

TRICARE Prior Authorization Request Form for ivabradine (Corlanor)



6122

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;

- The provider may **call: 1-866-684-4488**
or the completed form may be **faxed to:**
1-866-684-4477

- The patient may attach the completed form to the prescription and **mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
or **email** the form only to:
TPharmPA@express-scripts.com

Step 1

Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2

Please complete the clinical assessment:

<p>1. How old is the patient?</p>	<input type="checkbox"/> Greater than or equal to 18 years of age - Proceed to question 5 <input type="checkbox"/> Between 6 months through 17 years of age - Proceed to question 2 <input type="checkbox"/> Other - Coverage not approved.	
<p>2. For which indication is the requested medication being prescribed?</p>	<input type="checkbox"/> Heart failure (HF) due to dilated cardiomyopathy– Proceed to question 3 <input type="checkbox"/> Other - Coverage not approved.	
<p>3. Is the diagnosis stable symptomatic heart failure and in sinus rhythm?</p>	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Stop Coverage not approved
<p>4. Does the patient have an elevated heart rate?</p>	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Stop Coverage not approved
<p>5. For which indication is the requested medication being prescribed?</p>	<input type="checkbox"/> Heart failure (HF) with reduced ejection fraction – Proceed to question 6 <input type="checkbox"/> Postural orthostatic tachycardia syndrome (POTS) - Proceed to question 11 <input type="checkbox"/> Inappropriate sinus tachycardia (IST) - Proceed to question 11 <input type="checkbox"/> Other - Coverage not approved.	
<p>6. Is the diagnosis stable, symptomatic heart failure with left ventricular ejection fraction (LVEF) of less than or equal to 35% and in sinus rhythm?</p>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Stop Coverage not approved

<p>7. Does the patient have a resting heart rate greater than or equal to 70 beats per minute?</p>	<p><input type="checkbox"/> Yes Proceed to question 8</p>	<p><input type="checkbox"/> No Stop Coverage not approved</p>
<p>8. Does the patient have heart failure symptoms despite maximal therapy of a beta blocker that has been shown to have survival benefit in heart failure? Acceptable heart failure beta blockers and target doses include the following: metoprolol succinate ER 200 mg once a day; carvedilol 25 mg twice a day, or 50 mg twice a day if greater than 85 kg; carvedilol 80 mg ER once a day; bisoprolol 10 mg once a day (although not FDA-approved for HF) and NOT atenolol.</p>	<p><input type="checkbox"/> Yes Proceed to question 11</p>	<p><input type="checkbox"/> No Proceed to question 9</p>
<p>9. Has the patient tried and experienced intolerance to a heart failure beta blocker (for example, metoprolol succinate, carvedilol, bisoprolol)?</p>	<p><input type="checkbox"/> Yes Proceed to question 11</p>	<p><input type="checkbox"/> No Proceed to question 10</p>
<p>10. Does the patient have a contraindication to the use of beta blockers? – NOTE: Please select the option that best applies to this patient’s condition.</p>	<p><input type="checkbox"/> Hypersensitivity to beta blockers – Proceed to question 11 <input type="checkbox"/> Cardiogenic shock or overt cardiac failure – Proceed to question 11 <input type="checkbox"/> Severe sinus bradycardia – Proceed to question 11 <input type="checkbox"/> Second and third degree heart block – Proceed to question 11 <input type="checkbox"/> Asthma – Proceed to question 11 <input type="checkbox"/> Chronic obstructive pulmonary disease – Proceed to question 11 <input type="checkbox"/> None of the above – Coverage not approved.</p>	
<p>11. Is this drug being prescribed by a cardiologist or heart failure specialist?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No Stop Coverage not approved</p>

**Step
3**

I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date