

# 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. Incomplete form will delay authorization process.

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

**DRUG INFORMATION:** Complete information below. Authorization process will be delayed if incomplete.

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  $\leq$  35%
- Patient is in sinus rhythm with resting heart rate  $\geq$  70 bpm
- Patient is currently on maximal dose of a  $\beta$ -blocker or has a contraindication to  $\beta$ -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 #: \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 7/16/2015

REVISED/UPDATED: 8/11/2015; 12/27/2015; 12/15/2016; 9/19/2017;