Program: Tekturna (aliskiren) and Tekturna HCT (aliskiren/hctz)

DESCRIPTION
The purpose of this document is to provide approval criteria and guidelines for prior authorization of benefits (PAB) of Tekturna (aliskiren) and Tekturna HCT (aliskiren/hctz). Claims submitted without obtaining prior authorization of benefits will reject on the pharmacy claim system.
Tekturna (aliskiren) and Tekturna HCT (aliskiren/hctz) are subject to quantity limits and will only be approved for the dosing limit that is supported by the FDA for the approved indication. Requests for quantities greater than the quantity limit will be reviewed for medical necessity by the health plan.

Applicable lines of business
RIteCare and Managed Pharmacy

Formulary
Tekturna (aliskiren) 150, 300mg tablets
Tekturna HCT (aliskiren/hctz) 150/12.5, 150/25mg, 300/12.5, 300/25mg tablets

Quantity limits apply

APPROVAL DURATION AND QUANTITY LIMITS
Approval Duration: Lifetime

APPROVAL CRITERIA
I. Failure of two angiotensin converting enzyme inhibitors (ACEIs) **OR**
II. Failure of two angiotensin receptor blockers (ARBs) **OR**
III. Failure of one angiotensin converting enzyme inhibitor (ACEI) and one angiotensin receptor blocker (ARB)
IV. Requests for greater than the limits listed in the table will need request for review

Look Back Criteria in Claims System
180 days look back for use of at least a 5 days supply of two ACEIs, **OR** two ARBs **OR** one ACEI and one ARB, if yes, approve, if no reject for PA