



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI (required): _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bystolic 2.5mg | <input type="checkbox"/> Inderal 10mg | <input type="checkbox"/> Sectral 200mg |
| <input type="checkbox"/> Bystolic 5mg | <input type="checkbox"/> Inderal 20mg | <input type="checkbox"/> Sectral 400mg |
| <input type="checkbox"/> Bystolic 10mg | <input type="checkbox"/> Inderal 40mg | <input type="checkbox"/> Tenoretic 50mg |
| <input type="checkbox"/> Bystolic 20mg | <input type="checkbox"/> Inderal 60mg | <input type="checkbox"/> Tenoretic 100mg |
| <input type="checkbox"/> Coreg 3.125mg | <input type="checkbox"/> Inderal 80mg | <input type="checkbox"/> Tenormin 25mg |
| <input type="checkbox"/> Coreg 6.25mg | <input type="checkbox"/> Inderal LA 60mg | <input type="checkbox"/> Tenormin 50mg |
| <input type="checkbox"/> Coreg 12.5mg | <input type="checkbox"/> Inderal LA 80mg | <input type="checkbox"/> Tenormin 100mg |
| <input type="checkbox"/> Coreg 25mg | <input type="checkbox"/> Inderal LA 120mg | <input type="checkbox"/> Toprol XL 25mg |
| <input type="checkbox"/> Coreg CR 10mg | <input type="checkbox"/> Inderal LA 160mg | <input type="checkbox"/> Toprol XL 50mg |
| <input type="checkbox"/> Coreg CR 20mg | <input type="checkbox"/> Inderide 25mg-40mg | <input type="checkbox"/> Toprol XL 100mg |
| <input type="checkbox"/> Coreg CR 40mg | <input type="checkbox"/> Inderide 25mg-80mg | <input type="checkbox"/> Toprol XL 200mg |
| <input type="checkbox"/> Coreg CR 80mg | <input type="checkbox"/> InnoPran XL 80mg | <input type="checkbox"/> Trandate 100mg |
| <input type="checkbox"/> Corgard 20mg | <input type="checkbox"/> InnoPran XL 120mg | <input type="checkbox"/> Trandate 200mg |
| <input type="checkbox"/> Corgard 40mg | <input type="checkbox"/> Kerlone 10mg | <input type="checkbox"/> Trandate 300mg |
| <input type="checkbox"/> Corgard 80mg | <input type="checkbox"/> Kerlone 20mg | <input type="checkbox"/> Zebeta 5mg |
| <input type="checkbox"/> Corgard 120mg | <input type="checkbox"/> Levatol 20mg | <input type="checkbox"/> Zebeta 10mg |
| <input type="checkbox"/> Corgard 160mg | <input type="checkbox"/> Lopressor 50mg | <input type="checkbox"/> Ziac 2.5mg-6.25mg |
| <input type="checkbox"/> Corzide 40mg-5mg | <input type="checkbox"/> Lopressor 100mg | <input type="checkbox"/> Ziac 5mg-6.25mg |
| <input type="checkbox"/> Corzide 80mg-5mg | <input type="checkbox"/> Lopressor HCT 50mg-25mg | <input type="checkbox"/> Ziac 10mg-6.25mg |
| | <input type="checkbox"/> Lopressor HCT 100mg-25mg | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Lopressor HCT 100mg-50mg | |

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. Is the patient currently taking the requested medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<p>2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>If no, please indicate:</p> <p><input type="checkbox"/> Requested medication covered under previous insurance plan</p> <p><input type="checkbox"/> Started medication in hospital</p> <p><input type="checkbox"/> Other: _____</p>																							
<p>3. Has the patient tried one generic beta-blocker or generic beta-blocker/diuretic combination product? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate:</p> <table border="0"> <tr> <td><input type="checkbox"/> Acebutolol</td> <td><input type="checkbox"/> Metoprolol succinate ER</td> </tr> <tr> <td><input type="checkbox"/> Atenolol</td> <td><input type="checkbox"/> Metoprolol/HCTZ</td> </tr> <tr> <td><input type="checkbox"/> Atenolol/chlorthalidone</td> <td><input type="checkbox"/> Nadolol</td> </tr> <tr> <td><input type="checkbox"/> Betaxolol</td> <td><input type="checkbox"/> Nadolol/bendroflumethiazide</td> </tr> <tr> <td><input type="checkbox"/> Bisoprolol</td> <td><input type="checkbox"/> Pindolol</td> </tr> <tr> <td><input type="checkbox"/> Bisoprolol/HCTZ</td> <td><input type="checkbox"/> Propranolol</td> </tr> <tr> <td><input type="checkbox"/> Carvedilol</td> <td><input type="checkbox"/> Propranolol ER</td> </tr> <tr> <td><input type="checkbox"/> Labetalol</td> <td><input type="checkbox"/> Propranolol/HCTZ</td> </tr> <tr> <td><input type="checkbox"/> Metoprolol tartrate</td> <td><input type="checkbox"/> Timolol</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Acebutolol	<input type="checkbox"/> Metoprolol succinate ER	<input type="checkbox"/> Atenolol	<input type="checkbox"/> Metoprolol/HCTZ	<input type="checkbox"/> Atenolol/chlorthalidone	<input type="checkbox"/> Nadolol	<input type="checkbox"/> Betaxolol	<input type="checkbox"/> Nadolol/bendroflumethiazide	<input type="checkbox"/> Bisoprolol	<input type="checkbox"/> Pindolol	<input type="checkbox"/> Bisoprolol/HCTZ	<input type="checkbox"/> Propranolol	<input type="checkbox"/> Carvedilol	<input type="checkbox"/> Propranolol ER	<input type="checkbox"/> Labetalol	<input type="checkbox"/> Propranolol/HCTZ	<input type="checkbox"/> Metoprolol tartrate	<input type="checkbox"/> Timolol		<input type="checkbox"/> Other: _____			
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Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

Prescriber Signature: _____	Date: _____
Office Contact Name: _____	Phone Number: _____

Based upon each patient’s prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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