Clinical Policy: Ivabradine (Corlanor)

Reference Number: CP.PMN.70
Effective Date: 11.01.15
Last Review Date: 02.25
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Ivabradine (Corlanor®) is a hyperpolarization-activated cyclic nucleotide-gated channel blocker.

FDA Approved Indication(s)

Corlanor is indicated:

- To reduce the risk of hospitalization for worsening heart failure in adult patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction (LVEF) ≤ 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;
- For the treatment of 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.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that ivabradine and Corlanor are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Heart Failure (must meet all)**:**

1. Diagnosis of chronic heart failure;
2. Prescribed by or in consultation with a cardiologist;
3. Age ≥ 6 months;
4. LVEF ≤ 35% for adults or ≤ 45% for pediatrics;
5. Member is in sinus rhythm with a resting heart rate of one of the following (a, b, c, or d):
   a. Age ≥ 6 to ≤ 12 months: ≥ 105 beats per minute;
   b. Age > 1 to < 3 years: ≥ 95 beats per minute;
   c. Age ≥ 3 to < 5 years: ≥ 75 beats per minute;
   d. Age 5 years and older: ≥ 70 beats per minute;
6. For brand Corlanor requests, member must use generic ivabradine, unless (a or b):
   a. Contraindicated or clinically significant adverse effects are experienced;
   b. Request is for Corlanor oral solution, and member has documented inability to swallow tablets;

7. Failure of two of the following beta-blockers recommended for heart failure at up to maximally indicated doses, each used for ≥ 30 days, unless clinically significant adverse effects are experienced or all are contraindicated: bisoprolol, carvedilol (immediate- or extended-release), extended-release metoprolol succinate;
8. Member has used one of the aforementioned beta blockers for ≥ 30 days within the past 60 days, unless clinically significant adverse effects are experienced or all are contraindicated;
9. Dose does not exceed both of the following (a and b):
   a. 15 mg per day;
   b. 2 tablets per day or 15 mL per day.

Approval duration:
HIM – 12 months
Medicaid/Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Heart Failure (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Corlanor for heart failure and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Corlanor requests, member must use generic ivabradine, unless (a or b):
   a. Contraindicated or clinically significant adverse effects are experienced;
   b. Request is for Corlanor oral solution, and member has documented inability to swallow tablets;
4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 15 mg per day;
   b. 2 tablets or 15 mL per day.

Approval duration:
HIM – 12 months
Medicaid/Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
DCM: dilated cardiomyopathy
FDA: Food and Drug Administration
LVEF: left ventricular ejection fraction

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Beta-Blockers Recommended for Heart Failure		
bisoprolol	**Heart Failure**[†] Initially, 1.25 mg PO QD for 48 hours, then 2.5 mg QD for the first month, then 5 mg QD.	10 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
carvedilol (Coreg®, Coreg CR®)	**Heart Failure** Immediate-release: Initially, 3.125 mg PO BID for 2 weeks. Dosage may be subsequently increased to 6.25, 12.5, and then 25 mg PO BID over successive intervals of at least 2 weeks. Extended-release: Initially, 10 mg PO QD for 2 weeks. Dosage may be subsequently increased to 20, 40, and then 80 mg PO QD over successive intervals of at least 2 weeks.	Immediate-release: 100 mg/day Extended-release: 80 mg/day
metoprolol succinate extended release (Toprol XL®)	**Heart Failure** 25 mg PO QD for 2 weeks in patients with NYHA class II heart failure, or 12.5 mg PO QD in patients with more severe heart failure. Double the dose every 2 weeks as tolerated, up to the target dosage of 200 mg PO QD.	200 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
†Off-label indication

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Acute decompensated heart failure
  - Clinically significant hypotension
  - Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present
  - Clinically significant bradycardia
  - Severe hepatic impairment
  - Pacemaker dependence (heart rate maintained exclusively by the pacemaker)
  - Concomitant use of strong cytochrome P450 3A4 (CYP3A4) inhibitors
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Heart failure	Adult and pediatric patients ≥ 40 kg: Initially 2.5 mg (pediatrics and vulnerable adults) or 5 mg PO BID. After 2 weeks of treatment, adjust dose based on heart rate. The maximum dose is 7.5 mg BID. Pediatric patients < 40 kg: Initially 0.05 mg/kg PO BID. Adjust dose at 2-week intervals by 0.05 mg/kg based on heart rate. The maximum dose is 0.2 mg/kg	15 mg/day

Indication	Dosing Regimen	Maximum Dose
	(patients aged 6 months to < 1 year) or 0.3 mg/kg (patients aged ≥ 1 year), up to a total of 7.5 mg BID.	

VI. Product Availability

- Tablets: 5 mg, 7.5 mg
- Oral solution: 5 mg/5 mL

VII. References

1. Corlanor Prescribing Information. Thousand Oaks, CA: Amgen Inc.; August 2021. Available at: https://www.corlanor.com. Accessed October 25, 2024.
2. Yancy CW, Jessup M, Bozkurt B, Butler J, et al. American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. *Circulation*. 2013 Oct 15;128(16):e240-327.
3. Yancy CW, Jessup M, Bozkurt B, et al. 2016 ACC/AHA/HFSA focused update on new pharmacological therapy for heart failure: an update of the 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. *Circulation*. 2016;134: 000-000.
4. Yancy CW, Jessup M, Bozkurt B, et al. 2017 ACC/AHA/HFSA focused update of the 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. *Circulation*. 2017;136:e137-e161.
5. Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. 2022 May, 79 (17) e263–e421. https://doi.org/10.1016/j.jacc.2021.12.012
6. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier; 2023. Available at: www.clinicalkey.com/pharmacology.
7. Maddox TM, Januzzi JL, Allen LA, et al. 2024 ACC Expert Consensus Decision Pathway for treatment of heart failure with reduced ejection fraction: A report of the American College of Cardiology Solution Set Oversight Committee. JACC. 2024; 83(15): 1444-1488.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.16.20	02.21
1Q 2022 annual review: no significant changes; references reviewed and updated.	09.21.21	02.22
Revised approval duration for Medicaid and Commercial line of business from length of benefit to 12 months or duration of request,	06.23.22	11.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
whichever is less. Template changes applied to other diagnoses/indications.		
1Q 2023 annual review: no significant changes; references reviewed and updated.	10.26.22	02.23
Clarified age ranges and corresponding beats per minute in initial criteria.	03.07.23	
1Q 2024 annual review: no significant changes; removed commercially unavailable branded therapeutic alternatives; references reviewed and updated.	11.17.23	02.24
1Q 2025 annual review: no significant changes; updated Section V to include specific weight-based maximum doses for pediatric patients per PI; references reviewed and updated. Revised policy/criteria section to also include generic ivabradine and added redirection to generic for brand requests per formulary status.	01.07.25	02.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.