Pharmacy Medical Necessity Guidelines: Inspra® (eplerenone)

Effective: March 14, 2017

Prior Authorization Required: √  Type of Review – Care Management
Not Covered: Type of Review – Clinical Review: √
Pharmacy (RX) or Medical (MED) Benefit: RX  Department to Review: RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

Fax Numbers: RXUM: 617.673.0988

Note: For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Step Therapy Criteria. Background, applicable product and disclaimer information can be found on the last page.

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS
Inspra (eplerenone) is indicated for improving survival of stable patients with left ventricular systolic dysfunction (left ventricular ejection fraction ≤40%) and congestive heart failure after an acute myocardial infarction (MI) with other agents. Inspra (eplerenone) is also indicated for hypertension, alone or combined with other agents.

Inspra (eplerenone) is indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and MIs.

These benefits have been observed in controlled trials of antihypertensive drugs from a wide variety of pharmacologic classes.

COVERAGE GUIDELINES

Note: Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of service. If the Member does not meet the initial step therapy criteria, the prescription will deny at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit PA requests to the plan using the Universal Pharmacy Medical Review Request Form for Members who do not meet the step therapy criteria at the point of service.

Please refer to the table below for formularies and medications subject to this policy:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Tufts Health Plan Large Group Plans</th>
<th>Tufts Health Plan Small Group and Individual Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>spironolactone</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>spironolactone/hydrochlorothiazide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eplerenone</td>
<td>Requires prior use of a drug on Step-1 or Step-2</td>
<td>Requires prior use of Step-1 or Step-2 Not Covered</td>
</tr>
</tbody>
</table>

Automated Step Therapy Coverage Criteria
The following stepped approach applies to coverage of Step-2 medications by the plan:

Step 1: Medications on Step-1 are covered without prior authorization.
Step 2: The plan may cover Inspra® (eplerenone) or eplerenone if the following criteria are met:
• The Member has had a trial of a Step-1 or Step-2 medication within the previous 180 days as evidenced by a previous paid claim under the prescription benefit administered by the plan.

Coverage Criteria Members not meeting the Automated Step Therapy Coverage Criteria at the Point of Service
The following stepped approach applies to eplerenone and Inspra (eplerenone):
1. Documented inability to tolerate the drug spironolactone (e.g., Aldactone®) because of clinically significant adverse effects  
   OR
2. The Member has had a trial of a Step-1 or Step-2 medication as evidenced by physician documented use, excluding the use of samples.

Note: The plan may cover medications on Step-2 if a Member has received one of the noncovered medications, listed below in the limitations section, within the previous 180 days as evidenced by physician documented use, excluding the use of samples.

LIMITATIONS
1. Medications on Step-2 are not covered unless the above step therapy criteria are met.
2. Previous use of samples or vouchers/coupons for brand name medications will not be considered for authorization.
3. The plan does not authorize coverage of non-covered medications through this step therapy program. The plan does not cover the following medications for all Commercial formularies: Aldactone® and Aldactazide®, Please refer to the Pharmacy Medical Necessity Guidelines for Non-Covered Drugs with Suggested Alternatives.
4. The plan does not cover the following medication for the MA/RI EHB formularies: Inspra®. Please refer to the Pharmacy Medical Necessity Guidelines for Non-Covered Drugs with Suggested Alternatives.

CODES
None

REFERENCES

APPROVAL HISTORY
July 2004: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
• June 14, 2005: No changes
• May 9, 2006: No changes
• May 8, 2007: No changes
• May 13, 2008: No changes
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BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service.
coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.