Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	February 13, 2020 June 16, 2022, February 20, 2023, March 24, 2025

Amlodipine (NORLIQVA® and KATERZIA®) oral solution/suspension

Clinical PA required (preferred): Norliqva® (amlodipine) solution

Non-Preferred: Katerzia® (amlodipine) suspension

LENGTH OF AUTHORIZATION: 6 months

REVIEW CRITERIA:

- Patient must be ≥ 6 years of age.
- Patient has hypertension **OR**
- Patient has coronary artery disease
    - Chronic stable angina,
    - Vasospastic angina (Prinzmetal's or Variant Angina)
    - Angiographically documented coronary artery disease (documented by angiography without heart failure or an ejection fraction <40%).
- Trial and failure of preferred calcium channel blockers or rationale why preferred agents cannot be tried (documentation required)**.**
- If request is for Katerzia, patient must also have documented trial and failure of Norliqva solution (documentation required).

CONTINUATION OF THERAPY

- Patient met initial review criteria; **AND**
- Documentation of improved clinical response; **AND**
- Patient has not experienced any treatment-restricting adverse effects; **AND**
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/