UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1243-7
Program	Prior Authorization/Non-Formulary
Medication	Amlodipine/valsartan/hydrochlorothiazide (generic Exforge HCT®*)
P&T Approval Date	3/2018, 3/2019, 3/2020, 6/2021, 6/2022, 10/2023, 10/2024
Effective Date	1/1/2025

1. Background:

The American College of Cardiology/American Heart Association Task Force recommends combination pills rather than individual components to improve adherence to antihypertensive therapy. This program allows for coverage of amlodipine/valsartan/hydrochlorothiazide (generic Exforge HCT*), a triple antihypertensive therapy, for members who have not achieved an adequate response with the medications taken separately due to lack of adherence.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Amlodipine/valsartan/hydrochlorothiazide (generic Exforge HCT*)** will be approved based on **both** of the following:

   a. Patient has a history of a trial resulting in a therapeutic failure (i.e. blood pressure goal not met), to **both** of the following taken concomitantly:

      i. amlodipine/valsartan (generic Exforge)
      ii. hydrochlorothiazide

   -AND-

   b. Patient is unable to adhere to antihypertensive therapy and prescriber determines combination therapy would be beneficial.

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Amlodipine/valsartan/hydrochlorothiazide (generic Exforge HCT*)** will be approved based on the following criterion:

   a. 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.

*Brand Exforge HCT is typically excluded from coverage.

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.

4. References:

1. Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension.* 2017
2. Exforge HCT [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2023.

Program	Prior Authorization/Non-Formulary – Amlodipine/valsartan/hydrochlorothiazide (generic Exforge HCT)
Change Control	
3/2018	New program.
3/2019	Annual review. No changes.
3/2020	Annual review. Updated references.
6/2021	Formatting changes. Updated reference.
6/2022	Annual review. Updated reference.
10/2023	Annual review. Updated reference.
10/2024	Annual review. No changes.