aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-309-8077 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/pennsylvania/providers/pharmacy

Corlanor

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes ☐ No	☐ New request	☐ Continuation of therapy request	
Directions for Use:	Strength:	Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:	
What medication(s) has the member tried and failed for this diagnosis? Please specify below.				

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
☐ Members 18 Years of Age or Older					
Does member have diagnosis of stable symptomatic chronic HF (NYHA Class II-III)?	☐ Yes	☐ No	Is LVEF ≤ 35%?	☐ Yes	☐ No
Is member in sinus rhythm with resting HR ≥70 BPM?	☐ Yes	☐ No	Is there continuation of therapy with maximally tolerated BB OR there is intolerance OR contraindication to BB?	☐ Yes	☐ No
Is there continuation of therapy with ACEI / ARB OR Entresto OR there is intolerance OR contraindication to ACEI / ARB OR Entresto?				☐ Yes	☐ No
Provider attestation that no contraindications to treatment exist? (check all that apply):	☐ Acute decompensated heart failure ☐ Blood pressure less than 90/50 mmHg ☐ Pacemaker dependent (for example: heart rate maintained exclusively by pacemaker) ☐ Sick sinus syndrome, sinoatrial block of third-degree AV block (unless functioning demand pacemaker is present) ☐ Severe hepatic impairment (Child-Pugh class C)				
☐ Pediatric Members 6 Months of Age or Older					
Does member have diagnosis of HF due to dilated cardiomyopathy?	☐ Yes	☐ No	Is member in sinus rhythm with resting HR of ≥70 BPM?	☐ Yes	☐ No
Provider attestation that no contraindications to treatment exist (check all that apply):	☐ Yes	☐ No	☐ Acute decompensated heart failure ☐ Blood pressure less than 90/50 mmHg ☐ Pacemaker dependent (for example: heart rate maintained exclusively by pacemaker)		

			☐ Sick sinus syndrome, sinoatrial block of third-degree AV block (unless functioning demand pacemaker is present) ☐ Severe hepatic impairment (Child-Pugh class C)

Does member have intolerance OR contraindication to trimethoprim-sulfamethoxazole? (for non-life-threatening reactions, the national AIDS guideline recommends re-challenge)	☐ Yes	☐ No

☐ **Renewal ONLY**

Is member responding to treatment?	☐ Yes	☐ No	Is HR within recommended range for continuation of maintenance dose (for example, 50-60 BPM or dose adjusted accordingly to achieve goals member seropositive for anti-toxoplasma IgG)?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call to check the status of a request.
Pennsylvania CHIP:1-800-822-2447.