INDIAN HEALTH SERVICE
National Pharmacy and Therapeutics Committee
Formulary Brief: ***Hypertension Guideline Update***
-April 2026-

Background:

The Indian Health Service (IHS) National Pharmacy and Therapeutics Committee (NPTC) provided a comprehensive review of the 2025 American Heart Association (AHA)/American College of Cardiology (ACC) Hypertension guidelines.[1] First-line medications listed on the National Core Formulary (NCF) relevant to this condition include antihypertensives from the following classes: Angiotensin Converting Enzyme Inhibitors (lisinopril), Angiotensin Receptor Blockers (losartan), Calcium Channel Blockers (amlodipine), and Thiazide-type diuretics (hydrochlorothiazide and chlorthalidone). First-line medications for the treatment of hypertensive disorders of pregnancy (HDP) were another crucial part of the guideline updates that included labetalol and extended-release (ER) nifedipine. Following clinical review and analysis, the NPTC voted to **ADD labetalol for HDP** and **nifedipine ER** to the NCF.

Discussion:

Hypertension (HTN) is a chronic condition characterized by persistently elevated blood pressure (BP), generally defined as ≥130/80 mmHg.[2] In the United States, approximately 46.7% of adults have HTN or are receiving treatment for it, and prevalence rises significantly with age, affecting nearly 75% of individuals older than 60 years.[3-5] Globally, it is the leading cause of death for women and the second leading cause for men.[6] HTN is the most prevalent and modifiable cardiovascular disease (CVD) risk factor and the leading cause of death and disability worldwide. Onset of HTN before the age of 45 is associated with a more than twofold greater risk of CVD and all-cause mortality.[7] Once BP is above normal (SBP ≥120 mmHg or DBP ≥80 mmHg), there may be irreversible vascular damage and residual risk, even if antihypertensive treatment is initiated.[1]

American Indian/Alaska Native (AI/AN) adults exhibit higher prevalence of HTN compared to non-Hispanic White adults. Recognizing that AI/ANs have higher rates of CVD and CVD-related premature death than any other racial/ethnic group, in December 2025, the NPTC launched the IHS Native Hearts Clinical Strategic Initiative. This agency-wide endeavor serves as a "get-with-the-guidelines approach" to support federal, tribal, and Urban Indian Organization programs to develop and implement strategies to ensure the diagnosis and management of coronary heart disease (CHD), heart failure (HF), HTN, and atrial fibrillation (AF).[9] Actional items include health education, screening and early diagnosis, and team-based clinical care. Please contact the NPTC if your site is interested in participating as a Native Hearts Advocates Pilot Program.

The 2025 AHA/ACC Hypertension guideline updates build upon the 2017 recommendations while placing greater emphasis on risk-based, patient-centered HTN management.[1] One of the most important changes is adoption of the PREVENT (Predicting Risk of CVD EVENTS) cardiovascular risk calculator, which replaces the pooled cohort equations and incorporates kidney function, statin use, and social determinants of health to better estimate 10- and 30-year cardiovascular risk. This shift supports treatment decisions based not only on BP values, but also on overall cardiovascular risk profile.

The guideline reaffirms a BP goal of <130/80 mmHg for most adults, while encouraging an ideal BP goal of <120/80 mmHg, particularly in patients with elevated CV risk, established ASCVD, diabetes, or CKD. Exceptions include patients with limited life expectancy, institutionalized individuals, and certain pregnant patients. Lifestyle modification remains foundational therapy and receives stronger emphasis, including sodium reduction, DASH diet, weight management, exercise, stress reduction, alcohol abstinence, and smoking cessation. The guideline also newly supports use of potassium-enriched salt substitutes in select patients without advanced CKD.

Out-of-office BP monitoring is further emphasized. Both home blood pressure monitoring and ambulatory blood pressure monitoring are recommended to confirm diagnosis, identify white-coat and masked hypertension, and guide medication titration. The guideline specifically advises against use of cuffless BP devices for diagnosis or management because of insufficient validation data.

