Corlanor (ivabradine) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA:_____
	Physician NPI #:_____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for ivabradine. Only FDA-approved dosing will be considered. Payment will be considered under the following conditions:

1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III or IV); and
    a. Patient is 18 years of age or older; and
    b. Patient has documentation of a left ventricular ejection fraction ≤ 35%; and
    c. Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and
    d. Patient has documentation of blood pressure ≥90/50 mmHg; or
2. Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class II to IV) due to dilated cardiomyopathy; and
    a. Pediatric patient age 6 months and less than 18 years old; and
    b. Patient has documentation of a left ventricular ejection fraction ≤ 45%; and
    c. Patient is in sinus rhythm with a resting heart rate (HR) defined below:
        i. 6 to 12 months — HR ≥ 105 bpm
        ii. 1 to 3 years — HR ≥ 95 bpm
        iii. 3 to 5 years — HR ≥ 75 bpm
        iv. 5 to 18 years — HR ≥ 70 bpm; and
3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g., carvedilol 50mg daily, metoprolol succinate 200mg daily,

or bisoprolol 10mg daily), or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and

4. Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose.
5. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Diagnosis:

☐ Stable, symptomatic heart failure (NYHA Class ll to lV)): NYHA Class (≥ 18 years of age): _____
_____

☐ Stable, symptomatic heart failure (NYHA/Ross Class ll to lV) due to dilated cardiomyopathy (6 months to < 18 years of age):NYHA/Ross Class: _____
_____

☐ Other: _____
_____

Provide left ventricular ejection fraction: Date obtained: _____
Provide resting heart rate in which patient is in sinus rhythm: _____
☐ Resting heart rate: _____ Date obtained: _____

For diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV) in members ≥ 18 years of age:
Does patient have blood pressure ≥90/50mmHg?
☐ No ☐ Yes Blood pressure: _____ Date obtained: _____

Treatment failure with maximally tolerated dose of beta-blocker with proven mortality benefit in a heart failure clinical trial:
Drug name and dose: _____ Trial dates: _____
Reason for failure: _____
Contraindication: _____

Trial and continued use with a preferred angiotensin system blocker at maximally tolerated dose:
Drug name and dose: _____ Trial dates: _____
Will an angiotensin system blocker be used concomitantly with ivabradine? ☐ No ☐ Yes

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.