

10/05/2015

Prior Authorization Form

**GEHA**

Cardizem, Cardizem CD, Cardizem LA, Matzim LA (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.  
 Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.  
 Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of  
 Cardizem, Cardizem CD, Cardizem LA, Diltiazem LA (including Matzim LA) (FA-PA).

Drug Name (select from list of drugs shown)

Cardizem (diltiazem)	Cardizem CD (diltiazem ext-rel)	Cardizem LA (diltiazem ext-rel), including generic Cardizem LA
Matzim LA (diltiazem ext-rel)		

**Quantity** \_\_\_\_\_ **Frequency** \_\_\_\_\_ **Strength** \_\_\_\_\_

**Route of Administration** \_\_\_\_\_ **Expected Length of Therapy** \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 Patient ID: \_\_\_\_\_  
 Patient Group No.: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Patient Phone: \_\_\_\_\_

**Prescribing Physician**

Physician Name: \_\_\_\_\_  
 Physician Phone: \_\_\_\_\_  
 Physician Fax: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
Comments: _____	

**Please circle the appropriate answer for each question.**

1. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Y	N	
2. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? (IF YES, PLEASE DOCUMENT DRUG NAME, TRIAL YEAR AND REASON FOR FAILURE) REQUIREMENT: 1 in a class with only 1 alternative: diltiazem ext-rel (except generic of Cardizem LA) [If yes, then no further questions.]	Y	N	

3. Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? (IF YES, PLEASE DOCUMENT THE REASON(S) THE PATIENT CAN NOT TRY THE FORMULARY ALTERNATIVES)	Y	N
Formulary alternatives are: diltiazem ext-rel (except generic of Cardizem LA)		

I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature and Date**