Beta Adrenergic Antagonists and Beta Adrenergic Antagonist/Diuretic Combination Drugs

Policy # 00338
Original Effective Date: 01/09/2013
Current Effective Date: 02/15/2017

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 the available data, brand name oral beta adrenergic antagonists (beta blockers) and brand name beta adrenergic antagonist/diuretic combination drugs, including, but not limited to Toprol XL® (metoprolol succinate), Coreg CR® (carvedilol phosphate), Bystolic® (nebivolol), Tenoretic® (atenolol/chlorthalidone), Lopressor HCT® (metoprolol tartrate/hydrochlorothiazide), and Dutoprol® (metoprolol succinate/hydrochlorothiazide) may be considered 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 beta adrenergic antagonists and brand name oral beta adrenergic antagonist/diuretic combination drugs when one of the following criteria is met:

- The patient has tried and failed a generic oral beta adrenergic antagonist or beta adrenergic antagonist/diuretic combination drug (e.g. metoprolol succinate ER, carvedilol, bisoprolol/hydrochlorothiazide, or metoprolol/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 beta adrenergic antagonists and brand name oral beta adrenergic antagonist/diuretic 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 beta adrenergic receptor antagonists (beta blockers) and beta blocker/diuretic combination drugs are used for 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 drug 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 beta adrenergic receptor antagonist (beta-blocker) or brand name beta blocker/diuretic combination drugs over the generic equivalent.
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drug over the available generic beta blockers or generic beta blocker/diuretic combination drugs. Generic drugs are considered to have equal bioavailability and efficacy in comparison to brand name drugs.

References
1. Express Scripts Beta-Blocker Step Therapy Policy. 09/19/2012.

Policy History
Original Effective Date: 01/09/2013
Current Effective Date: 02/15/2017
01/03/2013 Medical Policy Committee review
01/09/2013 Medical Policy Implementation Committee approval. New policy.
02/19/2013 Format revision. Coding section removed.

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01/09/2014 Medical Policy Committee review
01/15/2014 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/05/2015 Medical Policy Committee review
02/18/2015 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/04/2016 Medical Policy Committee review
02/17/2016 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/02/2017 Medical Policy Committee review
02/15/2017 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
Next Scheduled Review Date: 02/2018

**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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