

**CRITERIA FOR PRIOR AUTHORIZATION**

ARB/CCB Combinations Step Therapy

**PROVIDER GROUP** Pharmacy

**MANUAL GUIDELINES** The following drug requires prior authorization:  
Olmesartan/amlodipine (Azor®)  
Telmisartan/amlodipine (Twynsta®)  
Valsartan/amlodipine (Exforge®)

**CRITERIA FOR PRIOR AUTHORIZATION APPROVAL FOR ARB/CCB COMBINATIONS** (must meet all of the following):

- Patient must have a diagnosis of hypertension
- Patient must have a trial and failure of or intolerance to *concurrent* therapy with an angiotensin II receptor blocker (ARB) and a calcium channel blocker (CCB)

**LENGTH OF APPROVAL:** 12 months

\_\_\_\_\_  
DRUG UTILIZATION REVIEW COMMITTEE CHAIR

\_\_\_\_\_  
PHARMACY PROGRAM MANAGER  
DIVISION OF HEALTH CARE FINANCE  
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE