Corlanor

Qatar · access guide

How to access Corlanor for chronic heart failure from Qatar: 2026 pathway via Qatar cardiology and pharmacy supply | Reserve Meds

By Reserve Meds clinical & regulatory team. Last reviewed 2026-05-20.

Qatar has a national cardiac service of regional reference quality: the Heart Hospital at Hamad Medical Corporation (HMC) is the national adult cardiology and cardiac surgery centre and handles the full spectrum from coronary intervention to advanced heart failure, transplant assessment, and structural cardiology. Sidra Medicine provides paediatric cardiology of regional reference quality, and Sidra paediatric cardiology is the appropriate referral site for paediatric Corlanor patients given the FDA label includes children at or above 6 months on the oral solution formulation. Private cardiology services across Doha cover ongoing adult heart-failure care. These services run heart-failure clinics that move patients through the full guideline-directed medical therapy ladder: ACE inhibitor or ARB or ARNI (Entresto), evidence-based beta-blocker, mineralocorticoid receptor antagonist, SGLT2 inhibitor, and where the resting heart rate stays elevated on maximally tolerated beta-blocker, Corlanor (ivabradine, Amgen US license; Procoralan is the Servier-originated European brand of the same molecule, and may be the registered name actually stocked at some Qatari pharmacies). For a Qatar-resident adult or paediatric patient with HFrEF and a resting sinus rate at or above 70 bpm despite optimised beta-blocker therapy, the operational question is no longer whether selective sinoatrial node HCN channel blockade is reachable: it is whether the clinic considers Corlanor the right add-on.

This page explains how the pathway works in 2026 for a Qatar-resident patient: who qualifies, where the prescribing cardiologist conversation happens, how Corlanor or Procoralan is dispensed under the Ministry of Public Health (MOPH), what the realistic out-of-pocket exposure band is in QAR, what to monitor on therapy (heart rate at every titration step, the distinctive luminous phosphene visual phenomenon, atrial fibrillation surveillance), and how the indefinite oral treatment course settles into the family's heart-failure routine. It is concierge documentation written for a family already in conversation with a treating cardiologist who wants the operational reality laid out plainly.

Why Corlanor, and why now

Corlanor is ivabradine, a selective sinoatrial node HCN channel blocker. The HCN channel (hyperpolarization-activated cyclic nucleotide-gated channel) carries the funny current (I-f) that drives the spontaneous diastolic depolarisation of the sinoatrial pacemaker cells. Ivabradine binds and blocks this channel selectively. The clinical translation is a clean reduction in resting and exercise heart rate, with no negative inotropic effect, no effect on cardiac conduction below the SA node, and no effect on blood pressure. That selectivity is what distinguishes ivabradine from beta-blockers: a heart-failure patient already on a maximally tolerated beta-blocker dose whose resting heart rate remains at 70 bpm or above has a real residual prognostic burden that ivabradine addresses without compounding the negative inotropic load.

The FDA approved Corlanor in April 2015 for chronic HFrEF (NYHA II to IV, stable, sinus rhythm, resting HR at or above 70 bpm, on maximally tolerated beta-blocker or with documented contraindication). The paediatric expansion to children at or above 6 months with stable symptomatic dilated cardiomyopathy heart failure followed in April 2019, with an oral solution formulation. The European Procoralan label (Servier) is similar in shape and is registered across several Gulf markets. MOPH-registered dispense in Qatar may be under Corlanor or Procoralan brand depending on the pharmacy.

The pivotal trial is SHIFT, which randomised 6,558 adults with HFrEF, NYHA II-IV, LVEF at or below 35%, sinus rhythm, resting HR at or above 70 bpm, on stable GDMT including beta-blocker. The primary composite endpoint of cardiovascular death or heart-failure hospitalisation was significantly reduced.

Reserve Meds does not promote one heart failure agent over another. The page describes the Corlanor pathway because Corlanor is the medication the family has asked about.

What Corlanor is, in plain language

Corlanor for adults is an oral tablet. 5 mg starting dose, twice daily, with food, approximately twelve hours apart. The titration schedule is heart-rate-driven: at the 2-week review the resting HR is checked, the dose is adjusted up to 7.5 mg BID if HR is still above 60 bpm, held at 5 mg BID if HR is in the 50 to 60 bpm window, reduced to 2.5 mg BID if HR has dropped to 50 to 60 bpm with bradycardia symptoms, or stopped if HR has fallen below 50 bpm. Maintenance dose range is 2.5 to 7.5 mg BID.

The paediatric oral solution (children at or above 6 months) is weight-based, with HR-driven titration adapted to paediatric HR norms. Sidra paediatric cardiology runs the titration on a tighter cadence in the first months for paediatric DCM cases.

Treatment is indefinite. The patient who tolerates Corlanor and remains in HR target stays on it.

Eligibility at a Qatar cardiologist clinic

For Qatar-resident patients, the Heart Hospital at HMC handles adult cases and Sidra Medicine handles paediatric cases:

1. HFrEF with LVEF at or below 35% on recent echocardiogram (adult). 2. NYHA II to IV, clinically stable (adult). 3. Sinus rhythm. Atrial fibrillation as the predominant rhythm excludes ivabradine. 4. Resting heart rate at or above 70 bpm on maximally tolerated beta-blocker, or beta-blocker contraindication. 5. GDMT optimised: ACE / ARB / ARNI titrated, MRA added, SGLT2 inhibitor added where appropriate. 6. Baseline ECG without significant AV block or sinoatrial node dysfunction. 7. Pregnancy planning discussion for women of childbearing potential; effective contraception is required. 8. For paediatric patients at Sidra Medicine: age at or above 6 months with stable symptomatic dilated cardiomyopathy heart failure on standard paediatric GDMT, on oral solution.

