MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 22, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES, MANAGER, DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to the Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs are being proposed to reflect recommendations approved on October 26, 2021 by the Drug Utilization Review (DUR) Board. The proposed changes include the addition of Skyrizi® (risankizumab-rzaa) within the Immunomodulator Drugs clinical criteria, addition of new prior authorization criteria for Nurtec® ODT (rimegepant) for episodic migraines, addition of new prior authorization criteria for Gimoti® (metoclopramide), addition of new prior authorization criteria for Aduhelm® (aducanumab-avwa), and updates to the Entresto® (sacabitril/valsartan) clinical criteria to reflect new FDA-approved age indication.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective: February 28, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL N/A MSM 1200 - Prescribed Drugs	MTL N/A MSM 1200 - Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section L	**Immunomodulator Drugs**	Updated last review date. Added Skyrizi® (risankizumab-rzaa) to the current prior authorization criteria.
Appendix A Section S	**Anti-Migraine Medications**	Updated last review date. Added new prior authorization criteria for Nurtec® ODT (rimegepant) for episodic migraines.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section MM	**Gastrointestinal Prokinetic Agents**	Updated title to create new section for Gimoti® (metoclopramide). Added new prior authorization criteria for Gimoti®.
Appendix A Section UU	**Alzheimer's Disease Agents**	Updated title to create new section for Aduhelm® (aducanuman-avwa). Added new prior authorization criteria for Aduhelm®.
Appendix A Section JJJ	**Angiotension II Receptor Blocker**	Updated last review date. Updated age indication to match FDA-approved label.

L. Immunomodulator Drugs

Therapeutic Class: Immunomodulators
Last Reviewed by the DUR Board: ~~October 18, 2018~~ October 26, 2021

Actemra® (tocilizumab)	Ilumya® (tildrakizumab)	Siliq® (brodalumab)
Amevive® (alefacept)	Infle ctra® (infliximab)	Simponi® (golimumab)
Arcalyst® (rilonacept)	Kevzara® (sarilumab)	Simponi® ARIA™ (golimumab)
Cimzia® (certolizumab pegol)	Kineret® (ankinra)	Skyrizi® (risankizumab-rzaa)
Consentyx® (secukinumab)	Olumiant® (baricitinib)	Stelara® (ustekinumab)
Enbrel® (etanercept)	Orencia® (abatacept)	Taltz® (ixekizumab)
Entyvio® (vedolizumab)	Otezla® (apremilast)	Xeljanz® (tofacitinib)
Humira® (adalimumab)	Remicade® (infliximab)	
Ilaris® (canakinumab)	Renflexis® (infliximab)	

Immunomodulator Drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Approval will be given if the following criteria are met and documented:

1~~a~~. For all recipients:

a. The recipient has had a negative tuberculin test; and

b. The recipient does not have an active infection or a history of recurring infections; and

c. The approval will not be given for the use of more than one biologic at a time (combination therapy); and

d. Each request meets the appropriate diagnosis-specific criteria (b-j).

2. Rheumatoid Arthritis (RA):

a. The recipient has a diagnosis of moderately to severely active RA; and

b. The recipient is 18 years of age or older; and

c. The recipient has had a rheumatology consultation, including the date of the visit; and one of the following:

1. The recipient has had RA for less than six months (early RA) and has high disease activity; and an inadequate or adverse reaction to a disease modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline and sulfasalazine); or

2. The recipient has had RA for greater than or equal to six months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine); or

3. The recipient has had RA for greater than or equal to six months (intermediate or long-term disease duration) and has high disease activity.

3. Psoriatic Arthritis:

a. The recipient has a diagnosis of moderate or severe psoriatic arthritis; and

b. The recipient is 18 years of age or older; and

c. The recipient has had a rheumatology consultation including the date of the visit or a dermatology consultation including the date of the visit; and

d. The recipient had an inadequate response or a contraindication to treatment with any one nonsteroidal anti-inflammatory (NSAID) or to any one of the following DMARDs: methotrexate, leflunomide, cyclosporine or sulfasalazine.

