



Prior Authorization for Non-Preferred Calcium Channel Blockers

Preferred (Dihydropyridines)	Non-Preferred, Prior Authorization Required
Adalat CC® (nifedipine ER) Norvasc® (amlodipine) Plendil® (felodipine) Procardia® XL (nifedipine ER)	Adalat® (nifedipine IR) Cardene® (nicardipine IR) Cardene® SR (nicardipine SR) DynaCirc® (isradipine IR) Sular® (nisoldipine)
Preferred (Non-Dihydropyridines)	Non-Preferred, Prior Authorization Required
Calan® (verapamil IR) Calan SR® (verapamil SR) Cardizem® (diltiazem IR) Dilt- XR® (diltiazem ER) Isoptin SR® (verapamil SR) Taztia XT® (diltiazem ER) Tiazac® (diltiazem)	Cardizem CD® (diltiazem) Cardizem LA® (diltiazem) Cardizem SR® (diltiazem) Cartia XT® (diltiazem ER) Matzim LA® (diltiazem ER) Verelan® (verapamil SR) Verelan PM® (verapamil)

Beneficiary Information

Name: _____
 Medicaid ID #: _____ Date of Birth: _____

Pharmacy Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____
 Requested Drug: _____ NDC: _____

Prescriber Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: _____
- An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: _____

Prescriber's Signature: _____ **Date:** _____

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
 This form will be returned unprocessed if it is not completed in its entirety.**