Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Antianginal Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Antianginal Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Antianginal Agent. See the Preferred Drug List (PDL) for the list of preferred Antianginal Agents at: https://papdl.com/preferred-drug-list.

2. A prescription for Ranexa (ranolazine).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antianginal Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antianginal Agent, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Antianginal Agents; **AND**

2. For Ranexa (ranolazine), **all** of the following:

   a. Is prescribed Ranexa (ranolazine) for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

   b. Does not have a history of a contraindication to Ranexa (ranolazine),

   c. Has documentation of baseline EKG results,

   d. **One** of the following:

      i. Has a documented history of therapeutic failure of **one** of the following:

         a) Beta blocker,
         b) Calcium channel blocker,
         c) Long-acting nitrate,

      ii. Has a documented history of intolerance or contraindication to **all** of the following:

         a) Beta blocker,
         b) Calcium channel blocker,
         c) Long-acting nitrate;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to

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meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRESCRIPTIONS FOR RANEXA (ranolazine): The determination of medical necessity of a request for renewal of a prior authorization for Ranexa (ranolazine) that was previously approved will take into account whether the beneficiary:

1. Has a documented improvement of chronic angina symptoms; **AND**

2. Does not have a contraindication to Ranexa (ranolazine); **AND**

3. Has documented EKG monitoring; **AND**

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antianginal Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

Gateway Health

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RANEXA (ranolazine) PRIOR AUTHORIZATION FORM

☐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:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

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? ☐beta blockers (e.g., atenolol, carvedilol, metoprolol, propranolol) ☐calcium channel blockers (e.g., amlodipine, diltiazem, felodipine, verapamil) ☐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 TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: