PRIOR AUTHORIZATION REQUEST FORM

Medicare Part D Corlanor

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note, any information left blank or illegible may delay the review process.

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what indication is this drug being prescribed (pick one)?

- ☐ Stable, Symptomatic Heart Failure
- ☐ Acute Decompensated Congestive Heart Failure (CHF)
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is patient's resting heart rate greater than or equal to 70 BPM? (Please submit most recent vitals and date measured)

☐ Yes ☐ No

Q4. Is patient's left ventricular ejection fraction (EF) less than or equal to 35%? (Please submit most recent EF and date measured)

☐ Yes ☐ No

Q5. Is patient in normal sinus rhythm?

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☐ Yes ☐ No

Q6. Does patient have documented failure of or intolerance to maximized beta-blocker therapy? (Please list all medications and doses tried/failed or contraindicated)

☐ Yes ☐ No

Q7. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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