Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Corlanor (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Corlanor (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Corlanor (ivabradine)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Is the patient responding to treatment and is the patient's resting heart rate less than or equal to 70 beats per minute (bpm)? Y N

   [No further questions.]

3. Does the patient have stable chronic heart failure with a left ventricular ejection fraction less than or equal to 35 percent? Y N

4. Is the patient in sinus rhythm? Y N

5. Is the patient's resting heart rate greater than or equal to 70 beats per minute (bpm)? Y N

6. Will the patient continue therapy with a maximally tolerated beta-blocker OR does the patient have an intolerance or contraindication to beta-blockers? Y N

   Please list agents tried:

   _____

7. Will the patient continue therapy with an Angiotensin Converting Enzyme Inhibitor/Angiotensin II Receptor Blocker (ACEI/ARB) or Entresto OR does the patient have an intolerance or contraindication to ACEI/ARBs? Y N

   Please list agents tried:

   _____

   [Note: Entresto requires PA.]

8. Does the patient have any of the following contraindications to treatment: A) Acute decompensated heart failure, B) Blood pressure less than 90/50 mmHg, C) Pacemaker dependent (i.e., heart rate maintained exclusively by pacemaker), D) Sick sinus syndrome, sinoatrial block of third degree AV block (unless a functioning demand pacemaker is present), E) Severe hepatic impairment (Child-Pugh class C)? Y N

9. Is the patient at least 18 years of age? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date