LOUISIANA BLUE

Beta Adrenergic Antagonists and Beta Adrenergic Antagonist/Diuretic Combination Drugs

Policy # 00338
Original Effective Date: 01/09/2013
Current Effective Date: 03/10/2025

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.*

For Patients With "Step Therapy" (generic before brand) ONLY:

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), Innopran XL®‡ (propranolol), Inderal XL®‡ (propranolol), Tenoretic®‡ (atenolol/chlorthalidone), Lopressor HCT®‡ (metoprolol tartrate/hydrochlorothiazide), Kapspargo™‡ (metoprolol succinate), 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 ONE 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**.******

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For Patients With "Prior Authorization" ONLY:
Based on review of available data, the Company may consider Innopran XL (propranolol), Inderal XL (propranolol), or Kapspargo (metoprolol succinate) to be **eligible for coverage**** when the patient selection criteria are met:

Patient Selection Criteria
Coverage eligibility will be considered for Innopran XL (propranolol), Inderal XL (propranolol), or Kapspargo (metoprolol succinate) when the patient selection criteria are met for the respective drug:

- For Innopran XL or Inderal XL requests ONLY:
  - Patient has tried and failed (e.g. intolerance or inadequate response) at least TWO generic beta adrenergic antagonists (e.g., metoprolol succinate, propranolol ER, acebutolol, atenolol, betaxolol, bisoprolol, metoprolol tartrate, nadolol, pindolol, propranolol, sotalol, timolol) unless there is clinical evidence or patient history that suggests the use of the required drugs will be ineffective or cause an adverse reaction to the patient.
- For Kapspargo requests ONLY:
  - Patient has tried and failed (e.g. intolerance or inadequate response) at least TWO generic beta adrenergic antagonists (e.g., metoprolol succinate, propranolol ER, acebutolol, atenolol, betaxolol, bisoprolol, metoprolol tartrate, nadolol, pindolol, propranolol, sotalol, timolol) unless there is clinical evidence or patient history that suggests the use of the required drugs will be ineffective or cause an adverse reaction to the patient; OR
  - BOTH of the following:
    - Patient is unable to swallow tablets; AND
    - Patient is not taking any medication in tablet or capsule form.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Innopran XL (propranolol), Inderal XL (propranolol), and Kapspargo (metoprolol succinate) when patient selection criteria are not met or for usage not included in the above patient selection criteria to be **not medically necessary**.******

For Patients With BOTH "Prior Authorization" AND "Step Therapy":
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), Innopran XL (propranolol), Inderal XL (propranolol), Tenoretic (atenolol/chlorthalidone), Lopressor HCT (metoprolol tartrate/hydrochlorothiazide), Kapspargo (metoprolol succinate), and Dutoprol (metoprolol succinate/hydrochlorothiazide) may be considered **eligible for coverage**** when one of the below patient selection criteria is met:

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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 all of the specific drug's criteria are met for the requested drug:

- For Innopran XL or Inderal XL requests ONLY:
  - Patient has tried and failed (e.g. intolerance or inadequate response) at least TWO generic beta adrenergic antagonists (e.g., metoprolol succinate, propranolol ER, acebutolol, atenolol, betaxolol, bisoprolol, metoprolol tartrate, nadolol, pindolol, propranolol, sotalol, timolol) unless there is clinical evidence or patient history that suggests the use of the required drugs will be ineffective or cause an adverse reaction to the patient.
- For Kapspargo requests ONLY:
  - Patient has tried and failed (e.g. intolerance or inadequate response) at least TWO generic beta adrenergic antagonists (e.g. metoprolol succinate, propranolol ER, acebutolol, atenolol, betaxolol, bisoprolol, metoprolol tartrate, nadolol, pindolol, propranolol, sotalol, timolol) unless there is clinical evidence or patient history that suggests the use of the required drugs will be ineffective or cause an adverse reaction to the patient; OR
  - BOTH of the following:
    - Patient is unable to swallow tablets; AND
    - Patient is not taking any medication in tablet or capsule form.
- For all other brand beta adrenergic antagonist products:
  - The patient has tried and failed ONE 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**.**

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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

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

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 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.

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Policy History

Original Effective Date: 01/09/2013
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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.
01/09/2014	Medical Policy Committee review
01/15/2014	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

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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.
02/01/2018	Medical Policy Committee review
02/21/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/06/2018	Medical Policy Committee review
09/19/2018	Medical Policy Implementation Committee approval. Added brand Innopran XL and Inderal XL to step 2. Also separated out into step, step/PA, and PA only to address the PA added to Innopran XL and Inderal XL.
02/07/2019	Medical Policy Committee review
02/20/2019	Medical Policy Implementation Committee approval. Added new drug, Kapspargo to the policy with PA criteria for members with PA.
02/06/2020	Medical Policy Committee review
02/12/2020	Medical Policy Implementation Committee approval. No change to coverage.
02/04/2021	Medical Policy Committee review
02/10/2021	Medical Policy Implementation Committee approval. No change to coverage.
02/03/2022	Medical Policy Committee review
02/09/2022	Medical Policy Implementation Committee approval. No change to coverage.
02/02/2023	Medical Policy Committee review
02/08/2023	Medical Policy Implementation Committee approval. No change to coverage.
02/01/2024	Medical Policy Committee approval
02/14/2024	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/06/2025	Medical Policy Committee review
02/12/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 02/2026

**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.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.