**Kansas Medical Assistance Program**
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

# Prior Authorization for Non-Preferred ARB/Calcium Channel Blocker Combinations

| Preferred | Non-Preferred, Prior Authorization Required |
|---|---|
| Azor® (amlodipine/olmesartan)<br>Exforge® (amlodipine/valsartan) | Twynsta® (amlodipine/telmisartan) |

**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 check the appropriate box and provide the required information to receive the requested non-preferred drug.

☐ **Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____

☐ **Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: _____

☐ **An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: _____

**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.**



**Prior Authorization Phone #**
1-800-285-4978 or 785-274-5499