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

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	
☐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#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

- ☐BiDil tablet
- ☐Dilatrate-SR capsule
- ☐GoNitro powder – *go to question 2*
- ☐Isordil tablet
- ☐isosorbide dinitrate IR tablet
- ☐isosorbide dinitrate ER tablet
- ☐Minitran patch
- ☐Nitro-DUR patch
- ☐nitroglycerin ER capsule
- ☐nitroglycerin 0.4 mg translingual spray – *go to question 2*
- ☐Nitrolingual translingual spray – *go to question 2*
- ☐NitroMist translingual spray – *go to question 2*

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis (*submit documentation*):	Dx code (*required*):

Question	Response
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Vasodilators, Coronary? *Check all that apply.* ☐isosorbide mononitrate tablet ☐Nitro-BID ointment ☐isosorbide mononitrate ER tablet ☐nitroglycerin patch	☐Yes – *submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.* ☐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" Vasodilators, **Nitrostat SL tablet** and **nitroglycerin sublingual tablet**?	☐Yes – *submit all supporting documentation of preferred agent tried and treatment outcomes, including contraindications or intolerances.* ☐No

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

Prescriber Signature:	**Date**:

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