



Fax completed prior authorization request form to 855-247-3677 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/rbha-forproviders/pharmacy](http://www.mercycareaz.org/providers/rbha-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"/> <b>Urgent</b> – 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 of third-degree AV block (unless functioning demand pacemaker is present) <input type="checkbox"/> Severe hepatic impairment (Child-Pugh class C)
--	--	--	---

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
--	------------------------------	-----------------------------

<input type="checkbox"/> <b>Renewal ONLY</b>					
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

**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 800-564-5465 to check the status of a request.