OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check **ALL** boxes below to qualify. Chart notes/documentation **MUST** be attached to this request or authorization process will be delayed**.**

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

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/26/2017;~~ **8/17/2018**