

**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.*****

Member's CareSource # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Member's Name	Prescriber's Name
Prescriber's Indiana License # <input type="text"/>	Specialty
Prescriber's NPI # <input type="text"/>	Office Contact
Prescriber's Fax <input type="text"/> - <input type="text"/> - <input type="text"/>	Prescriber Phone <input type="text"/> - <input type="text"/> - <input type="text"/>
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 a Camzyos/mavacamten REMS program? Yes No
6. Has the member tried and failed 90 days or greater of a beta-adrenergic blocker or non-dihydropyridine calcium channel blocker therapy? Yes No

-OR-

Please provide medical rationale for the use of Camzyos (mavacamten) over a 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 Diagnosis Code: _____

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 \geq 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 \geq 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 year 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 Entresto (sacubitril-valsartan) Sprinkle:

1. One of the following:
 - Member is less than 12 years of age and/or < 50 kg Weight: _____
 - Member is 12 years of age or old, ≥ 50 kg, and cannot swallow tablet formation
2. Prescriber attests to the following:
 - Member is/will NOT be using concomitant angiotensin converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) therapy

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 there documentation of 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 and 10 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: _____

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.

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OMPP Approved: 10/1/2024