

# Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  Commercial (Traditional)  Commercial (Individual/Optimized)  
 Medicaid

This request is:  Urgent (life threatening)  Non-Urgent (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

## Ranexa<sup>®</sup> (ranolazine)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_  
 Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_  
 Provider Address: \_\_\_\_\_  
 Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product Information

New request  Continuation request

Drug product:  Ranexa 500 mg tablet  Ranexa 1000 mg tablet  
 Start date (or date of next dose): \_\_\_\_\_  
 Date of last dose (if applicable): \_\_\_\_\_  
 Dosing frequency: \_\_\_\_\_

### Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have chronic stable angina (medical records supporting diagnosis must be submitted)
2. Must have progress notes supporting past trials of at least 1 formulary anti-anginal agent from all 3 of the following drug classes:
  - Beta blocker: acebutolol, atenolol, carvedilol, metoprolol, nadolol, or propranolol
  - Calcium channel blocker (CCB): amlodipine, felodipine, or nifedipine
  - Long acting (LA) nitrate: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin patch
3. Documentation that Ranexa will be used in addition (add-on) to another anti-anginal medication or patient has contraindication to beta-blockers, calcium channel blockers, and long-acting nitrates.
4. Cannot have creatinine clearance less than 60 ml/min
5. Cannot be combined with a strong inhibitor or inducer of CYP3A (i.e. ketoconazole, itraconazole, ritonavir, rifampin, phenytoin, carbamazepine, etc).

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

**New request**  
**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- Chronic stable angina
- Other – the patient's condition is: \_\_\_\_\_

**B. Which of the following has patient used (list drug name and dates of use)?**

	Drug name(s)	Dates of use
<input type="checkbox"/> Beta blocker(s)	_____	_____
<input type="checkbox"/> CCB(s)	_____	_____
<input type="checkbox"/> LA Nitrate(s)	_____	_____
<input type="checkbox"/> Not all requirements are met – Below is rationale for use:		
_____		

**D. Will Ranexa be used as an add-on to another anti-anginal?**

- Yes, *which one*: \_\_\_\_\_
- No, *why not*: \_\_\_\_\_

**E. What is the patient's creatinine clearance? \_\_\_\_\_**

**F. Will patient be using in combination with a strong CYP4A inhibitor or inducer? \_\_\_\_\_**