pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CORLANOR (ivabradine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Corlanor** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (solution, tablet, etc.):	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):		Weight (kg):
Is Corlanor being prescribed by or in consultation with a cardiologist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*	

Does the beneficiary have any of the following contraindications to Corlanor? *Check all that apply.* ☐Acute decompensated heart failure ☐Clinically significant hypotension ☐Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present ☐Clinically significant bradycardia ☐Severe hepatic impairment ☐Heart rate maintained exclusively by the pacemaker ☐In combination with strong CYP3A4 inhibitors (e.g, azole antifungals, HIV protease inhibitors)	☐Yes ☐No *Submit documentation including a complete medication list.*
INITIAL Requests	
Does the beneficiary have either of the following? ☐Stable, symptomatic chronic heart failure with LVEF ≤35% in sinus rhythm with resting HR ≥70 ☐Stable, symptomatic heart failure due to dilated cardiomyopathy in sinus rhythm with an elevated heart rate	☐Yes – *Submit documentation of dx.* ☐No – *Submit medical literature supporting the use of Corlanor for the dx.*
Did the beneficiary try and fail optimally titrated doses of both of the following? *Check all that apply.* ☐A beta blocker ☐An ACE inhibitor, angiotensin receptor blocker (ARB), or ARB/neprilysin inhibitor combo	☐Yes ☐No *Submit documentation.*
Does the beneficiary have a history of intolerance or contraindication to optimally titrated doses of the following? *Check all that apply.* ☐ACE inhibitors ☐ARB/neprilysin inhibitor combination ☐Angiotensin receptor blockers ☐Beta blockers	☐Yes ☐No *Submit documentation.*
RENEWAL Requests	
Is the beneficiary experiencing clinical benefit from the requested medication?	☐Yes ☐No *Submit documentation of response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: