Prior Authorization Form

CAREFIRST

Corlanor

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Corlanor.

Drug Name (select from list of drugs shown)
Corlanor (ivabradine)

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information
Patient Name: ____________________
Patient ID: ____________________
Patient Group No.: ____________________
Patient DOB: ____________________
Patient Phone:

Prescribing Physician
Physician Name: ____________________
Physician Phone: ____________________
Physician Fax: ____________________
Physician Address: ____________________
City, State, Zip: ____________________

Diagnosis: ____________________ **ICD Code:** ____________________

Comments: ____________________

Please circle the appropriate answer for each question.

	Question	Answer
1.	Is the requested drug being prescribed for an adult patient?	Y N
	[If no, then skip to question 10.]	
2.	Is the requested drug being prescribed to reduce the risk of hospitalization for worsening heart failure in a patient with stable, symptomatic chronic heart failure?	Y N
	[If no, then skip to question 9.]	
3.	Does the patient have a left ventricular ejection fraction (LVEF) less than or equal to 35 percent? [If yes, then documentation is required for approval.] Left ventricular ejection fraction percentage	Y N ____________

	[If no, then no further questions.]	
4.	Is the patient currently receiving optimal therapy for heart failure management (e.g., angiotensin-converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, sodium-glucose co-transporter-2 inhibitor [SGLT2I], mineralocorticoid receptor antagonist [MRA])?	Y N
	[If no, then no further questions.]	
5.	Is the patient receiving treatment with a maximally tolerated dose of a beta-blocker OR does the patient have an intolerance or contraindication to beta-blocker use?	Y N
	[If no, then no further questions.]	
6.	Is the patient in sinus rhythm?	Y N
	[If no, then no further questions.]	
7.	Is this request for continuation of therapy?	Y N
	[If yes, then no further questions.]	
8.	Does the patient have a resting heart rate greater than or equal to 70 beats per minute [BPM]?	Y N
	[No further questions.]	
9.	Is the requested drug being prescribed for the management of symptomatic inappropriate sinus tachycardia (IST)?	Y N
	[No further questions.]	
10.	Is this request for a pediatric patient 6 months of age or older?	Y N
	[If no, then no further questions.]	
11.	Is the requested drug being prescribed for the treatment of stable, symptomatic heart failure due to dilated cardiomyopathy (DCM)?	Y N
	[If no, then no further questions.]	
12.	Is the patient in sinus rhythm?	Y N
	[If no, then no further questions.]	
13.	Is this request for continuation of therapy?	Y N
	[If yes, then no further questions.]	
14.	Does the patient have an elevated heart rate?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date