Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Ivabradine - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the request for a reauthorization of ivabradine? If YES, go to 2. If NO, go to 7.

☐ Yes ☐ No

Q2. Is there documentation that the member has had clinical improvement or stabilization of signs and symptoms of disease?

☐ Yes ☐ No

Q3. Is the member in normal sinus rhythm (with documentation attached)?

☐ Yes ☐ No

Q4. Is the member 18 years of age or older? If YES, go to 5. If NO, go to 6.

☐ Yes ☐ No

Q5. Is there documentation showing that the member continues to use ivabradine in combination with a beta-blocker (bisoprolol, carvedilol, metoprolol succinate) unless contraindicated or not tolerated?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Is the request for brand Corlanor tablet or brand Corlanor oral solution? If YES, go to 20.

☐ Yes ☐ No

Q7. Is the drug being prescribed by or in consultation with a cardiologist?

☐ Yes ☐ No

Q8. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q9. Does the member have a contraindication to the requested drug?

☐ Yes ☐ No

Q10. Is the member in normal sinus rhythm (with documentation attached)?

☐ Yes ☐ No

Q11. Does the member have a resting heart rate greater than or equal to 70 beats per minute (with documentation attached)?

☐ Yes ☐ No

Q12. Is the member 18 years of age or older? If YES, go to 13. If NO, go to 17.

☐ Yes ☐ No

Q13. Is the requested drug is being used for the treatment of New York Heart Association (NYHA) class II, III, or IV heart failure symptoms (with documentation attached)?

☐ Yes ☐ No

Q14. Does the member have a left ventricular ejection fraction less than or equal to 35% (with documentation attached)?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q15. Does the member have a documented history of treatment failure with beta-blockers (bisoprolol, carvedilol, metoprolol succinate) at maximally tolerated doses OR have a contraindication or intolerance to beta-blocker therapy?

☐ Yes ☐ No

Q16. Will the member be taking ivabradine in combination with a beta blocker if tolerated? If YES, go to 20.

☐ Yes ☐ No

Q17. Is the member less than 18 years of age?

☐ Yes ☐ No

Q18. Is the requested drug is being used for the treatment of New York Heart Association (NYHA) class II, III, or IV heart failure symptoms due to dilated cardiomyopathy (with documentation attached)?

☐ Yes ☐ No

Q19. Does the member have a left ventricular ejection fraction less than or equal to 45% (with documentation attached)?

☐ Yes ☐ No

Q20. Is the request for brand Corlanor tablet? If YES, go to 21. If NO, go to 22.

☐ Yes ☐ No

Q21. Is there documentation of clinically significant adverse effects with generic ivabradine tablet that would not be expected to occur with brand, or a contraindication to the generic?

☐ Yes ☐ No

Q22. Is the request for brand Corlanor oral solution?

☐ Yes ☐ No

Q23. Is there documentation of an inability to swallow solid dosage forms?

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Member Name:	Prescriber Name:

☐ Yes	☐ No
Q24. Additional Information:	

Prescriber Signature _____ Date _____

v2026-06