OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

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

Drug Requested: Corlanor® (ivabradine)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Corlanor® is being prescribed by (or in consultation with) a cardiologist
- ❑ Diagnosis of stable, symptomatic heart failure with LVEF ≤ 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 ≥ 90/50 mmHg

*****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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

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

***REVISED/UPDATED:** ~~8/26/2017; 8/17/2018; (Reformatted) 1/29/2020;~~ **8/12/2022**;