BOSTON MEDICAL CENTER
HEALTHNet PLAN

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Pharmacy Policy

Corlanor®

Policy Number: 9.620
Version Number: 2
Version Effective Date: 3/1/2022

Product Applicability ☐ **All Plan+ Products**

Well Sense Health Plan
☐ New Hampshire Medicaid

Boston Medical Center HealthNet Plan
☐ MassHealth - MCO
☐ MassHealth - ACO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Corlanor®(Ivabradine)**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications unless otherwise excluded
Exclusion Criteria	Corlanor® will not be approved in members with acute decompensated heart failure, clinically significant hypotension, sick sinus syndrome, sinoatrial block, 3rd degree atrioventricular block (unless a functioning demand pacemaker is present), clinically significant bradycardia, severe hepatic impairment, heart rate maintained exclusively by the pacemaker, or in combination with strong cytochrome P450 3A4 (CYP3A4) inhibitors.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Required Medical Information	1. Diagnosis of worsening heart failure in members with stable, symptomatic chronic heart failure (NYHA class II-III) with reduced left ventricular ejection fraction **AND** a. The member is 18 years or older. **AND** b. The member has a left ventricular ejection fraction (EF) ≤ 35% **AND** c. The member is in sinus rhythm **AND** d. The member has a resting heart rate ≥70 beats per minute **AND** One of the following: a. The member is on maximum tolerated doses of beta blockers **OR** b. The member has a contraindication or intolerance to beta-blocker therapy **OR** 2. Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM). **AND** a. The member is 6 months of age or older. **AND** b. The member is in sinus rhythm **AND** c. The member has an elevated heart rate.
Age Restrictions	See required medical information on age restrictions.
Prescriber Restriction	Prescribed by a cardiologist or specialist in cardiac care.
Coverage Duration	Initial and Reauthorization: 12 months.
Other criteria	**Reauthorization** 1. Member has met initial criteria and has demonstrated a positive clinical response to therapy.

Applicable Coding:

Clinical Background Information and References

1. Borer JS, Böhm M, Ford I, et al. Effect of ivabradine on recurrent hospitalization for worsening heart failure in patients with chronic systolic heart failure: the SHIFT Study. Eur Heart J. 2012;33(22):2813-2820. [PubMed 22927555]
2. Corlanor® (ivabradine) [prescribing information]. Thousand Oaks, CA 91320-1799. Amgen Inc. 2015, 2017, 2019. Accessed 10/2020.
3. Corlanor® (Ivabradine) - drug information. UpToDate. Topic 101166 Version 112.0.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	Created policy for QHP Exchange only.	1/1/2021	P&T Committee
11/11/2021	Annual review: no changes	3/1/2022	P&T Committee

Next Review Date

11/2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.