

OPTIMA FAMILY CARE MEDALLION 4.0

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. Incomplete form will delay authorization process.

Drug Requested: **Corlanor®** (ivabradine)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL boxes MUST be checked and chart notes/documentation MUST be attached to this request to ensure authorization process will NOT be delayed.

- Corlanor® is being prescribed by (or in consultation with) a cardiologist
- Diagnosis of stable, symptomatic heart failure with LVEF \leq 35%
- Patient is in sinus rhythm with resting heart rate \geq 70 bpm
- Patient is currently on maximal dose of a β -blocker or has a contraindication to β -blockers
- Patient's blood pressure is \geq 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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*REVISED/UPDATED: 7/1/2018