OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit 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® Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)			Provider Information (required)		
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 (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic heart failure

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have New York Heart Association (NYHA) Class II, III, or IV symptoms? ❑ **Yes** ❑ **No**

Does the patient have a left ventricular ejection fraction ≤ 35%? ❑ **Yes** ❑ **No**

Is the patient in sinus rhythm? ❑ **Yes** ❑ **No**

Does the patient have a resting heart rate that is greater than or equal to 70 beats per minute? ❑ **Yes** ❑ **No**

Is the patient on a beta blocker at a maximally tolerated dose? ❑ **Yes** ❑ **No**

Does the patient have a contraindication or intolerance to beta-blocker therapy? ❑ **Yes** ❑ **No**

Does the patient have a trial and failure, contraindication, or intolerance to maximally tolerated doses of an Angiotensin converting enzyme (ACE) inhibitor? ❑ **Yes** ❑ **No**

Does the patient have a trial and failure, contraindication, or intolerance to maximally tolerated doses of an Angiotensin receptor blocker (ARB)? ❑ **Yes** ❑ **No**

Has the patient been hospitalized for worsening heart failure in the previous 12 months? ❑ **Yes** ❑ **No**

Was the medication prescribed by or in consultation with a cardiologist? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to Corlanor therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes

❑ 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)

❑ Requested strength/dose is not commercially available

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Other: _____

Corlanor® Prior Authorization Request Form (Page 2 of 2)

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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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.