

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

**This form is used for both preferred and non-preferred agents.**

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpdl.com/pa\\_criteria](http://www.iowamedicaidpdl.com/pa_criteria).

Non-Preferred:  Bystolic

Strength:	Quantity:	Days Supply:
Dosage Instructions:		
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: \_\_\_\_\_

# AmeriHealth Caritas Iowa Request for Prior Authorization

Nebivolol (Bystolic®)

Form applies to IA Health Link and *hawk-i* plans.

**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature:  
(Must match prescriber listed above.)

Date of submission:

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.

Check [www.amerihhealthcaritasia.com/Provider](http://www.amerihhealthcaritasia.com/Provider) to confirm your version of this form.