Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

Angiotensin Receptor Blockers

Non-formulary ARBs including:
- azilsartan (Edarbi®)
- azilsartan-chlorthalidone (Edarbyclor)
- candesartan (Atacand®)
- candesartan-hydrochlorothiazide (Atacand HCT®)
- eprosartan (Teveten®)
- eprosartan-hydrochlorothiazide (Teveten HCT®)
- olmesartan-amlodipine (Azor®)
- telmisartan (Micardis®)
- telmisartan-hydrochlorothiazide (Micardis HCT®)

Will be covered on the prescription drug benefit when the following criteria are met:

- Diagnosis of Congestive Heart Failure, Diabetes Mellitus, Post Myocardial Infarction, Hypertension, Proteinuria or Microalbuminuria on Problem List
- AND -
  - Documented treatment failure, intolerance or contraindication to:
    - ACE inhibitor or ACE-inhibitor-thiazide; AND
    - Losartan or Losartan-HCTZ; AND
    - Valsartan or Valsartan-HCTZ; AND
    - Irbesartan or Irbesartan-HCTZ
  - For HTN: in addition to above, documented treatment failure, intolerance or contraindication to or inadequate BP control with: thiazide diuretic and calcium channel blocker (e.g., amlodipine).
- OR -
- Dose change only: Patient previously met criteria and is already taking the drug.