

Drug Therapy Guidelines

Corlanor® (ivabradine)

Applicable

Medical Benefit		Effective: 5/1/18
Pharmacy- Formulary 1	x	Next Review: 3/19
Pharmacy- Formulary 2	x	Date of Origin: 9/15
Pharmacy- Formulary 3/Exclusive	x	Review Dates: 6/15, 3/17, 3/18
Pharmacy- Formulary 4/AON	x	

I. Medication Description

Corlanor (ivabradine) is a hyperpolarization-activated cyclic nucleotide-gated (HCN) channel blocker that inhibits the If or “funny” current. Inhibition of the funny current reduces spontaneous pacemaker activity at the cardiac sinus node and lowers heart rate. Unlike beta-blockers and calcium channel blockers, Corlanor decreases heart rate without affecting ventricular repolarization and myocardial contractility.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Corlanor can be provided when the following criteria are met:

- Prescribed by or in consultation with a cardiologist **AND**
- Member has stable symptomatic chronic heart failure **AND**
- Left ventricular ejection fraction is $\leq 35\%$ **AND**
- Resting heart rate is ≥ 70 bpm **AND**
- One of the following:
 - Member is receiving maximum tolerated beta-blocker therapy **OR**
 - Member has a contraindication to the use of beta-blocker therapy that does not pertain to ivabradine

IV. Quantity Limitations

5mg and 7.5mg tablets are limited to 60 tablets every 30 days.

V. Coverage Duration

Coverage is available for 12 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Stabilization of disease or in absence of disease progression **AND**

- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

Corlanor is available as 5mg and 7.5mg oral tablets.

VIII. Summary of Policy Changes

- 9/15/15: new policy
- 4/5/17: no policy changes
- 5/1/18: no policy changes

IX. References

1. Corlanor® (ivabradine). Prescribing information. Amgen, Inc. One Amgen Center Drive, Thousand Oaks, CA 91320-1799. Revised 1/2017.
2. Clinical Pharmacology: ivabradine. Accessed 1/2018.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.