

## VASODILATORS, CORONARY PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Vasodilators, Coronary, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Vasodilators, Coronary** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	total # of pages: _____	
<input type="checkbox"/> Renewal request	PA# _____	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

<b>Non-preferred medication requested:</b>	<input type="checkbox"/> BiDil tablet	<input type="checkbox"/> Nitro-DUR patch	
	<input type="checkbox"/> Dilatrate-SR capsule	<input type="checkbox"/> nitroglycerin ER capsule	
	<input type="checkbox"/> Isordil tablet	<input type="checkbox"/> nitroglycerin 0.4 mg translingual spray – <u>go to question 2</u>	
	<input type="checkbox"/> isosorbide dinitrate <u>IR</u> tablet	<input type="checkbox"/> Nitrolingual translingual spray – <u>go to question 2</u>	
	<input type="checkbox"/> isosorbide dinitrate <u>ER</u> tablet	<input type="checkbox"/> NitroMist translingual spray – <u>go to question 2</u>	
	<input type="checkbox"/> Minitran patch	<input type="checkbox"/> other: _____	
Strength: _____	Dose/directions: _____	Quantity: _____	Refills: _____
Diagnosis ( <u>submit documentation</u> ): _____		Dx code ( <u>required</u> ): _____	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Vasodilators, Coronary? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</u>  <input type="checkbox"/> No	
<input type="checkbox"/> isosorbide mononitrate tablet	<input type="checkbox"/> Nitro-BID ointment		
<input type="checkbox"/> isosorbide mononitrate ER tablet	<input type="checkbox"/> nitroglycerin patch	<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agent tried and treatment outcomes, including contraindications or intolerances</u>  <input type="checkbox"/> No	
2. For “as needed” agents indicated in the list above, does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred “as needed” Vasodilator, <b>Nitrostat SL tablet?</b>			

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

Prescriber Signature: _____	Date: _____
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