

# HCN CHANNEL BLOCKER PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

Date of Service (if differs from Today’s Date): \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:		Group Number:	

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Stable symptomatic heart failure (NYHA Class II-IV) due to dilated cardiomyopathy (DCM) <input type="checkbox"/> Stable symptomatic chronic heart failure (NYHA Class II-IV) <input type="checkbox"/> Inappropriate sinus tachycardia (IST) or chronic nonparoxysmal sinus tachycardia <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p><b>For all requests:</b></p> <p>1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, is the patient at risk if therapy is changed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please specify risk: _____</p> <p>3. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please specify FDA labeled contraindications: _____</p> <p>4. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., cardiologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Is the patient’s age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please provide support for using the requested agent for the patient’s age for the requested indication: _____</p> <p>6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____          _____          _____</p>	
<p><b>Please continue to the next page.</b></p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<b>For stable symptomatic heart failure (NYHA Class II-IV) due to dilated cardiomyopathy (DCM) requests:</b>			
7. Is the patient in sinus rhythm? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does the patient have an elevated heart rate? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For stable symptomatic chronic heart failure (NYHA Class II-IV) requests:</b>			
9. Does the patient have a left ventricular ejection fraction (LVEF) less than or equal to 35%? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is the patient in sinus rhythm? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the patient have a resting heart rate of greater than or equal to 70 beats per minute? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is the patient currently treated with a maximally tolerated beta blocker? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, will the patient continue beta blocker therapy? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, does the patient have an intolerance or hypersensitivity to ONE beta blocker? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			
_____			
If no, does the patient have an FDA labeled contraindication to ALL beta blockers? _____			
_____			
<b>For inappropriate sinus tachycardia (IST) or chronic nonparoxysmal sinus tachycardia requests:</b>			
13. Is the patient's IST symptomatic? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For renewal requests:</b>			
14. Has the patient had clinical benefit with the requested agent? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121		<b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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<b>BCBSMT: 888.723.7443</b>			
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