pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BETA BLOCKERS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Beta Blockers** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:

☐acebutalol capsule
☐Betapace tablet
☐betaxolol tablet
☐Bystolic tablet
☐carvedilol ER capsule **(skip to q. 3)**
☐Coreg tablet
☐Coreg CR **(skip to q. 3)**
☐Corgard tablet
☐Corzide tablet
☐Hemangeol sol'n
☐Inderal LA capsule
☐Inderal XL capsule
☐Innopran XL capsule
☐Lopressor tablet
☐metoprolol/HCTZ tablet
☐nadolol tablet
☐nadolol/bendroflumethiazide tab
☐Sotylize solution
☐Tenoretic tablet
☐Tenormin tablet
☐timolol tablet
☐Toprol XL tablet
☐Ziac tablet
☐_____

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

1. Has the Beneficiary tried and failed any of the preferred Beta Blockers? Check all that apply.
   ☐atenolol tablet
   ☐atenolol/chlorthalidone tablet
   ☐bisoprolol tablet
   ☐bisoprolol/HCTZ tablet
   ☐carvedilol tablet
   ☐labetalol tablet
   ☐metoprolol tablet
   ☐metoprolol succ ER tablet
   ☐pindolol tablet
   ☐propranolol solution
   ☐propranolol tablet
   ☐propranolol ER capsule
   ☐propranolol/HCTZ tablet
   ☐sotalol tablet

   ☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure.*
   ☐No

2. Does the Beneficiary have a contraindication or intolerance to any of the preferred agents listed in question (1)?

   ☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances / contraindications.*
   ☐No

3. **For Coreg CR/carvedilol ER requests only:** Which of the following apply to the Beneficiary? Check all that apply and submit supporting documentation for each.
   ☐has a diagnosis of mild to severe heart failure
   ☐is post-MI (myocardial infarction)
   ☐has a left ventricular ejection fraction (LVEF) ≤ 40%
   ☐has tried and failed, or cannot try, carvedilol tablet

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

Prescriber Signature:	**Date**: