



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Corlanor Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#		DEA#	
Office Address:	City:	State:		Zip Code:	
Office Contact:	Office Phone		Office Fax:		
Dispensing Pharmacy Information					
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one):	Yes	No	Diagnosis:	ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request	
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:		
What medication(s) has the member tried and failed for this diagnosis? Please specify below.					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information					
<input type="checkbox"/> Members 18 Years of Age or Older					
Does member have diagnosis of stable symptomatic chronic HF (NYHA Class II-III)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is LVEF ≤ 35%?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member in sinus rhythm with resting HR ≥70 BPM?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there continuation of therapy with maximally tolerated BB OR there is intolerance OR contraindication to BB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there continuation of therapy with ACEI / ARB OR Entresto OR there is intolerance OR contraindication to ACEI / ARB OR Entresto?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider attestation that no contraindications to treatment exist? (check all that apply):	<input type="checkbox"/> Acute decompensated heart failure <input type="checkbox"/> Blood pressure less than 90/50 mmHg <input type="checkbox"/> Pacemaker dependent (for example: heart rate maintained exclusively by pacemaker) <input type="checkbox"/> Sick sinus syndrome, sinoatrial block of third-degree AV block (unless functioning demand pacemaker is present) <input type="checkbox"/> Severe hepatic impairment (Child-Pugh class C)				
<input type="checkbox"/> Pediatric Members 6 Months of Age or Older					
Does member have diagnosis of HF due to dilated cardiomyopathy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member in sinus rhythm with resting HR of ≥70 BPM?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider attestation that no contraindications to treatment exist (check all that apply):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Acute decompensated heart failure <input type="checkbox"/> Blood pressure less than 90/50 mmHg		

			<input type="checkbox"/> Pacemaker dependent (for example: heart rate maintained exclusively by pacemaker) <input type="checkbox"/> Sick sinus syndrome, sinoatrial block or third-degree AV block (unless functioning demand pacemaker is present) <input type="checkbox"/> Severe hepatic impairment (Child-Pugh class C)
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Does member have intolerance OR contraindication to trimethoprim-sulfamethoxazole? (for non-life-threatening reactions, the national AIDS guideline recommends re-challenge)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Renewal ONLY

Is member responding to treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is HR within recommended range for continuation of maintenance dose (for example, 50-60 BPM or dose adjusted accordingly to achieve goals member seropositive for anti-toxoplasma IgG)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.