



**Kansas Medical Assistance Program**

P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Step Therapy Prior Authorization for ARB/CCB Combination Therapy**

Olmesartan/amlodipine (Azor®)  
Telmisartan/amlodipine (Twynsta®)  
Valsartan/amlodipine (Exforge®)

Submit PDL form:

[http://www.kdheks.gov/hcf/pharmacy/pdl\\_authorization\\_forms/ARB\\_calcium\\_channel\\_blockers\\_combo.pdf](http://www.kdheks.gov/hcf/pharmacy/pdl_authorization_forms/ARB_calcium_channel_blockers_combo.pdf)

**Beneficiary Information**

Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_

**Prescriber Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please provide the required information to receive the requested medication:

1. **Diagnosis:** \_\_\_\_\_
2. **Concurrent therapy with an Angiotensin II receptor blocker (ARB) and a calcium channel blocker (CCB)**
  - Trial and Failure – provide name of drug(s) tried and clinical symptoms of failure: \_\_\_\_\_
  - Intolerance - provide name of drug(s) tried and clinical symptoms of intolerance: \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.**

**This form will be returned unprocessed if it is not completed in its entirety.**