



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

Preferred	Non-Preferred
<i>Dihydropyridines</i>	
Amlodipine generic Felodipine ER/SR generic Nicardipine generic Nifedipine ER/SR, IR generic Nimodipine generic Nymalize (nimodipine oral solution)*	Isradipine generic Katerzia (amlodipine oral suspension) Nisoldipine ER/SR generic
<i>Non-Dihydropyridines</i>	
All generic products unless otherwise noted Cardizem LA 120 mg (diltiazem ER) 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, generic Dilacor XR, generic Tiazac) Dilt-XR (diltiazem ER, generic Dilacor XR) Taztia XT (diltiazem ER, generic Tiazac) Verapamil IR, CR/ER/SA/SR generics (generic Calan, Calan SR, Isoptin SR, Verelan)	Diltiazem CD/ER 360 mg generic (generic Cardizem CD) Matzim LA (diltiazem ER, generic Cardizem LA) Verapamil ER/SR generic (generic Verelan PM)

*preferred but requires PA; CR/ER/SR/XL=extended-release; IR=immediate-release

LENGTH OF AUTHORIZATION: 1 Year

NOTE: Nymalize is preferred but requires prior authorization.

PA CRITERIA:

Nymalize and Katerzia

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

Isradipine Generic

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

Nisoldipine ER/SR Generic

- ❖ Approvable for members who have experienced ineffectiveness, allergies, contraindications, drug-to-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)

- ❖ Approvable for members who have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions or a history of 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 Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL List.