

## Calcium Channel Blockers

**Phone: 215-991-4300**
**Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE:** Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

**Q1. For a non-preferred Calcium Channel Blocker that contains only one active ingredient:** Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request. Include drug name, dose, and start/stop dates.

**Q2. For a non-preferred Calcium Channel Blocker combination product that contains more than one active ingredient (e.g., amlodipine-atorvastatin), the member has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently.** Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.

**Q3. Additional Information:**

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date



**HEALTH PARTNERS PLANS**  
**PRIOR AUTHORIZATION REQUEST FORM**

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Member Name:

Prescriber Name:

v2026