AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Ivabradine (Corlanor®)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult **www.iowamedicaidpdl.com/pa_criteria**.

Non-Preferred

☐ Corlanor®

Dosage Instructions:

Strength: 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?

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

Does patient have blood pressure ≥90/50mmHg?

☐ Yes: Blood pressure: ☐ No Date obtained:

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

Drug name and dose: Trial dates:

Failure reason:

Contraindication:

Trial and continued use with a preferred ACE inhibitor or ARB at maximally tolerated dose:

Drug name and dose: Trial dates:

Is ACE inhibitor or ARB to be used concomitantly with ivabradine? ☐ Yes ☐ No

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.