iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

**Fax Completed Form To**
1.833.404.2392
**Prescriber Help Desk**
1.833.587.2012
**Online**
covermymeds.com/main/prior-authorization-forms/

# Request for Prior Authorization
# IVABRADINE (CORLANOR®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| Pharmacy NPI | Pharmacy fax | NDC |

**Prior authorization is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:**

**1) Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and**
- **a) Patient is 18 years of age or older; and**
- **b) Patient has documentation of a left ventricular ejection fraction ≤ 35%; and**
- **c) Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and**
- **d) Patient has documentation of blood pressure ≥90/50 mmHg; or**

**2) Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class II to IV) due to dilated cardiomyopathy; and**
- **a) Pediatric patient age 6 months and less than 18 years old; and**
- **b) Patient has documentation of a left ventricular ejection fraction ≤ 45%; and**
- **c) Patient is in sinus rhythm with a resting heart rate (HR) defined below:**
  - **i. 6 to 12 months – HR ≥ 105 bpm**
  - **ii. 1 to 3 years – HR ≥ 95 bpm**
  - **iii. 3 to 5 years – HR ≥ 75 bpm**
  - **iv. 5 to 18 years – HR ≥ 70 bpm; and**

**3) Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g., carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily), or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and**

**4) Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose.**

**The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.**

**Non-Preferred**

☐ Corlanor ☐ Ivabradine

| Strength | Dosage | Instructions | Quantity | Days Supply |
|---|---|---|---|---|
| | | | | |

**Diagnosis:**

☐ Stable, symptomatic heart failure (NYHA Class II to IV)): NYHA Class (≥ 18 years of age):

☐ Stable, symptomatic heart failure (NYHA/Ross Class II to IV) due to dilated cardiomyopathy (6 months to < 18 years of age): NYHA/Ross Class: ____________________

☐ Other: ____________________

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**IVABRADINE (CORLANOR®)**

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**Provide left ventricular ejection fraction:** ______________________ Date obtained: __________

**Provide resting heart rate in which patient is in sinus rhythm:**

☐ Resting heart rate: ________________ Date obtained: ____________________

**<u>For diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV) in members ≥ 18 years of age:</u>**

**Does patient have blood pressure ≥90/50mmHg?**

☐ No ☐ Yes: Blood pressure: ______________ Date obtained: __________________

**Treatment failure with maximally tolerated dose of beta-blocker with proven mortality benefit in a heart failure clinical trial:**

Drug name & dose: _________________________________ Trial dates: ________________

Reason for failure: ____________________________________________________________

Contraindication: ______________________________________________________________

**Trial and continued use with a preferred angiotensin system blocker at maximally tolerated dose:**

Drug name & dose: _________________________________ Trial dates: __________________

Will an angiotensin system blocker be used concomitantly with ivabradine? ☐ No ☐ Yes

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|
| | |

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*