pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CALCIUM CHANNEL BLOCKERS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Calcium Channel Blockers** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Adalat CC tablet
☐Calan tablet
☐Calan SR tablet
☐Cardizem tablet
☐Cardizem CD capsule
☐Cardizem LA tablet
☐diltiazem ER 12-hr capsule
☐diltiazem LA tablet
☐isradipine capsule
☐Matzim LA tablet
☐nicardipine capsule
☐nisoldipine ER tablet
☐Norvasc tablet
☐Nymalize solution
☐Procardia capsule
☐Procardia XL tablet
☐Sular ER tablet
☐Tiazac capsule
☐verapamil ER PM capsule
☐Verelan capsule
☐_____

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Does the Beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Calcium Channel Blockers? *Check all that apply. (Generic name in italics for reference purposes only.)*

☐amlodipine tablet
☐afeditab CR tablet *(Adalat CC)*
☐Cartia XT capsule *(Cardizem CD)*
☐diltiazem CD/ER capsule *(Cardizem CD)*
☐diltiazem ER 24-hr capsule *(Tiazac ER)*
☐diltiazem IR tablet *(Cardizem)*
☐Dilt-XR capsule *(Dilacor)*
☐felodpine ER tablet
☐Nifedical XL tablet *(Procardia XL)*
☐nifedipine IR capsule
☐nifedipine ER tablet
☐nimodipine capsule
☐Taztia XT capsule *(Tiazac ER)*
☐verapamil IR tablet *(Calan)*
☐verapamil ER tablet *(Calan SR)*
☐verapamil SR/ER capsule *(Verelan)*
☐Verelan PM capsule

☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

☐No

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

Prescriber Signature:	**Date**: