

PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)	ENTRESTO (sacubitril and valsartan)
--------------------------------	---

Status: *CVS Caremark Criteria*
Type: *Initial Prior Authorization*

POLICY

FDA-APPROVED INDICATIONS

Entresto is indicated to reduce the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction. Entresto is usually administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has the diagnosis of chronic heart failure (New York Heart Association [NYHA] Class II-IV) and reduced ejection fraction less than or equal to 40%

REFERENCES

1. Entresto [package insert]. East Hanover, New Jersey: Novartis Pharmaceuticals Corporation; August 2015.
2. McMurray JV, Packer M, Desai AS, et al. Angiotensin-neprilysin inhibition versus enalapril in heart failure. *N Engl J Med.* 2014;371(11):993-1004.
3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed March 2017.
4. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 2017.