

### Clinical Pharmacy Program Guidelines for Epaned

Program	Prior Authorization
Medication	Epaned (enalapril oral solution)
Markets in Scope	Arizona, Colorado, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	3/2015
Pharmacy and Therapeutics Approval Date	9/2020
Effective Date	11/2020

**1. Background:**

Epaned is indicated for the treatment of hypertension, to lower blood pressure in adults and children older than one month of age. Epaned is also indicated for the treatment of symptomatic heart failure, usually in combination with diuretics and digitalis. In clinically stable asymptomatic patients with left ventricular dysfunction (ejection fraction less than or equal to 35 percent), Epaned decreases the rate of development of overt heart failure and decreases the incidence of hospitalization for heart failure.

**2. Coverage Criteria:**

<p><b>A. <u>Authorization Criteria</u></b></p> <p>1. <b><u>One</u></b> of the following:</p> <p style="padding-left: 40px;">a. Patient is less than 8 years of age</p> <p style="text-align: center;"><b>-OR-</b></p> <p style="padding-left: 40px;">b. <b><u>Both</u></b> of the following:</p> <p style="padding-left: 80px;">i. <b><u>One</u></b> of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Heart failure</li> <li>• Asymptomatic left ventricular dysfunction, defined as left ventricular ejection fraction less than or equal to 35%</li> </ul>
--

**-AND-**

ii. **One** of the following:

- a) History of failure, contraindication, or intolerance to two formulary oral anti-hypertensives (e.g., ACE inhibitor, ACE inhibitor combination, ARB, ARB combination, thiazide diuretic)

**-OR-**

- b) Patient is unable to ingest a solid dosage form (e.g. an oral tablet or capsule) due to one of the following:
- Oral/motor difficulties
  - Dysphagia

**Authorization will be issued for 12 months.**

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

**4. References:**

1. Epaned [package insert]. Greenwood Village, CO: Silvergate Pharmaceuticals, Inc.; December 2018.

Program	Prior Authorization- Epaned (enalapril oral solution)
<b>Change Control</b>	
Date	Change
3/2015	New Guideline
10/2016	Updated policy template. Updated language for inability to swallow tablets or capsules.
8/2017	Updated maximum age requirement to 8 years of age. Removed endnotes.
9/2018	Updated background to align with policy template. Updated reference.

9/2019	Rearranged criteria so that patients under 8 years do not require a diagnosis check, to match coding.
9/2020	Annual review. Added additional clinical rules and updated references.