4. Ankylosing Spondylitis:

a. The recipient has a diagnosis of ankylosing spondylitis; and

b. The recipient is 18 years or older; and

c. The recipient has had an inadequate response to NSAIDs; and

d. The recipient has had an inadequate response to any one of the DMARDs (methotrexate, hydroxychloroquine, sulfasalazine, leflunomide, minocycline).

5. Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis:

a. The recipient has a diagnosis of moderately or severely active juvenile RA or juvenile idiopathic arthritis; and

b. The recipient is at an appropriate age, based on the requested agent, and:

1. Abatacept: Six years of age or older

2. Adalimumab, canakinumab, etanercept, tocilizumab: Two years of age or older.

c. And the recipient has at least five swollen joints; and

d. The recipient has three or more joints with limitation of motion and pain, tenderness or both; and

e. The recipient has had an inadequate response to one DMARD.

6. Plaque Psoriasis:

a. The recipient has a diagnosis of chronic, moderate to severe plaque psoriasis; and

b. The recipient is 18 years of age of older; and

c. The agent is prescribed by a dermatologist; and

d. The recipient has failed to adequately respond to a topical agent; and

e. The recipient has failed to adequately respond to at least one oral treatment.

7. Crohn's Disease:

a. The recipient has a diagnosis of moderate to severe Crohn's Disease; and

b. The recipient is at an appropriate age, based on the requested agent;

1. Adalimumab, infliximab: Six years of age or older

2. All others: 18 years of age or older

c. And the recipient has failed to adequately respond to conventional therapy (e.g. sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide); or

d. The recipient has fistulizing Crohn's Disease.

8. Ulcerative Colitis:

a. The recipient has a diagnosis of moderate to severe ulcerative colitis; and

b. The recipient is at an appropriate age, based on the requested agent:

1. Infliximab: Six years of age or older.

2. Humira: five years of age or older.

3. All others: 18 years of age or older.

c. And the recipient has failed to adequately respond to one or more of the following standard therapies:

1~~a~~. Corticosteroids;

2. 5-aminosalicylic acid agents;

3. Immunosuppressants; and/or

4. Thiopurines.

9. Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflammatory Syndromes (FCAS) or Muckle-Wells Syndrome (MWS):

a. The recipient has a diagnosis of FCAS or MWS; and

b. The recipient is at an appropriate age, based on the requested agent:

1. Canakinumab: Four years of age or older.

2. Rilonacept: 12 years of age or older.

10. Cryopyrin-Associated Periodic Syndromes (CAPS): Neonatal-Onset Multisystem Inflammatory Disease (NOMID):

a. The recipient has a diagnosis of NOMID

b. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 months.

2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

S. Anti-Migraine Medications

Therapeutic Class: Serotonin 5-HT1 receptor agonists (triptans)
Last Reviewed by the DUR Board: July 25, 2019

Therapeutic Class: Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications
Last Reviewed by the DUR Board: October 26, 2021

Therapeutic Class: Ergot Derivatives
Last Reviewed by the DUR Board: July 22, 2021

Serotonin 5-HT1 receptor agonists commonly referred to as "triptans", CGRP Receptor Inhibitor medications and Ergot Derivatives or anti-migraine medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Serotonin 5-HT1 Receptor Agonists (triptans)

a. An approved prior authorization is required for any prescription exceeding the quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

1. The recipient's current medication history documents the use of prophylactic medications for migraine headache, or the medical provider agrees to initiate such therapy which includes beta-blockers, tricyclic antidepressants, anticonvulsants, Selective Serotonin Reuptake Inhibitors (SSRIs) and/or calcium channel blockers; or

2. The medical provider is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required monthly.

a. Recipient's current medication history must NOT have Monoamine Oxidase (MAO) Inhibitors present for approval of Imitrex® (sumatriptan), Maxalt® (rizatriptan) or Zomig® (zolmitriptan).

b. Recipients whose current medication history indicates the use of propranolol will NOT be granted prior authorization of Maxalt® (rizatriptan) 10mg tablet or 10mg orally disintegrating tablet.