A Qatar patient should arrive at the cardiology conversation with the most recent echocardiogram, ECG, NYHA statement, full medication list, NT-proBNP if measured, and any prior HF hospitalisation history.

The Qatar prescribing and supply picture

In 2026 the Qatar cardiology centres that prescribe ivabradine routinely include the Heart Hospital at HMC (national adult cardiac centre) and Sidra Medicine paediatric cardiology (for the ≥6 month paediatric DCM label). Both Corlanor (Amgen) and Procoralan (Servier) are seen in Qatari pharmacy stock; the brand actually dispensed depends on the pharmacy's import arrangement and MOPH registration.

1. Prescribing physician: board-certified adult cardiologist at HMC Heart Hospital for adult HFrEF, board-certified paediatric cardiologist at Sidra Medicine for paediatric DCM. 2. Pharmacy dispensing: hospital pharmacy at HMC or Sidra in inpatient or specialty outpatient setting; community pharmacy for ongoing refills. 3. Insurance and government coverage: Qatari nationals through HMC and Sidra pathways; commercial insurance pre-authorisation typically 7 to 14 days with a complete HFrEF pack. 4. Titration follow-up: cardiology at week 2, week 4, then every 3 months once on stable maintenance dose. ECG with HR check at every titration visit.

Cost band

Annual cash-pay cost for Corlanor or Procoralan in Qatar private pharmacy is approximately USD 1,200 to 2,500 (approximately QAR 4,400 to 9,100). This is much lower than specialty drugs in the Reserve Meds catalogue and Corlanor sits as a cardiology breadth entry rather than a high-cost specialty case. Where MOPH-registered generic ivabradine is dispensed, the annual cost can drop a further 30 to 60 percent.

For Qatari nationals through HMC or Sidra, the prescription is processed through institutional pharmacy formulary. Commercial pre-authorisation is straightforward with a complete HFrEF pack.

What to expect on Corlanor

Heart-rate titration is the principal early-treatment task. The cardiologist sets the 5 mg BID starting dose, reviews at week 2, steps up to 7.5 mg BID if HR target is not reached. Most adult patients stabilise on 5 mg or 7.5 mg BID within 4 to 6 weeks. Paediatric titration runs on a tighter cadence under Sidra paediatric cardiology.

The distinctive adverse event is the luminous phosphene phenomenon: bright spots or transient flashes in the visual field, more often peripheral, sometimes triggered by sudden light changes. This happens because the HCN channel ivabradine blocks in the SA node has a related isoform (I-h) in the retina. The phosphene is reported by approximately 14 percent of patients in pivotal trials, typically in the first 2 months, and most patients accommodate as the retina adjusts. Patients should be told to expect it, told it is not dangerous, and told to call the cardiologist only if the phenomenon is severe enough to affect driving or daily function. Paediatric patients may have more difficulty articulating phosphenes; the prescribing paediatric cardiologist screens for visual symptoms at every titration visit.

Other monitoring axes: bradycardia (HR check at every visit), atrial fibrillation (small but real increased incidence; pulse self-checks and any palpitation flag warrants a call), and the rare hypertension signal worth a BP at every visit. In SHIFT the meaningful outcome was reduction in heart-failure hospitalisation and, in higher-HR subgroups, cardiovascular mortality.

When Corlanor is the wrong drug

For a Qatar patient with resting HR below 70 bpm at baseline, with atrial fibrillation as the predominant rhythm, with severe hepatic impairment, with strong CYP3A inhibitors that cannot be stopped (clarithromycin, ketoconazole, itraconazole, ritonavir, nefazodone), or with second-or-third-degree AV block without pacemaker, the operational pathway shifts. Paediatric DCM patients should not start ivabradine until standard paediatric GDMT is optimised first under Sidra paediatric cardiology supervision.

For Qatar patients where Corlanor is not the chosen add-on, the alternatives are continued GDMT optimisation, ARNI uptitration if not at target, SGLT2 inhibitor addition, or in advanced cases device therapy or advanced heart-failure consultation through HMC Heart Hospital. Reserve Meds does not push one heart-failure agent over another.

Closing CTA

We are a US-based concierge coordinator. We are not the prescriber and not the dispensing pharmacy. On a Qatar Corlanor case we build the documentation pack with the treating cardiologist office at HMC Heart Hospital or Sidra Medicine (echocardiogram, ECG, NYHA statement, GDMT list, NT-proBNP, prior HF hospitalisation history), confirm the MOPH dispensing pathway (Corlanor, Procoralan, or generic ivabradine as locally registered), run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, and stay with the case through the titration window and into stable maintenance. Clinical decisions remain with your treating cardiologist.

Reserve Meds's role

US-based concierge coordinator for cross-border specialty medicine. We are not the prescriber, not the dispensing pharmacy, and not the manufacturer. All clinical decisions remain with your treating physician.

Composite case examples. This document is for general information only and does not constitute medical advice. Please consult your treating physician.
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