Manual Prior Authorization

MISSISSIPPI DIVISION OF MEDICAID

Valsartan/sacubitril (Entresto™)
[Angiotensin II receptor blocker (ARB)/ Neprilysin inhibitor combination]

PRIOR AUTHORIZATION CRITERIA:
Select the diagnosis:
☐ Heart failure (with or without hypertension);
- New York Heart Association (NYHA) Class _____

ICD-10 code(s):_____

Requests for Entresto (sacubitril/valsartan) may be approved if the following criteria are met: *(Yes should be checked for each statement):*

☐ Yes ☐ No Age ≥ 18 years

☐ Yes ☐ No Diagnosis of chronic heart failure (NYHA Class II-IV)

☐ Yes ☐ No Ejection Fraction ≤ 40%

☐ Yes ☐ No Has not used an ACE inhibitor within at least 36 hours prior to starting sacubtril/valsartan therapy or during therapy

☐ Yes ☐ No Current ARB will be discontinued before initiating treatment with Entresto, if applicable

Authorization is for 12 months. Quantity Limit: 60 tablets every 30 days.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Reauthorization: If this is a reauthorization request, answer the following question:
☐ Yes ☐ No Is there documentation of positive clinical response to therapy?

Additional information to consider:
Entresto (sacubitril/valsartan) should <u>not</u> be considered for use if:
- Pregnant or wishing to become pregnant or currently breastfeeding;
- History of angioedema related to previous ACE inhibitor or ARB therapy;
- Severe hepatic impairment (Child-Pugh C);
- Used in combination with Tekturna (aliskiren) and has a diagnosis of Diabetes; OR Renal Impairment (eGFR) < 60 mL/min/1.73 m^2.