

BETA BLOCKERS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Beta Blockers, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Beta Blockers (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

<u>PRIOR AUTHORIZATION REQUEST INFORMATION</u>		<u>PRESCRIBER INFORMATION</u>	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
<u>RECIPIENT INFORMATION</u>		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:			
<input type="checkbox"/> acebutalol	<input type="checkbox"/> Coreg CR (skip to q. 3)	<input type="checkbox"/> Lopressor	<input type="checkbox"/> pindolol
<input type="checkbox"/> Betapace	<input type="checkbox"/> Corgard	<input type="checkbox"/> Lopressor HCT	<input type="checkbox"/> propranolol HCTZ
<input type="checkbox"/> betaxolol	<input type="checkbox"/> Corzide	<input type="checkbox"/> metoprolol HCTZ	<input type="checkbox"/> Sectral
<input type="checkbox"/> bisoprolol	<input type="checkbox"/> Hemangeol	<input type="checkbox"/> nadolol	<input type="checkbox"/> Sotylize
<input type="checkbox"/> Bystolic	<input type="checkbox"/> Innopran XL	<input type="checkbox"/> nadolol/bendroflumethiazide	<input type="checkbox"/> Tenormin
<input type="checkbox"/> Coreg	<input type="checkbox"/> Levatol		<input type="checkbox"/> Tenoretic
			<input type="checkbox"/> timolol
			<input type="checkbox"/> Toprol XL
			<input type="checkbox"/> Trandate
			<input type="checkbox"/> Zebeta
Strength:	Directions:	Quantity:	Refills:
Diagnosis:		DX code (required):	
1. Has the Recipient tried and failed any of the preferred Beta Blockers? <u>Check all that apply.</u> <input type="checkbox"/> atenolol <input type="checkbox"/> Inderal LA <input type="checkbox"/> propranolol <input type="checkbox"/> atenolol/chlorthalidone <input type="checkbox"/> labetalol <input type="checkbox"/> propranolol ER capsule <input type="checkbox"/> bisoprolol/HCTZ <input type="checkbox"/> metoprolol <input type="checkbox"/> sotalol <input type="checkbox"/> carvedilol tablet <input type="checkbox"/> metoprolol XL			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and therapeutic failure</i> <input type="checkbox"/> No
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?			<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated intolerances / contraindications</i> <input type="checkbox"/> No
3. For Coreg CR requests only: Which of the following apply to the Recipient? <u>Check all that apply and submit supporting documentation for each.</u> <input type="checkbox"/> has a diagnosis of mild to severe heart failure <input type="checkbox"/> is post-MI (myocardial infarction) <input type="checkbox"/> has a left ventricular ejection fraction (LVEF) ≤ 40%			
4. For Coreg CR requests only: Does the Recipient have a history of trial and failure with carvedilol immediate-release?			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and therapeutic failure</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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