



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (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 with reduced left ventricular ejection fraction (LVEF)
 LVEF ≤ 35% ≤ 40% Other _____
 Heart failure due to dilated cardiomyopathy
 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 in adult members.

- Is the member's resting heart rate ≥ 70 beats per minute? Yes No
- Has the member tried 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 tried 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 Corlanor requests in pediatric members.

1. Does the member have normal sinus rhythm with an elevated heart rate? Yes No

2. Is the requested medication adjunctive to standard of care therapy?

Yes. Please document medication regimen. _____

No

Section III. Please also complete for all requests for Corlanor solution.

Is there a medical necessity for the solution formulation?

Yes. Please explain. _____

No

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

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 _____