iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

REQUEST FOR PRIOR AUTHORIZATION NEBIVOLOL (BYSTOLIC®)

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: ________________________________ DOB: ________________

Patient Address:____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:____________________________ Phone:_______________

Prescriber Address:____ Fax:__________________

Pharmacy Name:__________________________ Address:___________________________________ Phone:_______________

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: ___________________ NDC : |___|___|___|___|___|___|___|___|___|___|___||

Prior authorization is required for Bystolic®. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Bystolic

Strength	Dosage Instructions	Quantity	Days Supply
_________	______________________	________	__________

Diagnosis:____

Preferred Trial 1: Drug Name____________________ Strength___________ Dosage Instructions__________________

Trial date from:________________ Trial date to:___________________________

Specify failure:____

Preferred Trial 2: Drug Name____________________ Strength___________ Dosage Instructions__________________

Trial date from:________________ Trial date to:___________________________

Specify failure:____

Medical or contraindication reason to override trial requirements: ____

Other medical conditions to consider:____

Attach lab results and other documentation as necessary.

Prescriber Signature: ____ Date of Submission: _______________________
***MUST MATCH PRESCRIBER LISTED ABOVE**

***IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*

Rev. 4/19