

**HARVARD PILGRIM HEALTH CARE
RECOMMENDED MEDICATION REQUEST GUIDELINES**

IVABRADINE HCL (CORLANOR)

Generic	Brand	HICL	GCN	Exception/Other
IVABRADINE HCL	CORLANOR	33396		

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Is Corlanor being prescribed by (or in consultation with) a cardiologist or specialist in cardiac care?

If yes, continue to #2.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered when prescribed by (or in consultation with) a cardiologist or specialist in cardiac care. Your provider did not indicate that he or she specializes in cardiology and therefore your request was not approved.

2. Does the member have a diagnosis of symptomatic chronic heart failure (NYHA class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 35%?

If yes, continue to #3.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered for patients with a diagnosis of symptomatic chronic heart failure (NYHA Class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 35% in sinus rhythm. Your provider did not indicate that you have symptomatic chronic heart failure or that your left ventricular ejection fraction is less than or equal to 35% and therefore your request was not approved.

3. Does the member have a resting heart rate of 70 beats per minute or greater?

If yes, continue to #4.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered for patients with a resting heart rate of 70 beats per minute or more. Your provider did not indicate that you have a resting heart rate of 70 beats or more per minute and therefore your request was not approved.

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INITIAL CRITERIA (CONTINUED)

4. Is the member maintained on maximally tolerated doses of beta-blockers (e.g., carvedilol, metoprolol succinate, bisoprolol), or have a contraindication to beta-blockers?

If yes, **approve for 24 months by HICL.** (The quantity limits are hard-coded)
Please use status code #056 and the approval text provided.

APPROVAL TEXT: Your request for Corlanor has been approved for your condition with a quantity of 60 tablets per 30-day supply for a 24-month period.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered for members that are receiving maximally tolerated doses of beta-blockers (e.g. carvedilol, metoprolol succinate, bisoprolol), or for those patients who should not take beta-blockers. Your provider did not indicate that you meet either of these two conditions and therefore your request was not approved.

RENEWAL CRITERIA

1. Is Corlanor being prescribed by (or in consultation with) a cardiologist or specialist in cardiac care?

If yes, continue to #2.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered when prescribed by (or in consultation with) a cardiologist or specialist in cardiac care. Your provider did not indicate that he or she specializes in cardiology and therefore your request was not approved.

2. Does the member have a diagnosis of symptomatic chronic heart failure (NYHA class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 35%?

If yes, continue to #3.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered for patients with a diagnosis of symptomatic chronic heart failure (NYHA Class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 35% in sinus rhythm. Your provider did not indicate that you have symptomatic chronic heart failure or that your left ventricular ejection fraction is less than or equal to 35% and therefore your request was not approved.

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RENEWAL CRITERIA (CONTINUED)

3. Does the member have a resting heart rate between 50 and 60 beats per minute or greater?

If yes, continue to #4.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered for patients with a resting heart rate between 50 and 60 beats per minute or more. Your provider did not indicate that you have a resting heart rate between 50 and 60 beats or more per minute and therefore your request was not approved.

4. Is the member maintained on maximally tolerated doses of beta-blockers (e.g., carvedilol, metoprolol succinate, bisoprolol), or have a contraindication to beta-blockers?

If yes, **approve for 24 months by HICL.** (The quantity limits are hard-coded)

Please use status code #056 and the approval text provided.

APPROVAL TEXT: Your request for Corlanor has been approved for your condition with a quantity of #60 tablets per 30 day supply for a 24-month period.

If no, do not approve. Please use status code #238 and the denial text provided.

DENIAL TEXT: Per your health plan's Corlanor (ivabradine) guideline, this medication is only covered for members that are receiving maximally tolerated doses of beta-blockers (e.g., carvedilol, metoprolol succinate, bisoprolol), or for those patients who should not take beta-blockers. Your provider did not indicate that you meet either of these two conditions and therefore your request was not approved.

RATIONALE

Ensure that appropriate diagnostic, utilization, and safety criteria are utilized for the management of requests for ivabradine HCL.

FDA APPROVED INDICATIONS & DOSING

Corlanor is indicated to reduce the risk of hospitalization for worsening 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.

The recommended starting dose of Corlanor is 5 mg twice daily with meals. Assess patient after two weeks and adjust dose to achieve a resting heart rate between 50 and 60 beats per minute (bpm) as shown in Table 5. Thereafter, adjust dose as needed based on resting heart rate and tolerability. The maximum dose is 7.5 mg twice daily.

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FDA APPROVED INDICATIONS & DOSING (CONTINUED)

Dose Adjustments for Ivabradine	
Heart Rate	Dose Adjustment
> 60 BPM	Increase dose by 2.5 mg (given twice daily), up to a maximum dose of 7.5mg twice daily
50 - 60 BPM	Maintain dose
< 50 BPM or signs and symptoms of bradycardia	Decrease dose by 2.5mg (given twice daily) If current dose is 2.5mg twice daily, discontinue therapy
BPM = beats per minute	

In patients with a history of conduction defects, or other patients in whom bradycardia could lead to hemodynamic compromise, initiate therapy at 2.5 mg twice daily before increasing the dose based on heart rate.

REFERENCES

- Corlanor [Prescribing Information]. Thousand Oaks, California. Amgen, Inc. January 2017

Created: 05/11/15

Effective: 10/01/18

Client Approval: 07/18/18

P&T Approval: 09/27/18