UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 2064-13
Program	Prior Authorization/Medical Necessity
Medication	Entresto® (valsartan-sacubitril)
P&T Approval Date	8/2015, 1/2016, 2/2017, 9/2017, 2/2018, 2/2019, 11/2019, 11/2020, 4/2021, 4/2022, 9/2022, 11/2023
Effective Date	2/1/2024

1. Background:

Entresto (valsartan-sacubitril) is indicated to reduce the risk of cardiovascular death and hospitalization for heart failure. Benefits are most clearly evident in patients with left ventricular ejection fraction (LVEF) below normal. It is also indicated for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients aged one year and older.

2. Coverage Criteria [a]:

A. **Initial Therapy**

1. **Entresto** will be approved based on **one** of the following criteria:

a. As continuation of therapy initiated during an inpatient stay

-OR-

b. Both of the following:

(1) Diagnosis of pediatric heart failure with systemic left ventricular systolic dysfunction which is symptomatic.
(2) Prescribed by or in consultation with a cardiologist.

-OR-

c. **All** of the following:

(1) Diagnosis of heart failure (with or without hypertension)

-AND-

(2) **One** of the following:

(a) Ejection fraction is less than or equal to 40 percent

-OR-

(b) **Both** of the following:

i. Ejection fraction greater than 40 percent
ii. Patient has structural heart disease (i.e. left atrial enlargement (LAE) or left ventricular hypertrophy (LVH)

-AND-

(3) Heart failure is classified as one of the following:

(a) New York Heart Association Class II
(b) New York Heart Association Class III
(c) New York Heart Association Class IV

-AND-

(4) Patient does not have a history of angioedema

-AND-

(5) Patient will discontinue any use of concomitant ACE Inhibitor or ARB before initiating treatment with Entresto. ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto

-AND-

(6) Patient is not concomitantly on aliskiren therapy

-AND-

(7) Entresto is prescribed by or in consultation with a cardiologist

Authorization will be issued for 12 months

B. **Reauthorization**

1. **Entresto** will be approved based on **both of** the following criteria:

a. The Entresto dose has been titrated to a dose of 97 mg/103 mg twice daily or the maximum labeled dose for pediatric patients, or to a maximum dose as tolerated by the patient

-AND-

b. Documentation of positive clinical response to therapy

Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply Limits may be in place.

4. References:

1. Entresto [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2021.
2. McMurray JJ, Desai AS, Gong J. Dual angiotensin receptor and neprilysin inhibition as an alternative to angiotensin-converting enzyme inhibition in patients with chronic systolic heart failure: rationale for and design of the prospective comparison of ARNI with ACEI to determine impact on global mortality and morbidity in heart failure trial (PARADIGM-HF). European Journal of Heart Failure 2013; 15: 1062–1073
3. McMurray JJ, Packer M, Desai AS, et al. Angio-tensin-neprilysin inhibition versus enalapril in heart failure. N Engl J Med 2014;371:993-1004.
4. Heidenreich PA, Bozkurt, B, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiolgy/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2022;145(18):e895-e1032.

Program	Prior Authorization/Medical Necessity - Entresto (valsartan-sacubitril)
Change Control	
8/2015	New program.
1/2016	Added in continuation of coverage after initiation from an inpatient stay. Changed EF criteria to ≤ 35% based on PARADIGM HF trial. Modified beta blocker language to state patient should be stabilized on beta blocker therapy. Included requirement of BNP levels based on PARADIGM HF trial and ACCF/AHA guidelines. Added prescriber requirement. For reauthorization criteria added a component that patient's dose has been titrated.
2/2017	Removed requirement that angioedema must be associated with an ACE inhibitor or ARB, based on the 2016 ACC/AHA/HFSA recommendation that Entresto should not be administered to patients with a history of angioedema. Updated references.
9/2017	Removed BNP requirement.
2/2018	Updated metoprolol to remove specification of metoprolol succinate. Revised ejection fraction from 35% to 40%.
12/2018	Administrative change to add statement regarding use of automated processes.
2/2019	Annual review. Updated references.
11/2019	Added criteria for coverage of pediatric heart failure. Updated references.
11/2020	Annual review. Updated references.
4/2021	Updated criteria to allow coverage with ejection fraction greater than 40% with structural heart disease based on updated labeling.
4/2022	Annual review with no changes.
9/2022	Removed beta-blocker requirement. Updated references.
11/2023	Annual review. Clarified reauthorization criteria for pediatric patients.