

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1178-11
Program	Prior Authorization/Notification
Medication	Corlanor® (ivabradine)
P&T Approval Date	2/2016, 9/2016, 11/2017, 11/2018, 11/2019, 11/2020, 11/2021, 1/2023, 8/2023, 9/2024, 9/2025
Effective Date	11/16/2025

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 $\leq 35\%$, 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. Also, although not an FDA-approved indication, Corlanor has also shown to have efficacy in treating inappropriate sinus tachycardia (IST).

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) $\leq 35\%$

-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

-OR-

(3) **Both** of the following:

- (a) Diagnosis of inappropriate sinus tachycardia (IST)

-AND-

- (b) Patient is in sinus rhythm

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.
- Prior Authorization/Medical Necessity may be in place

4. References:

1. Corlanor [Package Insert] Thousand Oaks, CA: Amgen Inc.; August 2021
2. Sheldon, R.S., Grubb, B.P., et al. 2015 Heart Rhythm Society Expert Consensus Statement on the Diagnosis and Treatment of Postural Tachycardia Syndrome, Inappropriate Sinus Tachycardia, and Vasovagal Syncope. Heart Rhythm, 2015, 12(6), e41-e63.

Program	Prior Authorization/Notification – Corlanor® (ivabradine)
Change Control	
2/2016	New program.
9/2016	Updated heart rate from greater than 70 bpm to greater than or equal to 70 bpm
11/2017	Annual review. No changes.
11/2018	Annual review. Updated references.
11/2019	Added criteria for new pediatric indication. Updated references.
11/2020	Annual review. Updated references.
11/2021	Annual review. Updated references.
1/2023	No changes.
8/2023	Updated background and added criteria for use in inappropriate sinus tachycardia.
9/2024	Annual review. No changes.
9/2025	Annual review. No changes.