c. Prior authorization will NOT be given to patients with ischemic heart disease.

b. Prior Authorization Guidelines:

1. Approval for exceeding the quantity limits on triptans will be provided for a two-month period.

2. The prior authorization must be initiated by the prescriber. The approved prior authorization must be available if requested.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

2. Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications

a. CGRP General Criteria

1. Approval will be given if the following criteria are met and documented:

a. The recipient must have one of the following:

1. Both the following:

a. The recipient has a diagnosis of episodic migraines; and

b. The recipient has four to 14 migraine days per month, but not more than 14 headache days per month: or

2. All the following:

a. The recipient has a diagnosis of chronic migraines; and

b. The recipient has greater than or equal to 15 headache days per month, of which at least eight must be migraine days for at least three months; and

c. The recipient has been considered for medication overuse headache (MOH) and potentially offending medication(s) have been discontinued; and

b. The recipient is 18 years of age or older; and

c. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist; and

d. The recipient must meet two of the following:

1. One of the following:

a. The recipient has documented history of failure (after at least a two-month trial) or intolerance to Elavil® (amitriptyline) or Effexor® (venlafaxine); or

b. The recipient has a contraindication to Elavil® (amitriptyline) and Effexor® (venlafaxine); or

2. One of the following:

a. The recipient has documented history of failure (after at least a two-month trial) or intolerance to Depakote®/Depakote® ER (divalproex sodium) or Topamax® (topiramate); or

b. The recipient has a contraindication to both Depakote®/Depakote® ER (divalproex sodium) and Topamax® (topiramate); or

3. One of the following:

a. The recipient has documented history of failure (after at least a two-month trial) or intolerance to one of the following beta blockers:

1. Atenolol; or

2. Propranolol; or

3. Nadolol; or

4. Timolol; or

5. Metoprolol; or

b. The recipient has a contraindication to all the following beta blockers:

1. Atenolol; or

2. Propranolol; or

3. Nadolol; or

4. Timolol; or

5. Metoprolol.

2. Recertification Request:

a. The recipient must have a documented positive response to Aimovig® (erenumab-aooe), Ajovy® (fremanezumab-vfrm) or Emgality® (galcanezumab-gnlm) therapy, demonstrated by a reduction in headache frequency and/or intensity; and

b. The recipient has had a decrease in use of acute migraine medications (e.g., NSAIDs, triptans) since the start of CGRP therapy; and

c. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist; and

d. For chronic migraine only: The recipient continues to be monitored for MOH.

3. Prior Authorization Guidelines:

a. Initial request will be approved for six months.

b. Recertification request will be approved for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

b. CGRPs for Acute Migraines

1. Ubrelvy® (ubrogepant), Nurtec® ODT (rimegepant).

a. Approval will be given if all the following criteria are met and documented:

1. Recipient must have a diagnosis of acute migraine with or without aura; and

2. Recipient is 18 years of age or older; and

3. The prescribed dose will not exceed two doses per migraine and treating no more than eight migraine episodes per 30 days; and

4. The recipient has had at least one trial and failure of triptan agent; and

5. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

b. Recertification Request:

1. The recipient must have a documented positive response to the CGRP therapy; and

2. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

c. Prior Authorization Guidelines:

1. Initial request will be approved for six months.

2. Recertification request will be approved for 12 months.

3. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

2. CGRPs for Episodic Cluster Headache

a. Emgality® (galcanezumab-gnlm)

1. Approval will be given if all the following criteria are met and documented

a. The recipient has a diagnosis of episodic cluster headache; and

b. The recipient has experienced at least two cluster periods lasting from seven days to 365 days, separated by pain-free periods lasting at least three months.

c. The recipient is 18 years of age or older.

d. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

2. Recertification Request:

a. The recipient has documented positive response to Emgality® therapy, demonstrated by a reduction in headache frequency and/or intensity; and

b. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

3. Prior Authorization Guidelines:

a. Initial request will be approved for three months.

b. Recertification request will be approved for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. CGRP's Antagonists for Episodic Migraines

a. Nurtec® ODT (rimegepant).

