



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Ivabradine - Exchange**

**Fax back to: (833) 605-4407**  
Phone: (215) 991-4300

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**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?



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the request for brand Corlanor tablet or brand Corlanor oral solution? If YES, go to 20.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the drug being prescribed by or in consultation with a cardiologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the member have a contraindication to the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is the member in normal sinus rhythm (with documentation attached)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the member have a resting heart rate greater than or equal to 70 beats per minute (with documentation attached)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Is the member 18 years of age or older? If YES, go to 13. If NO, go to 17.	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No



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Q14. Does the member have a left ventricular ejection fraction less than or equal to 35% (with documentation attached)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Will the member be taking ivabradine in combination with a beta blocker if tolerated? If YES, go to 20. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Is the member less than 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q19. Does the member have a left ventricular ejection fraction less than or equal to 45% (with documentation attached)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q20. Is the request for brand Corlanor tablet? If YES, go to 21. If NO, go to 22. <input type="checkbox"/> Yes <input type="checkbox"/> 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?	



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q22. Is the request for brand Corlanor oral solution?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q23. Is there documentation of an inability to swallow solid dosage forms?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q24. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026