Pharmacy Medical Necessity Guidelines: Corlanor® (ivabradine)

Effective: October 15, 2019

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	Rx	Department to Review	RxUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Corlanor (ivabradine) represents a new class of heart failure agents, the hyperpolarization-activated cyclic nucleotide-gated (HCN) channel blockers. Corlanor (ivabradine) 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 ≤ 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.

COVERAGE GUIDELINES

The plan may authorize coverage of Corlanor (ivabradine) for Members when **all** the following criteria for a particular regimen are met and limitations do not apply:

1. The prescriber is a cardiologist

AND

2. Documented diagnosis of worsening heart failure with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤ 35%, who are in sinus rhythm with resting heart rate ≥ 70 beats per minute

AND

3. The Member is either on a maximally tolerated dose of a beta blocker or has a contraindication to beta-blocker use

LIMITATIONS

None

CODES

None

REFERENCES

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APPROVAL HISTORY

August 11, 2015: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. January 1, 2016: Administrative change to rebranded template.
2. August 9, 2016: Effective January 1, 2017, Medical Necessity Guideline applies to Tufts Health Together. Criteria for all plans requires prescriber is a cardiologist.
3. April 11, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline template update for Tufts Health RITogether
4. August 8, 2017: No Changes
5. August 7, 2018: No Changes
6. June 11, 2019: Administrative update to the template. Separated Medical Necessity Guidelines criteria for Commercial and Together. Commercial criteria was retired.
7. October 15, 2019: Effective 10/15/19, retiring MNG, as Corlanor is moving from Prior Authorization to Covered.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards

adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.