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

Corlanor® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
❑ Chronic heart failure
❑ Other diagnosis: ________________________________ ICD-10 Code(s): ____

Clinical information:
Does the patient have New York Heart Association (NYHA) Class II, III, or IV symptoms? ❑ **Yes** ❑ **No**
Does the patient have a left ventricular ejection fraction ≤ 35%? ❑ **Yes** ❑ **No**
Is the patient in sinus rhythm? ❑ **Yes** ❑ **No**
Does the patient have a resting heart rate that is greater than or equal to 70 beats per minute? ❑ **Yes** ❑ **No**
Is the patient on a beta blocker at a maximally tolerated dose? ❑ **Yes** ❑ **No**
Does the patient have a contraindication or intolerance to beta-blocker therapy? ❑ **Yes** ❑ **No**
Does the patient have a trial and failure, contraindication, or intolerance to maximally tolerated doses of an Angiotensin converting enzyme (ACE) inhibitor? ❑ **Yes** ❑ **No**
Does the patient have a trial and failure, contraindication, or intolerance to maximally tolerated doses of an Angiotensin receptor blocker (ARB)? ❑ **Yes** ❑ **No**
Has the patient been hospitalized for worsening heart failure in the previous 12 months? ❑ **Yes** ❑ **No**
Was the medication prescribed by or in consultation with a cardiologist? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:
Is there documentation of positive clinical response to Corlanor therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _______
What is the reason for exceeding the plan limitations?
❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

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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