

CALCIUM CHANNEL BLOCKERS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Calcium Channel Blockers** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:		
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> Adalat CC tablet <input type="checkbox"/> Calan tablet <input type="checkbox"/> Calan SR tablet <input type="checkbox"/> Cardizem tablet <input type="checkbox"/> Cardizem CD capsule <input type="checkbox"/> Cardizem LA tablet <input type="checkbox"/> diltiazem CD 360 mg capsule <input type="checkbox"/> diltiazem LA tablet	<input type="checkbox"/> felodipine ER tablet <input type="checkbox"/> isradipine tablet <input type="checkbox"/> Matzim LA tablet <input type="checkbox"/> nisoldipine ER tablet <input type="checkbox"/> Norvasc tablet <input type="checkbox"/> Nymalize solution <input type="checkbox"/> Procardia tablet	<input type="checkbox"/> Procardia XL tablet <input type="checkbox"/> Sular ER tablet <input type="checkbox"/> Tiazac capsule <input type="checkbox"/> verapamil ER PM capsule <input type="checkbox"/> verapamil SR 360 mg capsule <input type="checkbox"/> Verelan capsule <input type="checkbox"/> _____
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (<i>required</i>):	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Calcium Channel Blockers? <i>Check all that apply.</i> <input type="checkbox"/> amlodipine tablet <input type="checkbox"/> afeditab CR tablet <input type="checkbox"/> Cartia XT capsule <input type="checkbox"/> diltiazem CD capsule (except 360 mg) <input type="checkbox"/> diltiazem ER 12-hr capsule <input type="checkbox"/> diltiazem ER 24-hr capsule <input type="checkbox"/> diltiazem IR tablet <input type="checkbox"/> Dilt-XR capsule <input type="checkbox"/> nicardipine tablet <input type="checkbox"/> Nifediac CC tablet		<input type="checkbox"/> Nifedical XL tablet <input type="checkbox"/> nifedipine IR capsule <input type="checkbox"/> nifedipine ER tablet <input type="checkbox"/> nimodipine capsule <input type="checkbox"/> Taztia XT capsule <input type="checkbox"/> verapamil IR tablet <input type="checkbox"/> verapamil ER capsule <input type="checkbox"/> verapamil ER tablet <input type="checkbox"/> verapamil SR capsule (except 360 mg) <input type="checkbox"/> Verelan PM capsule	
		<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</i> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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