Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information

Requested Drug(s) & Strength(s):	[ ] Corlanor 5 mg tablet [ ] Corlanor 5 mg/5 mL oral solution [ ] Corlanor 7.5 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) ____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic heart failure (CHF)

[ ] Heart failure due to dilated Cardiomyopathy (DCM)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) ____(*Required)

Q4: Does the member have documentation of positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the postive response of the therapy) ____(*Required)

[ ] No (please provide medical justification for continuation of therapy) ____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic heart failure (CHF)

[ ] Heart failure due to dilated Cardiomyopathy (DCM)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) ____(*Required)

Q6: Does member have NYHA Class II, III, or IV symptoms? (Check only one that apply)

[ ] Yes (please specify NYHA class and symptoms) ____(*Required)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q7: Does the member have a left ventricular ejection fraction less than or equal to 35%? (Check only one that apply)

[ ] Yes (please provide documentaion supporting to left ventricular ejection fraction values)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q8: Is the member in sinus rhythm? (Check only one that apply)

[ ] Yes (please provide necessary documentation)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q9: Does the member have resting heart rate of greater than or equal to 70 beats per minute? (Check only one that apply)

[ ] Yes (please provide resting heart rate values)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q10: Is the member currently on beta-blocker or had an inadequate response or have contraindication(s) to beta-blockers (e.g., bisoprolol, carvedilol, metoprolol succinate extended release) ? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced, and the start and end date (s) of therapy (month/year)) ____(*Required)

[ ] No

Q11: Has the member been hospitalized for worsening heart failure in the previous 12 months? (Check only one that apply)

[ ] Yes (please specify date of hospitalization (month/year)) ____ (*Required)

[ ] No

Q12: Has the member had an inadequate response, intolerance or contraindication(s) to an ACE inhibitor (e.g., captopril, enalapril, lisinopril) or ARB (e.g., candesartan, losartan, valsartan). (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced, and the start and end date (s) of therapy (month/year)) ____(*Required)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q13: Does member have NYHA Class II, III, or IV symptoms? (Check only one that apply)

[ ] Yes (please specify NYHA class and symptoms) ____(*Required)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q14: Is the member in sinus rhythm? (Check only one that apply)

[ ] Yes (please provide necessary documentation)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q15: Does the member have elevated heart rate? (Check only one that apply)

[ ] Yes (please provide heart rate values)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q16: Has the member had an inadequate response, intolerance or contraindication(s) to beta blocker (e.g., bisoprolol, metoprolol succinate extended release)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced, and the start and end date (s) of therapy (month/year)) ____(*Required)

[ ] No

Q17: Has the member had an inadequate response, intolerance or contraindication(s) to Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced, and the start and end date (s) of therapy (month/year)) ____(*Required)

[ ] No

Q18: Has the member had an inadequate response, intolerance or contraindication(s) to Diuretic Agent (e.g., spironolactone, furosemide)? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) or intolerance experienced, and the start and end date (s) of therapy (month/year)) ____(*Required)

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q19: Is the reqeusted medication prescribed by or in consultation with a cardiologist? (Check only one that apply)

[ ] Yes

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[ ] No (please provide clinical rationale for the request) ____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	