



**GEORGIA MEDICAID FEE-FOR-SERVICE
CALCIUM CHANNEL BLOCKERS PA SUMMARY**

Preferred	Non-Preferred
<i>Dihydropyridines</i>	
Amlodipine generic Felodipine ER generic Nifedipine IR, ER generic Nimodipine generic	Isradipine generic Katerzia (amlodipine oral suspension) Levamlodipine generic Nicardipine generic Nimodipine oral solution 3 mg/mL generic Nisoldipine ER generic Norliqva (amlodipine oral solution) Nymalize (nimodipine oral solution 6 mg/mL)
<i>Non-Dihydropyridines</i>	
All generic products unless otherwise noted Cartia XT (diltiazem CD/ER, generic Cardizem CD) Diltiazem CD/ER except 360 mg (generic Cardizem CD) Diltiazem IR (generic Cardizem) Diltiazem ER (generic Cardizem LA, Dilacor XR, Tiazac) Dilt-XR (diltiazem ER, generic Dilacor XR) Tiadytl (diltiazem ER, generic Tiazac) Verapamil IR, ER/SR generics (generic Calan, Calan SR, Isoptin SR, Verelan, Verelan SR)	Diltiazem CD/ER 360 mg generic (generic Cardizem CD) Matzim LA (diltiazem ER, generic Cardizem LA) Verapamil ER generic (generic Verelan PM) Verapamil SR 360 mg generic

CD/ER/SR/XL=extended-release; IR=immediate-release

LENGTH OF AUTHORIZATION: 1 year

PA CRITERIA:

Isradipine Generic

- ❖ Approvable for members with severe hypertension or hypertensive urgency.
- ❖ Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred dihydropyridine calcium channel blockers.

Katerzia, Nimodipine Oral Solution Generic, Norliqva and Nymalize

- ❖ Approvable for members who are unable to swallow solid dosage forms of medication or medication is being administered in a feeding tube.

Levamlodipine Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred, generic amlodipine, is not appropriate for the member.

Nicardipine Generic and Nisoldipine ER Generic

- ❖ Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred dihydropyridine calcium channel blockers.



Diltiazem ER 360 mg (Generic Cardizem CD) and Matzim LA (Generic Cardizem LA)

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred diltiazem products are not appropriate for the member.

Verapamil ER (Generic Verelan PM) and Verapamil SR 360 mg Generic

- ❖ Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred products (1 diltiazem preferred product and 1 verapamil preferred product).

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.