

ALASKA MEDICAID

If the Tekturna step-edit does not result in automatic coverage, the following criteria will be applied to determine coverage:

Tekturna (Aliskiren), and Tekturna HCT (aliskiren and hydrochlorothiazide)

Tablets: Aliskiren 150 mg, 300 mg. Aliskiren/HCTZ 150 mg/12.5 mg, 150 mg/25 mg, 300 mg/12.5 mg, 300 mg/25 mg

PREFERRED DRUG:

Tekturna

Tekturna HCT

NON-PREFERRED DRUG:

NA

INDICATIONS:

Tekturna (aliskiren), and Tekturna HCT (aliskiren and hydrochlorothiazide) are both indicated for the treatment of hypertension.^{1,2}

CRITERIA FOR APPROVAL:

The following conditions must be met for coverage:

1. The patient has a diagnosis of hypertension; **AND**
2. Treatment with an Angiotensin II Receptor Blocker has failed; **OR**
3. Both ACE inhibitors and Angiotensin II Receptor Blockers are not appropriate for the patient.

LENGTH OF AUTHORIZATION:

1. Coverage may be approved for 12 months.

DISPENSING LIMIT:

1. The dispensing limit is a 30 day supply of medication.

REFERENCES:

¹ Tekturna prescribing information is available at:
<<http://www.pharma.us.novartis.com/product/pi/pdf/tekturna.pdf>>
Accessed 05/28/2009.

² Tekturna HCT prescribing information available at:
<http://www.pharma.us.novartis.com/product/pi/pdf/tekturna_hct.pdf>
Accessed 05/28/2009.