

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



MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (800) 788-2949



Today's Date
 / /

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

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

Patient's Medicaid # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name
Prescriber's IN License # <input type="text"/>	Specialty
Prescriber's NPI # <input type="text"/>	Prescriber's Signature
Return Fax # <input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone # <input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Dosage Regimen

PA Requirements for Camzyos (mavacamten):

1. Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (Provide documentation) Yes No
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. Member is 18 years of age or older Yes No
5. Member is enrolled in Camzyos/mavacamten REMS program Yes No
6. Member has 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 Corlanor Tablet (ivabradine) for Adults:

1. Diagnosis of heart failure (Provide documentation) Yes No
2. Left ventricular ejection fraction is less than or equal to 35% (Provide documentation) Yes No
3. Resting heart rate is greater than or equal to 70 beats per minute (Provide documentation) Yes No
4. Member is currently maximized on beta-blocker dose Yes No

Drug/dose/date(s): _____

OR

Member has contraindication to beta-blocker use Yes No

Please explain: _____

PA Requirements for Corlanor Oral Solution (ivabradine) for Pediatrics:

1. Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (Provide documentation)
 Yes No
2. Member is 6 months through 17 years of age Yes No
3. Left ventricular ejection fraction is less than or equal to 45% (Provide documentation) Yes No
4. Member is in sinus rhythm (Provide documentation) Yes No
5. Resting heart rate is elevated (Provide documentation) Yes No

PA Requirements for Verquvo (vericiguat):

1. Member is 18 years of age or older Yes No
2. Diagnosis of chronic, symptomatic heart failure (Provide documentation) Yes No
3. Left ventricular ejection fraction is less than or equal to 45% (Provide documentation) Yes No
4. Member has been hospitalized for heart failure in the past 180 days (Provide documentation)
 Yes No

OR

Member has received IV diuretics in the past 90 days (Provide documentation) Yes No

5. Member is female of childbearing age and has had a negative pregnancy test within the past 60 days
(Provide documentation) Yes No

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