MHS PHARMACY BENEFIT
MISCELLANEOUS CARDIAC AGENTS PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

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 retroactive PA ☐	Date(s) of service requested for retroactive 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
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

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PA Requirements for Corlanor Tablet (ivabradine) for Adults:

1. Diagnosis of heart failure (Provide documentation) ☐ Yes ☐ No
2. Left ventricular ejection fraction is less than or equal to 35% (Provide documentation) ☐ Yes ☐ No
3. Resting heart rate is greater than or equal to 70 beats per minute (Provide documentation) ☐ Yes ☐ No
4. Member is currently maximized on beta-blocker dose ☐ Yes ☐ No

   Drug/dose/date(s): _____

   OR

   Member has contraindication to beta-blocker use ☐ Yes ☐ No

   Please explain: _____

PA Requirements for Corlanor Oral Solution (ivabradine) for Pediatrics:

1. Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (Provide documentation) ☐ Yes ☐ No
2. Member is 6 months through 17 years of age ☐ Yes ☐ No
3. Left ventricular ejection fraction is less than or equal to 45% (Provide documentation) ☐ Yes ☐ No
4. Member is in sinus rhythm (Provide documentation) ☐ Yes ☐ No
5. Resting heart rate is elevated (Provide documentation) ☐ Yes ☐ No

PA Requirements for Verquvo (vericiguat):

1. Member is 18 years of age or older ☐ Yes ☐ No
2. Diagnosis of chronic, symptomatic heart failure (Provide documentation) ☐ Yes ☐ No
3. Left ventricular ejection fraction is less than or equal to 45% (Provide documentation) ☐ Yes ☐ No
4. Member has been hospitalized for heart failure in the past 180 days (Provide documentation) ☐ Yes ☐ No

   OR

   Member has received IV diuretics in the past 90 days (Provide documentation) ☐ Yes ☐ No
5. Member is female of childbearing age and has had a negative pregnancy test within the past 60 days (Provide documentation) ☐ Yes ☐ No