



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Corlanor<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Chronic heart failure	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p><b>Clinical information:</b></p> <p>Does the patient have New York Heart Association (NYHA) Class II, III, or IV symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a left ventricular ejection fraction ≤ 35%? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient in sinus rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a resting heart rate that is greater than or equal to 70 beats per minute? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient on a beta blocker at a maximally tolerated dose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a contraindication or intolerance to beta-blocker therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a trial and failure, contraindication, or intolerance to maximally tolerated doses of an Angiotensin converting enzyme (ACE) inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a trial and failure, contraindication, or intolerance to maximally tolerated doses of an Angiotensin receptor blocker (ARB)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient been hospitalized for worsening heart failure in the previous 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the medication prescribed by or in consultation with a cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p><b>Reauthorization:</b></p> <p><b>If this is a reauthorization request, answer the following question:</b></p> <p>Is there documentation of positive clinical response to Corlanor therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p><b>Quantity limit requests:</b></p> <p>What is the quantity requested per DAY? _____</p> <p><b>What is the reason for exceeding the plan limitations?</b></p> <p><input type="checkbox"/> Titration or loading-dose purposes</p> <p><input type="checkbox"/> 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)</p> <p><input type="checkbox"/> Requested strength/dose is not commercially available</p> <p><input type="checkbox"/> Other: _____</p>
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**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.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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