# Indiana Health Coverage Programs (IHCP) Miscellaneous Cardiac Agents Prior Authorization Request Form

**Humana Healthy Horizons®**, P.O. Box 14601, Lexington, KY 40512-4601
Phone: **800-555-2546** Fax: 877-486-2621

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 # ☐☐☐☐☐☐☐☐☐☐☐☐ | Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # ☐☐☐☐☐☐☐☐ | Specialty |
| Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐ | Prescriber's Signature |
| Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐ | Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐ |
| Check box if requesting retro-active PA ☐ | 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 |

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**PA Requirements for Camzyos (mavacamten):**

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

_____

_____

7. Requested dose exceeds 15 mg/day ☐ Yes ☐ No
**Note the following QL per strength: 2.5 mg, 5 mg, 10 mg, 15 mg capsule – max 1 capsule/day**

**PA Requirements for Corlanor (ivabradine) Tablet or Corlanor (ivabradine) Solution for Adults:**

1. Select one of the following:
☐ Diagnosis of heart failure (Provide documentation)
- 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:
☐ Member is currently maximized on beta-blocker dose
Drug/dose/date(s): _____

☐ Member has contraindication to beta-blocker use
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: 2.5 mg, 5 mg, 10 mg, 15 mg capsule – max 1 capsule/day**

☐ Solution — Requested dose does not exceed 15 mL/day ☐ Yes ☐ No
- Member is 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. Member is 18 years of age or older ☐ Yes ☐ No

**PA 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

2. Left ventricular ejection fraction is less than or equal to 45% (Provide documentation)
☐ Yes ☐ No

3. Member is in sinus rhythm (Provide documentation) ☐ Yes ☐ No

4. Resting heart rate is elevated (Provide documentation) ☐ Yes ☐ No

## PA Requirements for Corlanor (ivabradine) Tablet or Corlanor (ivabradine) Solution for Pediatrics:

5. Select one of the following:

☐ 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**

☐ 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)**

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

☐ Member is 1 through 17 years of age and < 40 kg
Requested dose does not exceed 0.3 mg/kg/dose twice daily, max of 15 mL (15 mg)/day
☐ Yes ☐ No Weight: _____

☐ Member is 6 months through < 1 year of age and < 40 kg
Requested dose does not 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 older, ≥ 50 kg, and cannot swallow tablet formulation

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):

3. Member is 18 years of age or older ☐ Yes ☐ No

4. Diagnosis of chronic, symptomatic heart failure (Provide documentation) ☐ Yes ☐ No

5. Left ventricular ejection fraction is less than or equal to 45% (Provide documentation)
☐ Yes ☐ No

6. Select one of the following::

☐ Member has been hospitalized for heart failure in the past 180 days (Provide documentation)

☐ Member has received IV diuretics in the past 90 days (Provide documentation)

7. For those of childbearing potential, documentation of a negative pregnancy test obtained within the past 60 days is attached ☐ Yes ☐ No

8. Requested dose exceeds 10 mg/day ☐ Yes ☐ No
**Note the following QL per strength: 2.5 mg, 5 mg, 10 mg tablet – max 1 tablet/day**