pennsylvania
DEPARTMENT OF HUMAN SERVICES

**Office of Medical Assistance Programs**
**Fee-for-Service, Pharmacy Division**
**Phone 1-800-537-8862 Fax 1-866-327-0191**

# RANEXA (ranolazine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antianginal Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | Suite #: | City/State/Zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

| | | |
|---|---|---|
| **Product requested:** ☐ranolazine ER tablet *(preferred, clinical PA required)* ☐Ranexa tablet *(non-preferred)* | Strength: | |
| Dose/directions: | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | Dx code (*required*): | |
| Does the beneficiary have liver cirrhosis or clinically significant liver impairment? [Contraindication to ranolazine.] | ☐Yes ☐No | *Submit documentation.* |
| Is a complete list of the beneficiary's current medications being submitted? | ☐Yes ☐No | *Submit documentation of current medication list.* |
| **INITIAL requests** | | |
| Does the beneficiary have a diagnosis of chronic angina? | ☐Yes ☐No | *Submit documentation of diagnosis.* |
| Does the beneficiary have a history of trial and failure, contraindication, or intolerance of medications from the following 3 drug classes used for the treatment of chronic angina?<br>☐beta blockers (e.g., atenolol, carvedilol, metoprolol, propranolol)<br>☐calcium channel blockers (e.g., amlodipine, diltiazem, felodipine, verapamil)<br>☐long-acting nitrates (e.g., isosorbide mononitrate, transdermal nitroglycerin) | ☐Yes ☐No | *Submit documentation of all medications tried and outcomes.* |
| Does the beneficiary have documentation of baseline (before starting ranolazine) EKG results? | ☐Yes ☐No | *Submit documentation of EKG results.* |
| **RENEWAL requests** | | |
| Since starting ranolazine, has the beneficiary experienced an improvement in chronic angina symptoms? | ☐Yes ☐No | *Submit documentation of clinical response.* |
| Does the beneficiary have documentation of recent (since starting ranolazine) EKG monitoring? | ☐Yes ☐No | *Submit documentation of EKG results.* |

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

| | |
|---|---|
| **Prescriber Signature:** | **Date**: |

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