



Louisiana

Angiotensin Converting Enzyme-Inhibitors and Angiotensin Converting Enzyme-Inhibitor Combination Drugs

Policy # 00347

Original Effective Date: 03/20/2013

Current Effective Date: 05/16/2018

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member's contract/certificate, and
- Medical necessity criteria and guidelines are met.

Based on review of available data, the Company may consider brand name oral angiotensin converting enzyme-inhibitors (ACE-I's) and brand name oral angiotensin converting enzyme-inhibitor combination drugs including, but not limited to, Altace[®] (ramipril), Accupril[®] (quinapril), Prinivil[®] (lisinopril), and Zestoretic[®] (lisinopril/hydrochlorothiazide) to be **eligible for coverage** when one of the below patient selection criteria is met:

Patient Selection Criteria

Coverage eligibility will be considered for brand name oral ACE-I's and brand name oral ACE-I combination drugs when one of the following criteria is met:

- The patient has tried and failed a generic oral angiotensin converting enzyme-inhibitor (e.g., lisinopril) or a generic oral angiotensin converting enzyme-inhibitor combination drug (e.g., lisinopril/hydrochlorothiazide); or
- There is clinical evidence or patient history that suggests the generically available products will be ineffective or cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of brand name oral ACE-I's and brand name oral ACE-I combination drugs when patient selection criteria are not met or for usage not included in the above patient selection criteria to be **not medically necessary**.**

Background/Overview

Oral ACE-I's and ACE-I combination drugs are used to treat various indications including hypertension, heart failure, and myocardial infarctions.

Rationale/Source

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests the generically available drugs will be ineffective or cause an adverse reaction to the patient. Based on a review of the data, in the absence of the above mentioned caveat, there is no advantage of using a brand name oral ACE-I or brand name oral ACE-I combination drug over the available

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generic oral ACE-I's or generic oral ACE-I combination drugs. Generic drugs are considered to have equal bioavailability and efficacy in comparison to brand name drugs.

References

1. Sanders GD, Coeytaux R, Dolor RJ, et al. Angiotensin-converting enzyme inhibitors (ACEIs), angiotensin II receptor antagonists (ARBs), and direct renin inhibitors for treating essential hypertension: an update [internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2011 June. Report No.: 11-EHC063-EF. Available at <http://www.ncbi.nlm.nih.gov/books/NBK61789/pdf/TOC.pdf>
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Policy History

Original Effective Date: 03/20/2013

Current Effective Date: 05/16/2018

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| 03/07/2013 | Medical Policy Committee review |
| 03/20/2013 | Medical Policy Implementation Committee approval. New policy. |
| 03/06/2014 | Medical Policy Committee review |
| 03/19/2014 | Medical Policy Implementation Committee approval. Coverage eligibility unchanged. |
| 05/07/2015 | Medical Policy Committee review |
| 05/20/2015 | Medical Policy Implementation Committee approval. Coverage eligibility unchanged. |
| 05/05/2016 | Medical Policy Committee review |
| 05/18/2016 | Medical Policy Implementation Committee approval. Coverage eligibility unchanged. |
| 05/04/2017 | Medical Policy Committee review |
| 05/17/2017 | Medical Policy Implementation Committee approval. Coverage eligibility unchanged. |
| 05/03/2018 | Medical Policy Committee review |
| 05/16/2018 | Medical Policy Implementation Committee approval. Coverage eligibility unchanged. |

Next Scheduled Review Date: 05/2019

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****Medically Necessary (or "Medical Necessity")** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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