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

Heart Failure Agents 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) ☐ Verquvo (vericiguat)

☐ 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% ☐ < 45% ☐ Other ____

New York Heart Association (NYHA) ☐ Class I ☐ Class II ☐ Class III ☐ Class IV

☐ 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 all Corlanor requests.

For Corlanor in pediatric members, please complete questions 2 through 4. For Corlanor in adult members, please complete questions 1 through 3. For all Corlanor solution requests, please also complete question 5.

1. For Corlanor requests in adult members, is the member's resting heart rate ≥ 70 beats per minute? ☐ Yes ☐ No
2. 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 why oral beta-blockers are not appropriate for 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)?
☐ 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. ______________________

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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 why an ACE-I, ARB, or ARNI is not appropriate for this member. ______________

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4. For Corlanor requests in pediatric members, does the member have normal sinus rhythm with an elevated heart rate? ☐ Yes ☐ No
5. For Corlanor Solution requests, is there a medical necessity for the solution formulation?
☐ Yes. Please explain. ____
☐ No

Section II. Please complete for Verquvo requests in adult members.

1. Has the member tried an ACE-I, ARB, or 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. ______________________

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☐ No. Please explain contraindication to the use of an ACE-I, ARB, or ARNI in combination with a beta blocker this member. ____

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2. Has the member had a heart failure hospitalization within six months?
☐ Yes. Date ______________________ ☐ No
3. Has the member had outpatient IV diuretic therapy for heart failure within three months?
☐ Yes. Date _______ ☐ No

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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.

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

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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 __________________