2686

KANSAS MEDICAID
PRIOR AUTHORIZATION
For Non-Preferred Drugs
Beta Blockers

Request Date ___ / ___ / ____

BENEFICIARY INFORMATION

Beneficiary Medicaid ID Number

Beneficiary Date of Birth ___ / ___ / ____

Beneficiary Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber Medicaid ID #

Prescriber NPI #

NDC Requested:

Strength _____ Quantity _____ Length of Therapy on Prescription _____

Indicate: Preferred Drug Tried_____ Length of trial:_____

Prescription instructions(sig):_____

Unless otherwise indicated, the chemical name includes branded products

Please see page 2 for the preferred and non-preferred drugs.

Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

( ) Medical intolerance to Preferred Drug. Provide clinical symptoms:_____

( ) Inadequate response to Preferred Drug.

( ) Absence of appropriate formulation or indication of the drug. Please specify:_____

Signature of Prescriber_____ Date ___ / ___ / ____

*Prescriber signature mandatory

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FAX TO: **KANSAS Medicaid Prior Authorizations**

Fax: (866) 246-8512

PA HELPDESK: (877) 475 - 7567

Beta-Blockers			
Preferred Drug Covered		**Non-preferred Prior Authorization Required**	
Acebutolol	Sectral®	Bisoprolol	Zebeta®
Atenolol	Tenormin®	Penbutolol	Levatol®
Betaxolol	Kerlone®	Propranolol XL	Inderal LA®
Carvedilol	Coreg®	**Non-preferred**	
Carvedilol CR	Coreg CR®	Nebivolol	Bystolic®
Metoprolol Tartrate	Lopressor®		
Metoprolol Succinate	Toprol XL®		
Nadolol	Corgard®		
Pindolol	Visken®		
Propranolol	Inderal® Propranolol Intensol®		
Propranolol XL	InnoPran XL®		
Sotalol	Betapace®		
Sotalol AF	Betapace AF®		
Timolol	Blocadren®		