



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Entresto

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Effective Date: 10/24/2023

Last Review Date: 10/2023

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	

### 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]). The prescriber **MUST** submit chart notes or other documentation



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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**



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- 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<sup>2</sup>]), the requested drug will not be used in combination with Tekturna (aliskiren)

#### Approval Duration and Quantity Restrictions:

**Approval:** 12 months

**Quantity Level Limit:** Reference Formulary for drug specific quantity level limits

#### 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.