Hyperpolarization-Activated Cyclic Nucleotide-Gated (HCN) Channel Blocker (Corlanor) Prior Authorization with Quantity Limit

FDA APPROVED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Corlanor® (ivabradine)Tablet, Solution	To reduce the risk of hospitalization for worsening heart failure in adult patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute and either are on maximally tolerated doses of beta blockers or have a contraindication to beta-blocker use. 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.		1

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

Target Agent

Corlanor

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Target Agent(s) will be approved when ALL of the following are met: 1. ONE of the following: A. The requested agent is eligible for continuation of therapy AND ONE of the following: 1. Information has been provided that indicates the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days **OR** 2. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed **OR** B. BOTH of the following: 1. The patient has stable, symptomatic heart failure (e.g., NYHA Class II, III, IV; ACCF/AHA Class C, D) **AND** 2. ONE of the following: A. ALL of the following: 1. The patient has heart failure due to dilated cardiomyopathy (DCM) **AND** 2. The patient is in sinus rhythm with an elevated heart rate **OR** B. ALL of the following: 1. The patient has a baseline OR current left ventricular ejection fraction of less than or equal to 35% **AND**

Module	Clinical Criteria for Approval
	2. Prior to initiating therapy with the requested agent, the patient is in sinus rhythm with a resting heart rate of greater than or equal to 70 beats per minute **AND** 3. ONE of the following: A. The patient will be using standard CHF therapy (e.g., beta blockers, ACE inhibitors) in combination with the requested agent **OR** B. The patient has an intolerance, hypersensitivity or FDA labeled contraindication to ALL standard CHF therapy (e.g., beta blockers, ACE inhibitors) that is not expected to occur with the requested agent **AND** 2. If the patient has an FDA approved indication, then ONE of the following: A. The patient's age is within FDA labeling for the requested indication for the requested agent **OR** B. The prescriber has provided information in support of using the requested agent for the patient's age for the requested indication **AND** 3. The patient does NOT have any FDA labeled contraindications to the requested agent **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria. **Renewal Evaluation** **Target Agent(s)** will be approved when ALL of the following are met: 4. The patient has been previously approved for the requested agent through the plan's Prior Authorization process **AND** 5. The patient has had clinical benefit with the requested agent **AND** 6. If the requested agent is being used for heart failure (not due to DCM), ONE of the following: A. The patient will be using standard CHF therapy (e.g., beta blockers, ACE inhibitors) in combination with the requested agent **OR** B. The patient has an intolerance, hypersensitivity, or FDA labeled contraindication to ALL standard CHF therapy (e.g., beta blockers, ACE inhibitors) that is not expected to occur with the requested agent **AND** 7. The patient does NOT have any FDA labeled contraindications to the requested agent **Length of Approval:** 12 months

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. ALL of the following: 1. The requested quantity (dose) is greater than the program quantity limit **AND** 2. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND**

Module	Clinical Criteria for Approval
	3. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **OR** 3. ALL of the following: 1. The requested quantity (dose) is greater than the program quantity limit **AND** 2. The requested quantity (dose) is greater than the maximum FDA labeled dose for the requested indication **AND** 3. The prescriber has provided information in support of therapy with a higher dose for the requested indication **Length of Approval**: 12 months