

Medications

Preferred	Non-Preferred
All generic products, except Diltiazem SR 24-hour Cardizem LA Cartia XT Diltia XT Diltiazem ER, HCL, XR Taztia XT Verapamil HCL	All brands with generics available, except Cardizem LA Calan, SR Cardizem, CD, SR Covera HS Diltiazem SR 24-hour Dilacor XR Isoptin SR Tiazac Verelan Verelan PM

Criteria

- ❖ **Grandfathering:** Grandfathering in place for Covera HS. Look back 180 days in claims history for same product (not specific to strength) to bypass edit 75.
- ❖ **Contingent therapy:** Contingent therapy in place for Covera HS. Claims history reviewed for 2 claims of 1 diltiazem preferred agent and 1 verapamil preferred agent within the past 180 days to bypass edit 75.

Approval of non-preferred Non-Dihydropyridine Calcium Channel Blockers will be considered in the following circumstances:

<p>1. Which medication is being requested?</p> <p>If Diltiazem SR 24-Hour = Go to next question. If other medication = Go to question 3.</p>
<p>2. In all calls, DENY and advise the caller that Cardizem LA and numerous other agents are preferred.</p> <p>If caller agrees, DENY the PA request. If caller refuses, DENY and refer to RPH. Inform prescriber that he must submit a written letter of medical necessity stating the reason(s) that Cardizem LA and at least one other preferred medication are not appropriate for the member.</p>
<p>3. Is the member allergic to TWO preferred products?</p> <p><i>(Faxed documentation required to support and list the specific allergic reaction.)</i></p> <p>If YES = APPROVE after receiving documentation from physician. If NO = Go to next question.</p>
<p>4. Does the member have any contraindications or drug-drug interactions to TWO preferred products?</p> <p><i>(Faxed documentation required to support and list the specific drug interaction or why it is contraindicated.)</i></p> <p>If YES = APPROVE after receiving documentation from physician. If NO = Go to next question.</p>
<p>5. Did the member demonstrate a history of intolerable side effects requiring the discontinuation of TWO preferred products?</p> <p><i>(Faxed documentation required listing specific side effects.)</i></p> <p>If YES = APPROVE after receiving documentation from physician.</p>



If NO = DENY and refer to RPH.

References

1. Drug Facts and comparisons [database online]. Available at: <http://online.factsandcomparisons.com/>. Accessed April 20, 2010.
2. Clinical Pharmacology [database online]. Available at: <http://clinicalpharmacology.com/>. Accessed April 20, 2010.

Documentation

Member Information		Prescriber Information	
Name:		Name:	
ID#:		License:	
DOB:		Phone:	
		Fax:	
		Address:	
Pharmacy Information			
Name:		NABP/NCPDP#:	
Medicaid Provider #:			
Phone:		Fax:	

- Approved
- Denied
- Pended

Name of person spoke to:	Date:
PA Rep:	Date:

RPh:

In the event of a denial, advise all callers of appeal rights and the reason for denial.