## Corlanor

Saudi Arabia · access guide

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

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

Saudi Arabia has built one of the deepest adult and paediatric cardiology infrastructures in the wider region. King Faisal Specialist Hospital and Research Centre cardiology in Riyadh and Jeddah, the King Abdulaziz Cardiac Center at King Abdulaziz Medical City, Prince Sultan Cardiac Centre in Riyadh and the Eastern Province, King Fahad Medical City cardiology, King Fahd Hospital of the University (KFHU) in Khobar, the Dr Sulaiman Al Habib network, and Saudi German Hospitals all run heart-failure clinics that move patients through the full guideline-directed medical therapy (GDMT) ladder: ACE inhibitor or ARB or ARNI, evidence-based beta-blocker, mineralocorticoid receptor antagonist, SGLT2 inhibitor, and where the resting heart rate stays elevated on maximally tolerated beta-blocker dose, Corlanor (ivabradine, Amgen US license; Procoralan is the Servier-originated European brand of the same molecule). For a Saudi-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, how the prescription is dispensed, and how the titration schedule fits into a Saudi family's life.

This page explains how the pathway works in 2026 for a Saudi-resident patient: who qualifies, where the prescribing cardiologist conversation happens, how Corlanor (or in some Gulf markets Procoralan) is dispensed, what the realistic out-of-pocket exposure band is in SAR, what to monitor on therapy (heart rate at every titration step, the distinctive luminous phosphene visual phenomenon, and 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 specifically addresses without compounding the negative inotropic load.

The FDA approved Corlanor in April 2015 for chronic heart failure with reduced ejection fraction (HFrEF, NYHA class II to IV, stable, sinus rhythm with resting heart rate at or above 70 bpm, on maximally tolerated beta-blocker or with a documented beta-blocker 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 for weight-based paediatric dosing. The European Procoralan label (Servier) is similar in shape and is registered across most Gulf markets; Saudi SFDA registration is in place for the indication.

The pivotal trial is SHIFT (Systolic Heart failure treatment with the I-f inhibitor ivabradine Trial), which randomised 6,558 adults with HFrEF, NYHA II-IV, LVEF at or below 35%, sinus rhythm, resting HR at or above 70 bpm, and stable GDMT including beta-blocker, to ivabradine or placebo. The primary composite endpoint of cardiovascular death or heart-failure hospitalisation was significantly reduced. The benefit emerged on the hospitalisation component primarily, with cardiovascular mortality reduction in the higher-HR subgroups.

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, and the dose is adjusted up to 7.5 mg BID if resting HR is still above 60 bpm and the patient is tolerating, held at 5 mg BID if resting HR is in the 50 to 60 bpm target window, reduced to 2.5 mg BID if resting HR has dropped to 50 to 60 bpm with symptoms of bradycardia, or stopped if resting HR has fallen below 50 bpm or symptoms are intolerable. The target maintenance dose range is 2.5 to 7.5 mg BID.

The paediatric formulation (children at or above 6 months) is an oral solution, weight-based dosing, with a similar HR-driven titration philosophy adapted to paediatric heart-rate norms. The prescribing paediatric cardiologist runs the titration on a tighter cadence in the first months.

Treatment is indefinite. As long as Corlanor is tolerated, the resting HR stays in target, and the underlying heart failure benefits from continued I-f inhibition, the patient remains on it.

## Eligibility at a Saudi cardiologist clinic

For Saudi-resident patients, the cardiology services apply the FDA label criteria with SFDA local adaptation:

1. HFrEF with LVEF at or below 35%, documented on recent transthoracic echocardiogram. 2. NYHA class II to IV, clinically stable (no decompensation requiring hospitalisation or IV therapy in the prior 4 weeks). 3. Sinus rhythm at baseline ECG. Atrial fibrillation as the predominant rhythm excludes ivabradine; ivabradine has no effect on the AV node. 4. Resting heart rate at or above 70 bpm on the office ECG, on maximally tolerated beta-blocker (bisoprolol, carvedilol, metoprolol succinate per GDMT guidelines), or with documented beta-blocker contraindication or intolerance. 5. GDMT optimised: ACE inhibitor / ARB / ARNI (Entresto) titrated, MRA (spironolactone or eplerenone) added, SGLT2 inhibitor (Farxiga or Jardiance) added where appropriate. 6. Baseline ECG without significant AV block (second or third degree without pacemaker) or sinoatrial node dysfunction. 7. Pregnancy planning discussion for women of childbearing potential; effective contraception is required because of embryo-fetal toxicity. 8. For paediatric patients: age at or above 6 months, stable symptomatic dilated cardiomyopathy heart failure on standard paediatric GDMT, on oral solution formulation with weight-based dose.

