HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
CORLANOR®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Corlanor® (ivabradine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by or in consultation with a cardiologist?	☐	☐	
2. Does the member have a left ventricular ejection fraction ≤35%?	☐	☐	**Please provide documentation**
3. Is the member in sinus rhythm with a resting heart rate ≥70 beats per minute?	☐	☐	**Please provide documentation**
4. Is the member currently on a maximally tolerated dose of a beta blocker, unless contraindicated?	☐	☐	**Please provide documentation**
5. Is the member on maximally tolerated angiotensin converting enzyme inhibitor or angiotensin receptor blocker?	☐	☐	**Please provide documentation**
6. Is the member currently on a maximally tolerated dose of an aldosterone antagonist, unless contraindicated?	☒	☐	**Please provide documentation**
7. Does the member have any of the following? • Acute decompensated heart failure • Blood pressure less than 90/50 • Sick sinus syndrome • Sinoatrial block or 3rd degree AV block (unless a functioning demand pacemaker is present) • Severe hepatic impairment • Pacemaker dependence • Current treatment with a CYP3A4 inhibitor	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member meet initial authorization criteria?	☐	☐	**Please provide documentation**
3. Is the member receiving ongoing care for heart failure?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM-018
Origination Date: 03/02/2018
Reviewed/Revised Date: 03/25/2020
Next Review Date: 03/25/2021
Current Effective Date: 03/26/2020