



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Corlanor (ivabradine)

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:
Member/Subscriber Number:	Supervising Physician:
Date of Birth:	Fax: Phone:
Group Number:	Office Contact:
Address:	NPI: State Lic ID:
City, State ZIP:	Address:
Primary Phone:	City, State ZIP:
	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)? <input type="checkbox"/> Stable, Symptomatic Heart Failure <input type="checkbox"/> Acute Decompensated Congestive Heart Failure (CHF) <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Is patient's left ventricular ejection fraction (EF) less than or equal to 35%? (Please submit most recent EF and date measured) <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Is patient in normal sinus rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Patient Name:	Prescriber Name: Supervising Physician:
Q6. Does patient have documented failure of or intolerance to maximized beta-blocker therapy? (Please list all medications and doses tried/failed or contraindicated) <input type="checkbox"/> Yes <input type="checkbox"/> 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

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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