US Family Health Plan
Prior Authorization Request Form for
Nebivolol (Bystolic)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Does the patient have hypertension?	☐ Yes Proceed to Question 3	☐ No Coverage not approved
3. Has the patient tried and failed or was intolerant to two generic beta-blockers?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[2 November 2016]