

Blue Cross and Blue Shield of Vermont and the Vermont Health Plan Prior Approval Form Bystolic™ (nebivolol)

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met, BCBSVT/TVHP will authorize coverage of Bystolic™ (nebivolol).
Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone: _____
 Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE: *(if this is a renewal proceed to question 2)*

	<u>YES</u>	<u>NO</u>
1. Has the patient been diagnosed with Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is patient greater than 18 years old?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient had a 30 day trial of Atenolol?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had a 30 day trial of Metoprolol?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had a 30 day trial of Nadolol?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does patient have a known hypersensitivity to Bystolic™ or any of its components?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does patient have severe bradycardia, heart block greater than first degree, cardiogenic shock, decompensated cardiac failure, sick sinus syndrome, or severe hepatic impairment (Child-Pugh >B)?	<input type="checkbox"/>	<input type="checkbox"/>

Initial Approval: 12 months Renewal Approval: 24 months

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