1. Approval will be given if all criteria are met and documented:

a. The recipient is 18 years of age or older; and

b. The recipient has a documented diagnosis of episodic migraines, having 4-18 migraine days per month but not more than 18 headache days per month; and

c. Two of the following:

1. The recipient has a documented history of failure (after at least a two-month trial) or intolerance to Elavil® (amitriptyline) or Effexor® (venlafaxine); or has a contraindication to both Elavil® (amitriptyline) and Effexor ® (venlafaxine); or

2. The recipient has a documented history of failure (after at least a two-month trial) or intolerance to Depakote/Depakote ER (divalproex) or Topamax (topiramate); or has a contraindication to both Depakote/Depakote ER (divalproex) and Topamax (topiramate); or

3. The recipient has a history of failure (after at least a two-month trial) or intolerance to one of the following beta blockers:

a. Atenolol; or

b. Propranolol; or

c. Nadolol; or

d. Timolol; or

e. Metroprolol; and

d. Medication will not be used in combination with any other CGRP inhibitor.

2. Prior Authorization Guidelines:

1. Initial request will be approved for six months.

2. Recertification requests will be approved for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

4. Ergot Derivatives

a. Brand D.H.E. 45 (dihydroergotamine mesylate) injection, Generic dihydroergotamine mesylate injection, Brand Migranal nasal spray, or Generic dihydroergotamine mesylate nasal spray

1. Approval will be given if all criteria are met and documented:

a. The recipient has a diagnosis of headaches with or without aura; and

b. The medication will be used for the acute treatment of migraine; and

c. The recipient is 18 years of age or older; and

d. One of the following:

1. The recipient has tried and failed or has intolerance to two triptants (e.g., eletriptan, rizatriptan, sumatriptan); or

2. The recipient has contraindication to all triptans; and

e. The medication is prescribed by or in consultation with either a Neurologist, a Pain Specialist, or a Headache Specialist; and

f. If the recipient has more than four headache days per month, they must meet at least one of the following:

1. The recipient is currently being treated with Elavil (amitriptyline) or Effexor

MM. ~~RESERVED FOR FUTURE USE~~ Gimoti® (metoclopramide)

Therapeutic Class: Gastrointestinal Prokinetic Agents
Last Reviewed by the DUR Board: October 26, 2021

Gastrointestinal Prokinetic Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if all the following criteria are met and documented:

   a. The recipient has a diagnosis of acute diabetic gastroparesis; and

   b. The recipient is 18 years of age or older; and

   c. The recipient does not have any of the following:

      1. History of signs or symptoms of tardive dyskinesia (TD); or

      2. History of a dystonic reaction to metoclopramide; or

      3. Known or suspected circumstances where stimulation of gastrointestinal (GI) motility could be dangerous (e.g., GI hemorrhage, mechanical obstruction, or perforation); or

      4. Known or suspected pheochromocytoma or other catecholamine-releasing paraganglioma; or

      5. Diagnosis of epilepsy or any other seizure disorder; or

      6. Hypersensitivity to metoclopramide (e.g., angioedema, bronchospasm); or

      7. Moderate or severe renal impairment (creatinine clearance [CrCl] < 60 mL/minute); or

      8. Moderate or severe hepatic impairment (Child-Pugh B or C); and

   d. One of the following:

      1. The recipient has had an adequate (e.g., 2-4 week) trial and failure of oral (e.g., tablet, solution, orally disintegrating tablet) or injectable (e.g., intramuscular) metoclopramide; or

      2. The recipient is NOT a candidate for oral metoclopramide (e.g., demonstrated or documented erratic absorption of oral medications)

2. Recertification Request:

   a. Recipient continues to meet all initial authorization criteria; and

   b. At least 2 weeks have passed (i.e., DUR holiday) since completion of a previous course or metoclopramide treatment of any dosage form; and

   c. Recipient demonstrated improvement in signs and symptoms of diabetic gastroparesis (e.g., nausea, vomiting, early satiety, postprandial fullness, bloating, upper abdominal pain); and

   d. Prescriber attestation that the patient is being monitored for extrapyramidal symptoms (e.g., tardive dyskinesia, dystonia) or other serious adverse events (e.g., suicidal ideation, fluid retention)

