Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Corlanor - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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 Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour 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 reauthorization?

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of chronic heart failure (CHF)?

☐ Yes ☐ No

Q4. Does the patient have stable symptomatic NYHA class II to IV heart failure with reduced left ventricular ejection fraction (EF)?

☐ Yes ☐ No

Q5. Is documentation attached showing the patient has EF less than or equal to 35%?

☐ Yes ☐ No

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Q6. Is the patient in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute?

☐ Yes ☐ No

Q7. Has the patient experienced intolerance, contraindication, or is on maximally tolerated doses of beta-blockers?

☐ Yes ☐ No

Q8. Does the patient have a documented diagnosis of stable symptomatic heart failure due to Dilated Cardiomyopathy (CHF-DC)?

☐ Yes ☐ No

Q9. Is the patient in sinus rhythm with an elevated heart rate?

☐ Yes ☐ No

Q10. Is the request for brand Corlanor?

☐ Yes ☐ No

Q11. Is there documentation of inadequate response, intolerance, or contraindication to generic ivabradine?

☐ Yes ☐ No

Q12. Requested Duration:

☐ 12 Months ☐ Other

Q13. Additional Information:

Prescriber Signature

Date

v2025

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