FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Request for Prior Authorization

NEBIVOLOL (BYSTOLIC®)

(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 complete 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.

Preferred	**Non-Preferred**
☐ Nebivolol	☐ 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.*