AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Entresto		Page: 1 of 3
Effective Date:	8/1/2024		Last Review Date: 7/30/2024
Applies to:	☒Illinois ☒New Jersey	☒Florida Kids ☒Maryland	☐Florida ☒Pennsylvania Kids

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Entresto under the patient's prescription drug benefit.

Description:

Adult Heart Failure
Entresto is indicated to reduce the risk of cardiovascular death and hospitalization for heart failure in adult patients with chronic heart failure. Benefits are most clearly evident in patients with left ventricular ejection fraction (LVEF) below normal.

LVEF is a variable measure, so use clinical judgment in deciding whom to treat.

Pediatric Heart Failure
Entresto is indicated for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients aged one year and older. Entresto reduces NT-proBNP and is expected to improve cardiovascular outcomes.

Applicable Drug List:

Entresto

Policy/Guideline:

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

- The patient is 18 years of age or older
  AND
- The requested drug is being prescribed to reduce the risk of cardiovascular death and hospitalization for heart failure
  AND
- The patient has a diagnosis of symptomatic chronic heart failure
  AND
  - The patient has ANY of the following:
    A. Left ventricular ejection fraction less than or equal to 40 percent (i.e., Heart Failure with reduced Ejection Fraction [HFrEF]),
    B. Previous left ventricular ejection fraction less than or equal to 40 percent and a follow-up left ventricular ejection fraction measurement of greater than 40 percent (i.e., Heart Failure with improved Ejection Fraction [HFimpEF]).

i. The prescriber MUST submit chart notes or other documentation supporting a current or previous left ventricular ejection fraction percentage less than or equal to 40 percent.

AND

- Chart notes or other documentation supporting a current or previous left ventricular ejection fraction of less than or equal to 40 percent have been submitted to CVS Health

AND

- The patient will receive concomitant treatment with a maximally tolerated dose of a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)

OR

- The patient has experienced an intolerance to a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)

OR

- The patient has a contraindication that would prohibit a trial of a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)

OR

- The patient has ANY of the following:
  A. left ventricular ejection fraction of 41 to 49 percent (i.e., Heart Failure with mildly reduced Ejection Fraction [HFmrEF])
  B. left ventricular ejection fraction greater than or equal to 50 percent (i.e., Heart Failure with preserved Ejection Fraction [HFpEF])

AND

- The patient has evidence or history of spontaneous or provokable increased left ventricular filling pressures (e.g., elevated natriuretic peptide, noninvasive and invasive hemodynamic measurement). The prescriber MUST submit chart notes or other documentation supporting evidence or history of spontaneous or provokable increased left ventricular filling pressures.

AND

- Chart notes or other documentation supporting evidence or history of spontaneous or provokable increased left ventricular filling pressures have been submitted

OR

- This request is for a pediatric patient one year of age or older

AND

- The requested drug is being prescribed for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction

AND

- If the patient has a diagnosis of diabetes, the requested drug will not be used in combination with Tekturna (aliskiren)

  OR
- If the patient has renal impairment (estimated Glomerular Filtration Rate [eGFR] less than 60 milliliters per minute per 1.73 meters squared [mL/min/1.73m^2]), the requested drug will not be used in combination with Tekturna (aliskiren)

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit:

- Entresto Oral Tablet 24-26 Mg: 60 per 30 days
- Entresto Oral Tablet 49-51 Mg: 60 per 30 days
- Entresto Oral Tablet 97-103 Mg: 60 per 30 days

References:

1. Entresto [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2021.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. https://online.lexi.com. Accessed March 29, 2023.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 03/29/2023).
4. Heidenreich PA, Bozkurt B, Aguilar D et. al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol.* 2022; 79:e263-e421.