



Please complete ALL information below and fax your request to 1-888-671-5285

### Corlanor® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for <b>GENERIC</b> <input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>	Directions for Use:	

Clinical Information (required)
<b>Select the Type(s) of Coverage Determination Requested:</b> <input type="checkbox"/> <b>Prior Authorization-</b> Request is for a drug that requires prior authorization under the plan. <input type="checkbox"/> <b>Quantity Limit-</b> Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____
<b>Select the diagnosis below:</b> <input type="checkbox"/> Stable, symptomatic chronic heart failure <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<b>Clinical information:</b> Is the patient's left ventricular ejection fraction less than or equal to 35%? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient in sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been clinically stable for at least 4 weeks on an optimized and stable clinical regimen which includes both of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <li>• Maximally tolerated doses of beta blockers or inability to tolerate beta blockers</li> <li>• Angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) or inability to tolerate ACE inhibitor or ARB</li> </ul> Was the medication prescribed by or in consultation with a cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Quantity limit requests:</b> Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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