UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1178-7
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
Effective Date	2/1/2022; Oxford only: 2/1/2022

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.; August 2021

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.