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 ≤ 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 #: ____

***Approved by Pharmacy and Therapeutics Committee**: 7/16/2015
REVISED/UPDATED: ~~8/11/2015~~; ~~12/27/2015~~; ~~12/15/2016~~; **8/11/2017**;