therapy program has been developed to encourage the use of generic Step-1 products prior to the use of a Step-2 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

Standard Criteria:
The Plan May Authorize Coverage Of The Products in Appendix A For Members Meeting The Following Criteria When Step Therapy Is Not Met At Point Of Sale From Claims History:

1. Prescribers must provide documentation (including dates of trial and outcome) that the member has tried and failed the appropriate number of Step 1 agents as indicated in Appendix A ;OR
2. Prescriber must provide documentation that the member has a contraindication to or other clinical rationale preventing the use of ALL Step 1 agents indicated in Appendix A

+ *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.

Appendix A: Step Therapy Details

ACEI		
Step 1	**Step 2**	**Coverage Criteria**
Benazepril Benzapril/HCTZ Benzapril/Amlodipine Enalapril Enalapril/HCTZ Fosinipril Fosinopril/HCTZ Lisinopril Lisinpril/HCTZ Ramipril	Captopril Tablet Prestalia Tablet	. Pharmacy Claims Indicating The Use of 3 Step 1 Generic ACEI Or Generic ACEI Combo Drugs In The Past 365 Days.

ARB		
Step	**Step 2**	**Coverage Criteria**
Irbesartan Tablet Irbesartan-Hctz Tablet Losartan Tablet Losartan -Hctz Tablet Olmesartan Tablet Olmesartan–Hctz Tablet Telmisartan Tablet Telmisartan-Hctz Tablet Valsartan Tablet Valsartan-Hctz Tablet	Amlodipine/Olmesartan Tablet Amlodipine/Telmisartan Tablet Candesartan Tablet Candesartan/Hctz Tablet Eprosartan Tablet	Pharmacy Claims Indicating The Use of A Trial Of 3 Step 1 Generic ARBs Or Generic ARB Combo Drugs in the last 365 days.

Beta-Blockers I		
Step 1	**Step 2**	**Coverage Criteria**

Acebutolol Cap Atenolol Tab Betaxolol Tab Bisoprolol Tab Carvedilol IR Tab Labetolol Tab Metoprolol Succinate Tab Metoprolol Tartrate Tab Nadolol mg Tab Propranolol Tab	Nebivolol (Bystolic) Tablet	Pharmacy Claims Indicating The Use of two (2) Step 1 Agent in the last 130 days

Beta – Blockers II		
Step 1	**Step 2**	**Coverage Criteria**
Acebutolol Cap Atenolol Tab Betaxolol Tab Bisoprolol Tab Carvedilol IR Tab Labetolol Tab Metoprolol Succinate ER Tab Metoprolol Tartrate Tab Nadolol Tab Propranolol Tab	Carvedilol ER Cap	Pharmacy Claims Indicating The Use of Carvedilol IR And One Other Beta Blocker In The Last 130 days

BB DUTOPROL		
Step 1	**Step 2**	**Coverage Criteria**
Hydrochlorothiazide Cap 12.5 Mg Hydrochlorothiazide 25mg Tab Metoprolol Succinate ER Tab	Dutoprol Tab ER 24 Hr	Pharmacy Claims Indicating The Use of Metoprolol and Hydrochlorothiazide Given Separately For At Least 30 Days In The Past 130 Days

Original Approval Date	Original Effective Date	Policy Owner	Approved By
12/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary Of Revisions**	**Revision Effective Date**	**Approved By**
12/10/2020	Created separate policies per applicable line of business. Coverage duration changed to 1 year. Addition of policy statement and standard criteria. Changed trial look back to 130 days from 120 days.		P&T Committee
11/11/2021	Annual review: Propranolol ER removed from ST. Bystolic updated to Nebivolol to reflect generic availability. Updated criteria to standard ST language.	3/1/2022	P&T Committee

Next Review Date

11/2022

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.

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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.