

Request for Prior Authorization NEBIVOLOL (BYSTOLIC®)



FAX Completed Form To I (877) 733-3195 Provider Help Desk I (844) 236-1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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.					` ,
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: Preferred Trial 2: Drug Name Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	IA Medicaid Member ID #	Patient name			DOB
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: Preferred Trial 2: Drug Name Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Patient address	l			
Pharmacy name Address Pharmacy name Address 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 I: Drug Name Strength Dosage Instructions Trial date from: Specify failure: Preferred Trial 2: Drug Name Trial date to: Specify failure: Preferred Trial 2: Drug Name Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Provider NPI	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 Bystolic Strength Dosage Instructions Quantity Days Supply Diagnosis: Preferred Trial I: Drug Name Strength Dosage Instructions Trial date from: Specify failure: Preferred Trial 2: Drug Name Strength Dosage Instructions Trial date from: Strength Dosage Instructions Trial date from: Strength Dosage Instructions Medical or contraindication reason to override trial requirements:	Prescriber address			Fax	
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	Pharmacy name			Phone	
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	Prescriber must complete all inform	ation above. It must be legi	ible, correct, and co	mplete or fo	orm will be returned.
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 I: 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:	Pharmacy NPI	Pharmacy fax		NDC	
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: Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	documented trials and thera chemical entity at a therape is provided that the use of the	apy failures with two proutic dose. The required nese agents would be m	eferred cardio-sed trials may be o	elective b verridden	eta-blockers of a different
Strength Dosage Instructions Quantity Days Supply Diagnosis: Preferred Trial I: 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:	<u>Preferred</u> No	on-Preferred			
Diagnosis: Preferred Trial I: 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:	☐ Nebivolol ☐	Bystolic			
Preferred Trial 1: Drug Name Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Strength	Dosage Instructions	Quantity	Day	rs Supply
Trial date from: Trial date to: Specify failure: Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Diagnosis:				
Preferred Trial 2: Drug Name Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Preferred Trial I: Drug Name		Strength	Dosage Instructions	
Preferred Trial 2: Drug Name Strength Dosage Instructions Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Trial date from:	Trial date to:			
Trial date from: Trial date to: Specify failure: Medical or contraindication reason to override trial requirements:	Specify failure:				
Specify failure: Medical or contraindication reason to override trial requirements:	Preferred Trial 2: Drug Name		Strength	Dosage Instructions	
Medical or contraindication reason to override trial requirements:	Trial date from:	Trial date to:			
	Specify failure:				
Other medical conditions to consider:	Medical or contraindication reas	on to override trial requir	ements:		
	Other medical conditions to cor	nsider:			
Attach lab results and other documentation as necessary.	Attach lab results and other docu	ımentation as necessary.			
Prescriber Signature: Date of Submission:	·		Data of Submissions		

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.

*MUST MATCH PRESCRIBER LISTED ABOVE