A Saudi patient should arrive at the cardiology conversation with the most recent documentation: echocardiogram report, ECG, NYHA class statement, complete current medication list with doses and durations, recent NT-proBNP if measured, and any prior heart-failure hospitalisation history.

## The Saudi prescribing and supply picture

In 2026 the Saudi cardiology centres that prescribe Corlanor or Procoralan routinely include KFSHRC Riyadh and Jeddah (the kingdom reference cardiology services), the King Abdulaziz Cardiac Center at KAMC Riyadh, Prince Sultan Cardiac Centre in Riyadh and the Eastern Province, King Fahad Medical City cardiology, KFH Jeddah, KFHU Khobar, and the Dr Sulaiman Al Habib network and Saudi German Hospitals in the private sector.

1. Prescribing physician: board-certified adult cardiologist for adult HFrEF, board-certified paediatric cardiologist for paediatric DCM. 2. Pharmacy dispensing: hospital pharmacy if prescribed inpatient or specialty outpatient; community pharmacy for ongoing refills. Both Corlanor (Amgen) and Procoralan (Servier) are seen in Saudi pharmacy; some private outlets stock generic ivabradine where SFDA generic registration applies. 3. Insurance pre-authorisation: NPHIES and the major Saudi commercial insurers handle ivabradine as a cardiology-prescribed branded therapy. Most pre-authorisations turn around within 7 to 14 days with a complete HFrEF documentation pack. 4. Titration follow-up: cardiology visit at week 2, week 4, then every 3 months once on stable maintenance dose. Resting ECG with HR check at every titration visit.

## Cost band

Annual cash-pay cost for Corlanor in Saudi private pharmacy is approximately USD 1,200 to 2,500 (approximately SAR 4,500 to 9,400). 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 SFDA-registered generic ivabradine is dispensed, the annual cost can drop a further 30 to 60 percent.

For Saudi nationals on government coverage, the prescription is processed through the institutional pharmacy formulary. For commercial insurance, the pre-authorisation is straightforward where the HFrEF documentation pack is complete.

## What to expect on Corlanor

Heart-rate titration is the principal early-treatment task. The prescribing cardiologist sets the 5 mg BID starting dose, reviews at week 2, and steps up to 7.5 mg BID if the HR target window is not yet reached. Most patients stabilise on 5 mg or 7.5 mg BID within 4 to 6 weeks.

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 that ivabradine blocks in the SA node also 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 (the visual phenomenon attenuates as the retina adjusts) and continue therapy. 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.

Other monitoring axes are bradycardia (the HR check at every visit), atrial fibrillation (small but real increased incidence on ivabradine; pulse self-checks and any palpitation flag is worth a call), and the rare hypertension signal (paradoxical in some patients, worth a BP at every visit). Conduction disturbances are uncommon but warrant ECG review at clinical change.

In SHIFT the meaningful outcome signal was reduction in heart-failure hospitalisation and, in the higher-HR subgroups, cardiovascular mortality. The day-to-day patient experience is usually unremarkable: lower resting heart rate, same exercise tolerance or modest improvement, and the phosphene that fades.

## When Corlanor is the wrong drug

For a Saudi patient with resting HR below 70 bpm at baseline (no I-f reduction benefit and bradycardia risk), with atrial fibrillation as the predominant rhythm (ivabradine has no effect on AV-nodal conduction in AF), with severe hepatic impairment (ivabradine is CYP3A4 metabolised and exposure increases substantially), with strong CYP3A inhibitors on board 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.

For Saudi patients where Corlanor is not the chosen add-on, the alternatives are continued GDMT optimisation, ARNI uptitration if not yet at target dose, SGLT2 inhibitor addition where not yet on board, or in advanced cases referral for device therapy (CRT, ICD) or advanced heart-failure consultation. 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 Saudi Corlanor case we build the documentation pack with the treating cardiologist office (echocardiogram, ECG, NYHA statement, GDMT list, NT-proBNP, prior HF hospitalisation history), confirm the SFDA 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.

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*reserved for you.*

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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