CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
MISCELLANEOUS CARDIAC AGENTS PRIOR AUTHORIZATION (PA) REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's Indiana License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ _____ Start Date: _____

Requested Medication & Strength	Quantity	Directions for Use

PA Requirements for Camzyos (mavacamten):

1. Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy? (Provide documentation) □ Yes □ No
   Diagnosis Code: _____
2. Left ventricular ejection fraction is greater than or equal to 55%? (Provide documentation) □ Yes □ No
3. Left ventricular outflow tract (LVOT) gradient of 50 mm Hg or greater? (Provide documentation) □ Yes □ No
4. Is the member 18 years of age or older? □ Yes □ No
5. Is the member enrolled in Camzyos/mavacamten REMS program? □ Yes □ No
6. Has the member tried and failed 90 days or greater of beta-adrenergic blocker or non-dihydropyridine calcium channel blocker therapy? □ Yes □ No

   -OR-

   Please provide medical rationale for the use of Camzyos (mavacamten) over beta-adrenergic blocker and non-dihydropyridine calcium channel blocker therapy:

   _____

PA Requirements for Camzyos (mavacamten) (continued):

7. Does the requested dose exceeds 15mg/day? □ Yes □ No

Note the following QL per strength: 2.5 mg, 5 mg 10 mg and 15 mg capsule - max 1 capsule/day.

Requirements for Corlanor (ivabradine) Tablet or Corlanor (ivabradine) Solution for Adults

1. Select one of the following:

☐ Diagnosis of heart failure (Provide documentation)

Diagnosis Code: _____

- Left ventricular ejection fraction is less than or equal to 35%? (Provide documentation) □ Yes □ No
- Resting heart rate is greater than or equal to 70 beats per minute? (Provide documentation) □ Yes □ No

☐ Diagnosis of inappropriate sinus tachycardia

2. Select one of the following:

☐ Is the member currently maximized on beta-blocker dose? □ Yes □ No

Drug/dose/date(s): _____

☐ Does the member have a contraindication to beta-blocker use? □ Yes □ No

Please explain: _____

_____

3. Select one of the following:

☐ Tablet -- Requested dose does not exceed 15 mg/day? □ Yes □ No

Note: The following QL per strength: 5 mg, 7.5 mg, tablet – max 2 tablets/day

☐ Solution -- Requested dose does not exceed 15 mL/day? □ Yes □ No

- Is the member unable to swallow tablet formulation? (Provide documentation) □ Yes □ No

Note: Only approvable for a member who is 18 years of age or older and cannot swallow tablets.

4. Is the member 18 years of age or older? □ Yes □ No

Requirements for Corlanor (ivabradine) Tablet or Corlanor (ivabradine) Solution for Pediatrics

1. Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy? (Provide documentation) □ Yes □ No

Diagnosis Code: _____

2. Is the member's left ventricular ejection fraction less than or equal to 45%? (Provide documentation) □ Yes □ No

3. Is the member in sinus rhythm? (Provide documentation) □ Yes □ No

4. Does the member have an elevated resting heart rate? (Provide documentation) □ Yes □ No

5. Select one of the following:

☐ The member is 6 months through 17 years of age and ≥ 40 kg

Request is for tablet formulation? □ Yes □ No

Requested dose does not exceed 15 mg/day? □ Yes □ No

Note: The following QL per strength: 5 mg, 7.5 mg, tablet – max 2 tablets/day

☐ The member is 12 through 17 years of age and ≥ 40 kg

Request is for solution formulation? □ Yes □ No

Member is unable to swallow tablet formulation? (Provide documentation) □ Yes □ No

Requested dose does not exceed 15 mL/day? □ Yes □ No

Note: Only approvable for a member who cannot swallow tablets (must submit chart documentation).

Requirements for Corlanor (ivabradine) Tablet or Corlanor (ivabradine) Solution for Pediatrics (continued)

☐ The member is 6 months through 11 years of age and ≥ 40 kg
Requested dose does not exceed 15 mL/day? □ Yes □ No

☐ The member is 1 through 17 years of age and < 40 kg
Does the requested dose exceed 0.3 mg/kg/dose twice daily, max of 15 mL (15 mg)/day?
□ Yes □ No Weight: _____

☐ The member is 6 months through < 1 year of age and < 40 kg
Does the requested dose exceed 0.2 mg/kg/dose twice daily?
□ Yes □ No Weight: _____

PA Requirements for Verquvo (vericiguat):

1. Is the member 18 years of age or older? □ Yes □ No
2. Does the member have a diagnosis of chronic, symptomatic heart failure? (Provide documentation)
   □ Yes □ No
   Diagnosis Code: _____
3. Is the member's left ventricular ejection fraction less than or equal to 45%? (Provide documentation)
   □ Yes □ No
4. Select one of the following:
   ☐ The member been hospitalized for heart failure in the past 180 days. (Provide documentation)
   ☐ The member has received IV diuretics in the past 90 days. (Provide documentation)
5. If the member is of childbearing potential, is a negative pregnancy test taken within the past 60 days attached? □ Yes □ No
6. Does the requested dose exceed 10mg/day? □ Yes □ No
   Note the following QL per strength: 2.5 mg, 5 mg 10 mg and 15 mg capsule - max 1 capsule/day.

NOTE: Please attach other relevant information you would like considered for this review.

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____