UnitedHealthcare Community Plan

# Clinical Pharmacy Program Guidelines for Corlanor

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| Program | Prior Authorization |
| Medication | Corlanor® (ivabradine) tablets and oral solution |
| Markets in Scope | Arizona, California, Colorado, Hawaii, Maryland, Nevada, New York, New York EPP, Rhode Island, Pennsylvania- CHIP, New Jersey, South Carolina |
| Issue Date | 9/2015 |
| Pharmacy and Therapeutics Approval Date | 11/2020 |
| Effective Date | 1/2021 |

## 1. Background:

Corlanor (ivabradine) is a hyperpolarization-activated cycle nucleotide-gated channel blocker indicated to reduce the risk of hospitalization for worsening of heart failure in patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤ 35%, who are in sinus rhythm with resting heart rate ≥ 70 beats per minute and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use. It is also indicated to treat stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older, who are in sinus rhythm with an elevated heart rate.

## 2. Coverage Criteria:

**A. Symptomatic Chronic Heart Failure**

1. **Initial Therapy**

a. **Corlanor** will be approved based on **one** of the following criteria:

(1) **All** of the following:

(a) Worsening heart failure in a diagnosis of stable, symptomatic chronic [e.g. New York Heart Association (NYHA) class II, III or IV] heart failure

**-AND-**

(b) Patient has a left ventricular ejection fraction (EF) ≤ 35%

**-AND-**

(c) The patient is in sinus rhythm

**-AND-**

(d) Patient has a resting heart rate ≥ 70 beats per minute

**-AND-**

(e) **One** of the following:

i. Patient is on maximum tolerated doses of beta blockers (e.g., carvedilol, metoprolol succinate, bisoprolol)

**-OR-**

ii. Patient has a contraindication or intolerance to beta-blocker therapy

-OR-

(2) **All** of the following:

(a) Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM)

-AND-

(b) Patient is in sinus rhythm

-AND-

(c) Patient has an elevated heart rate.

**Authorization will be issued for 12 months**

**B. Reauthorization**

1. **Corlanor** will be approved based on the following criterion:

a. Documentation of positive clinical response to Corlanor therapy

**Authorization will be issued for 12 months.**

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

## 4. References:

1. Corlanor [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2019.

| Program | Prior Authorization - Corlanor® (ivabradine) |
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| **Change Control** | |
| Date | Change |
| 9/2015 | New policy; new FDA-approved drug |
| 9/2016 | Updated policy template and removed prescriber check to align with Employer and Individual's policy |
| 11/2017 | Annual review. Updated references. |
| 11/2018 | Annual review. No changes to criteria. |
| 11/2019 | Annual review. Added criteria for treatment of stable symptomatic heart failure due to dilated cardiomyopathy. |
| 11/2020 | Annual review. Added additional clinical rules section. Updated references. |