Prior Authorization Request Form for
ivabradine (Corlanor)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: _____ Secure Fax #: _____

Step 2

Please complete the clinical assessment:

1. How old is the patient?	☐ Greater than or equal to 18 years of age - Proceed to question **5** ☐ Between 6 months through 17 years of age - Proceed to question **2** ☐ Other - **Coverage not approved.**	
2. For which indication is the requested medication being prescribed?	☐ Heart failure (HF) due to dilated cardiomyopathy– Proceed to question **3** ☐ Other - **Coverage not approved.**	
3. Is the diagnosis stable symptomatic heart failure and in sinus rhythm?	☐ Yes Proceed to question **4**	☐ No **Stop** Coverage not approved
4. Does the patient have an elevated heart rate?	☐ Yes Proceed to question **11**	☐ No **Stop** Coverage not approved
5. For which indication is the requested medication being prescribed?	☐ Heart failure (HF) with reduced ejection fraction – Proceed to question **6** ☐ Postural orthostatic tachycardia syndrome (POTS) - Proceed to question **11** ☐ Inappropriate sinus tachycardia (IST) - Proceed to question **11** ☐ Other - **Coverage not approved.**	
6. Is the diagnosis stable, symptomatic heart failure with left ventricular ejection fraction (LVEF) of less than or equal to 35% and in sinus rhythm?	☐ Yes Proceed to question **7**	☐ No **Stop** Coverage not approved

7. Does the patient have a resting heart rate greater than or equal to 70 beats per minute?	☐ Yes Proceed to question **8**	☐ No **Stop** Coverage not approved
8. Does the patient have heart failure symptoms despite maximal therapy of a beta blocker that has been shown to have survival benefit in heart failure? Acceptable heart failure beta blockers and target doses include the following: metoprolol succinate ER 200 mg once a day; carvedilol 25 mg twice a day, or 50 mg twice a day if greater than 85 kg; carvedilol 80 mg ER once a day; bisoprolol 10 mg once a day (although not FDA-approved for HF) and NOT atenolol.	☐ Yes Proceed to question **11**	☐ No Proceed to question **9**
9. Has the patient tried and experienced intolerance to a heart failure beta blocker (for example, metoprolol succinate, carvedilol, bisoprolol)?	☐ Yes Proceed to question **11**	☐ No Proceed to question **10**
10. Does the patient have a contraindication to the use of beta blockers? – NOTE: Please select the option that best applies to this patient's condition.	☐ Hypersensitivity to beta blockers – Proceed to question **11** ☐ Cardiogenic shock or overt cardiac failure – Proceed to question **11** ☐ Severe sinus bradycardia – Proceed to question **11** ☐ Second and third degree heart block – Proceed to question **11** ☐ Asthma – Proceed to question **11** ☐ Chronic obstructive pulmonary disease – Proceed to question **11** ☐ None of the above – **Coverage not approved**.	
11. Is this drug being prescribed by a cardiologist or heart failure specialist?	☐ Yes **Sign and date below**	☐ No **Stop** Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: