Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
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.

<u>Non-Preferred</u>

☐ 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.