Iowa Department of Human Services

Request for Prior Authorization
IVABRADINE (CORLANOR®)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(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 is 18 years of age or older; and

2) Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and

3) Patient has documentation of a left ventricular ejection fraction ≤35%; and

4) Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and

5) Patient has documentation of blood pressure ≥90/50 mmHg; and

6) 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 patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and

7) Patient has documentation of a trial and continued use with a preferred ACE inhibitor or preferred ARB 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®

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**

Diagnosis:

☐ Stable, symptomatic heart failure: NYHA Class:_____

☐ Other:_____

Provide left ventricular ejection fraction:_____ Date obtained:_____

Is patient in sinus rhythm with a resting heart rate of ≥70 beats per minute?

☐ No ☐ Yes: Resting heart rate:_____ Date obtained:_____

Request for Prior Authorization-*Continued*
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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 ACE inhibitor or ARB at maximally tolerated dose:

Drug name & dose:_____ Trial dates:_____

Is ACE inhibitor or ARB to 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 Human Services, that the member continues to be eligible for Medicaid.*