Pharmacologic treatment recommendations are now more explicitly tied to CV risk.

- For adults with existing CVD, diabetes, CKD, or a ≥7.5% 10-year CVD risk, antihypertensive medication is recommended when BP is ≥130/80 mmHg.
- Lower-risk patients with stage 1 HTN should first undergo 3–6 months of lifestyle intervention before medication escalation if BP remains uncontrolled.
- For stage 2 HTN (≥140/90 mmHg), the guideline recommends initiating therapy with two first-line agents, preferably as a single-pill combination, to improve adherence and accelerate BP control.

- Guidelines now classify SBP ≥180 mmHg or DBP ≥120 mmHg without acute target organ damage as severe HTN rather than hypertensive urgency and recommend outpatient medication intensification instead of an ED referral.

The 2025 update also significantly expands guidance on secondary and resistant HTN, particularly primary aldosteronism. Screening is now recommended for all patients with resistant or stage 2 HTN regardless of potassium level, recognizing that hypokalemia is often absent. Additional screening triggers include adrenal masses, obstructive sleep apnea, muscle weakness, or family history of early HTN or stroke. Mineralocorticoid receptor antagonists remain preferred add-on therapy for resistant HTN.

A new addition to the guideline is incorporation of renal denervation (RDN) as a potential adjunctive therapy for resistant HTN. RDN receives a Class IIb recommendation for carefully selected patients whose BP remains uncontrolled despite optimized medical therapy or who are unable to tolerate multiple antihypertensive medications.

Special population recommendations were expanded substantially. In CKD, ACE inhibitors or ARBs remain preferred in patients with albuminuria or reduced eGFR because of renal and CV protective effects. Neurologic recommendations now include stronger BP targets to reduce dementia risk, with a systolic BP goal of <130 mmHg recommended to reduce mild cognitive impairment and cognitive decline. Updated stroke recommendations provide more specific BP targets following intracerebral hemorrhage and endovascular reperfusion therapy.

Pregnancy-related hypertension management received major updates. The guideline recommends treating chronic HTN in pregnancy to a goal of <140/90 mmHg, with prompt treatment initiation for severe HTN (≥160/110 mmHg). Preferred agents include labetalol and extended-release nifedipine due to favorable maternal and fetal safety profiles. All ACE inhibitors, direct renin inhibitors, atenolol, ARBs, nitroprusside, and MRAs should be avoided during pregnancy because of fetal risk, though many antihypertensives can be resumed postpartum. A 2018 meta-analysis showed that low-dose aspirin started at 12 weeks gestation in women at moderate or high risk for preeclampsia reduced the risk of preeclampsia, preterm birth, and fetal growth restriction.[10]

Finally, the guideline strongly emphasizes team-based care and health equity, recognizing pharmacists, nurses, dietitians, and community health workers as essential to improving BP control and reducing disparities. The document promotes system-level interventions, telehealth integration, and community partnerships to improve long-term hypertension outcomes and reduce cardiovascular morbidity and mortality.[1]

Findings:

Overall, the 2025 AHA/ACC Hypertension guidelines reflect a comprehensive shift toward earlier intervention, risk-based treatment decisions, combination pharmacotherapy when appropriate, and sustained use of home monitoring and team-based care. The overarching goal is not only improved BP control, but also meaningful reductions in CV, renal, and pregnancy-related complications through coordinated, patient-centered management strategies.

HDP affects 15.9% of U.S. deliveries and disproportionately impacts AI/AN women, women ≥35 years, and women with obesity. Given the disproportionately high prevalence of HDP among AI/AN women and the elevated rates of pregnancy-related morbidity and mortality in these communities, the addition of labetalol and extended-release nifedipine to the NCF is essential to ensure timely access to guideline-recommended therapy.

If you have any questions regarding this document, please contact the NPTC at IHSNPTC1@ihs.gov . For more information about the NPTC, please visit the NPTC website.

References:

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