

**State of Idaho, Division of Medicaid
Prior Authorization Form
ACE INHIBITOR / CALCIUM CHANNEL BLOCKERS**

* **CONFIDENTIAL INFORMATION** *

Phone: 1-208-364-1829 *One drug per form ONLY – Use black or blue ink* **Fax: 1-208-364-1864**

Patient Name: _____	Medicaid ID #: _____	Date of Birth: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store #: _____	Pharmacy Phone: _____	Pharmacy Fax: _____

Azor[®], Exforge[®] and amlodipine/benazepril are the preferred agents and will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.

Lexxel[®] (enalapril/felodipine) and Tarka[®] (trandolapril/verapamil) will only be authorized if there is documented failure of 1 (one) preferred agent within the past 180 days.

Medication Requested:

Azor [®]	NO PA REQUIRED
Exforge [®]	NO PA REQUIRED
amlodipine/benazepril (generic Lotrel [®])	NO PA REQUIRED

<u>Drug</u>	<u>Strength</u>	<u>Instructions</u>
<input type="checkbox"/> Lexxel [®]	_____	_____
<input type="checkbox"/> Tarka [®]	_____	_____

History of Preferred Agent:

<u>Drug</u>	<u>Date(s) of Trial</u>	<u>Reason(s) for Failure</u>
_____	_____	_____

Other Pertinent Information for Review:

To ensure continuity of care, please make sure corresponding ICD-9 diagnosis codes are submitted on professional office claims to Medicaid on a routine basis.

Prescriber Signature: _____ **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only

Date: _____	RPh: _____	Tech: _____	PA#: _____
Approved _____	Denied _____	Comments: _____	

All current PA forms and criteria for use are available at: <http://www.medicaidpharmacy.idaho.gov> (PA Criteria & Forms)