

CORLANOR (ivabradine) PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Corlanor (ivabradine), please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Corlanor (accessible at:

<http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

<u>PRIOR AUTHORIZATION REQUEST INFORMATION</u>				<u>PRESCRIBER INFORMATION</u>			
<input type="checkbox"/> New request		<input type="checkbox"/> Additional info (PA#: _____)		Prescriber name:			
<input type="checkbox"/> Renewal request		# of pages in request: _____					
Name of office contact:				Specialty:			
Contact's phone number:				State license #:			
LTC facility contact/phone:				NPI:		MA Provider ID#:	
<u>RECIPIENT INFORMATION</u>				Street address:			
Recipient Name:				Suite #:		City/state/zip:	
Recipient ID#:		DOB:		Phone:		Fax:	
<u>CLINICAL INFORMATION</u>							
Medication Requested: <input type="checkbox"/> Corlanor		Strength:		Directions:		Qty:	Refills:
Diagnosis:					Diagnosis code (required):		
<u>All Requests</u>							
1. Is the Recipient taking any of the following medications? Check all that apply.							<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit Recipient's complete current medication list</i>
<input type="checkbox"/> Clarithromycin		<input type="checkbox"/> Itraconazole		<input type="checkbox"/> Nefazodone		<input type="checkbox"/> Ritonavir	
<input type="checkbox"/> Indinavir		<input type="checkbox"/> Ketoconazole		<input type="checkbox"/> Nelfinavir		<input type="checkbox"/> Telithromycin	<input type="checkbox"/> Voriconazole
2. Which of the following apply to the Recipient? Check all that apply and submit documentation for each.							
<input type="checkbox"/> acute decompensated heart failure		<input type="checkbox"/> blood pressure < 90/50 mmHg		<input type="checkbox"/> sick sinus syndrome			
<input type="checkbox"/> severe hepatic impairment		<input type="checkbox"/> heart rate < 60 bpm (prior to taking Corlanor)		<input type="checkbox"/> sinoatrial block			
<input type="checkbox"/> pacemaker dependence		<input type="checkbox"/> 3 rd degree AV block					
3. If prescriber is NOT a cardiologist, is the requested medication being prescribed in consultation with a cardiologist?						<input type="checkbox"/> Yes – <i>submit documentation of consultation</i> <input type="checkbox"/> No or not applicable	
For INITIAL requests, continue to next section. For RENEWAL requests, send to DHS.							
<u>Initial Requests</u>							
1. Does the Recipient have stable, symptomatic heart failure?						<input type="checkbox"/> Yes – <i>submit documentation supporting diagnosis</i> <input type="checkbox"/> No	
2. What is the Recipient's left ventricular ejection fraction (LVEF)? LVEF: _____ %						<i>Submit results of diagnostic evaluation</i>	
3. Is the Recipient in sinus rhythm with a resting heart rate ≥ 70 beats per minute?						<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No	
4. Has the Recipient been hospitalized for heart failure in the past 12 months?						<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No	
5. Is the Recipient currently taking one of the following beta blockers at the maximum tolerated dose for heart failure: carvedilol, metoprolol succinate ER/XL, or bisoprolol?						<input type="checkbox"/> Yes – <i>submit documentation of current medication and dose</i> <input type="checkbox"/> No	
6. Does the Recipient have a contraindication or intolerance to, or has the Recipient tried and failed, the following types of medications (taken at maximally-tolerated FDA-approved doses)? Check all that apply.						<input type="checkbox"/> Yes – <i>submit documentation of name and dose of each medication tried</i> <input type="checkbox"/> No	
<input type="checkbox"/> ACE inhibitor or ARB (ex. lisinopril, enalapril, quinapril, Benicar, losartan, valsartan)							
<input type="checkbox"/> mineralocorticoid receptor blocker (ex. eplerenone [Inspra], spironolactone)							
<input type="checkbox"/> diuretic (ex. HCTZ, furosemide, bumetanide, torsemide, metolazone)							
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION							
Prescriber Signature:						Date:	

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