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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Corlanor and Entresto Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Corlanor (ivabradine)

☐ Entresto (sacubitril/valsartan)

Dose, frequency and duration of medication requested _____

Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. _____ ☐ No

Indication (check all that apply)

☐ Chronic heart failure

LVEF ☐ ≤ 35% ☐ ≤ 40% ☐ Other _____

☐ Other (please specify) _____

Please indicate prescriber specialty below.

☐ Cardiology ☐ Other

☐ Specialist consult details (if the prescriber submitting the request is not a specialist) _____

_____

_____

Name(s) of the specialist(s) _____ Date(s) of last visit or consult _____

Contact information _____

Section I. Please complete for Corlanor requests.

1. Is the member's resting heart rate ≥ 70 beats per minute? ☐ Yes ☐ No
2. Has the member had a trial with a beta-blocker (e.g., carvedilol, metoprolol succinate, or bisoprolol) at maximally tolerated doses?

   ☐ Yes. Please list the specific drug name, dose, dates/duration of use, and outcomes below.

   Drug name/dose _____ Dates/duration of use _____

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

   Briefly describe the details of adverse reaction or inadequate response. _____

   _____

☐ No. Please explain contraindication to oral beta-blocker or clinical rationale for not using a beta-blocker in this member. _____

_____

3. Has the member had a trial with an angiotensin-converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) or angiotensin receptor neprilysin inhibitor (ARNI) in combination with a beta-blocker?
   ☐ Yes. Please list the specific drug name(s), dates/duration of use, and outcomes below.
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe the details of adverse reaction or inadequate response. _____

   _____

   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe the details of adverse reaction or inadequate response. _____

   _____

   ☐ No. Please explain contraindication to the use of an ACE-I, ARB, or ARNI in combination with a beta-blocker or clinical rationale for not using these agents in this member.

   _____

Section II. Please complete for Entresto requests.

Has the member remained symptomatic despite receiving standard of care therapy with an ACE-I or ARB in combination with a beta-blocker?

☐ Yes. Please list the specific drug name(s), dates/duration of use, and outcomes below.
Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe the details of adverse reaction or inadequate response. _____

_____

Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe the details of adverse reaction or inadequate response. _____

_____

☐ No. Please explain contraindication to the use of an ACE-I or ARB in combination with a beta-blocker or clinical rationale for not using these agents in this member.

_____

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

_____

Section IV. Please include any other pertinent information (if needed).

_____

_____

_____

over

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____