3. Prior Authorization Guidelines:

   a. Prior Authorization approval will be for two months

   b. Recertification requests will be approved for two months

   c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

UU. ~~RESERVED~~ Aduhelm® (aducanumab-avwa)

Therapeutic Class: Alzheimer's Disease Agents
Last Reviewed by DUR Board: October 26th, 2021

Aduhelm® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

    a. Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

        1. Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, one the following;

            a. Diagnosis of mild cognitive impairment due to Alzheimer's disease; or

            b. Diagnosis of probable Alzheimer's disease dementia; and

        2. All of the following:

            a. Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4; and

            b. Repeatable Battery for the Assessment of Neuropsychological (RBANS) score less than or equal to 85; and

            c. Mini-Mental State Examination score of 24-30; or

            d. Montreal Cognitive Assessment (MoCA) of 17 or above; and

    b. Documentation of beta-amyloid protein disposition, as evidenced by one of the following:

        1. Positive amyloid positron emission tomography (PET) scan; or

        2. Both of the following:

            a. Attestation that the patient does not have access to amyloid PET scanning; and

            b. Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., AB42 level, AB42:AB40 ratio); and

c. Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.) have been ruled out; and

d. All of the following:

1. Recipient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less); and

2. Recipient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment; and

3. Recipient had no history of relevant brain hemorrhage, bleeding disorder, and cerebrovascular abnormalities in last six months; and

e. A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment to rule out other causes (e.g., stroke, small vessel disease, tumor); and

f. Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting; and

g. The medication is prescribed by a neurologist, geriatrician, or geriatric psychiatrist, or other expert in the disease state.

2. Recertification Request:

a. Approval will be given if the following criteria are met and documented:

1. Submission of medical records (e.g., chart notes, laboratory values) documenting recipientis benefitting from therapy as defined by both of the following:

a. Based on the NIA-AA criteria, one of the following:

1. Recipient continues to have a diagnosis of mild cognitive impairment due to Alzheimer's disease; or

2. Recipient continues to have a diagnosis of probable disease dementia; and

b. All of the following;

1. CDR-G score of 0.5 of CDR-SB score of 0.5-4; and

2. RBANS score less than or equal to 85; and

3. Mini-Mental State Examination score of 24-30; and

2. Recipient has a follow-up brain MRI has been completed after the initiation of therapy to show one of the following:

a. Both of the following:

1. Less than ten new incident microhemorrhages; and

2. Two or less focal areas of superficial siderosis; or

b. If ten or more new incident microhemorrhages or greater than two focal areas of superficial siderosis are present then both of the following:

1. Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances); and

2. Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H); and

3. The medication is prescribed by a neurologist, geriatrician, or geriatric psychiatrist.

3. Prior Authorization Guidelines

a. Prior Authorization approval will be for six months.

b. Recertification requests will be approved for six months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

JJJ. Entresto® (sacubitril/valsartan)

Therapeutic Class: Angiotension II Receptor Blocker
Last Reviewed by the DUR Board: October 26, 2021

Entresto® (sacubitril/valsartan) is subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis of chronic heart failure NYHA Class II to IV; and

   b. The recipient has reduced left ventricular ejection fraction (LVEF); and

   c. The recipient is ~~18 years~~One year of age or older; and

   d. The recipient has had a trial of an angiotensin converting enzyme (ACE) or an angiotensin receptor blocker (ARB) for at least four weeks prior to the initiation of therapy; and

   e. The recipient will not concurrently receive an ACE inhibitor; and

   f. The recipient is on an individualized dose of a beta blocker or the recipient has a contraindication to beta blocker use; and

   g. Entresto® will be given twice daily with a maximum dose of 97/103 mg.

2. Prior Authorization Guidelines:

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx