SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid)</u> on this request. All other information may be filled in by office staff; <u>fax to 1-800-750-9692</u>. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

Drug Requested: Corlanor[®] (ivabradine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.		
Memb	oer Name:	
	oer Sentara #:	
Presci	riber Name:	
Presci	riber Signature:	Date:
Office	Contact Name:	
Phone	Number:	Fax Number:
DEA (OR NPI #:	
DRUG INFORMATION: Authorization may be delayed if incomplete.		
Drug	Form/Strength:	
Dosin	g Schedule:	Length of Therapy:
Diagn	osis:	ICD Code, if applicable:
Weigh	nt:	Date:
suppo		all that apply. All criteria must be met for approval. To including lab results, diagnostics, and/or chart notes, must be
	Corlanor® is being prescribed by (or in c	consultation with) a cardiologist
	Diagnosis of stable, symptomatic heart f	Tailure with LVEF $\leq 35\%$
	Member is in sinus rhythm with resting heart rate ≥ 70 bpm	
	Member is currently on maximal dose of a β -blocker or has a contraindication to β -blockers e.g., carvedilol, metoprolol (verified by chart notes or pharmacy paid claims)	
	Member's blood pressure is $\geq 90/50 \text{ mm}$	nHg

**Use of samples to initiate therapy does not meet step edit/preauthorization criteria. **

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

^{*}Approved by Pharmacy and Therapeutics Committee: 8/26/2017; 7/21/2022

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