

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Ranexa (IL88)

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at 1-855-684-5250. Please contact Aetna Better Health Illinois Medicaid at 1-866-212-2851 with questions regarding the Prior Authorization process.

When conditions are met, we will authorize the coverage of Ranexa (IL88).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Ranexa (ranolazine)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N

[If no, then no further questions.]

2. Does patient have a diagnosis of Chronic Angina? Y N

[If no, then no further questions.]

3. Has the patient tried at least 1 formulary anti-anginal agent from ALL 3 different drug classes? List medications tried: Y N

BETA-BLOCKER: acebutolol, atenolol, carvedilol, metoprolol, nadolol, propranolol \ CALCIUM CHANNEL BLOCKER: amlodipine, diltiazem, felodipine, isradipine, nifedipine, nicardipine, verapamil \ LONG-ACTING NITRATE: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin patch

[If no, then skip to question 5.]

4. Will Ranexa be used in addition (add-on) to another anti-anginal medication (i.e., beta-blocker, calcium channel blocker, long-acting nitrate)? If yes, please document name of additional medication: Y N

[If yes, then no further questions.]

5. Does the patient have contraindications to beta-blockers, calcium channel blockers AND long-acting nitrates? If yes, please specify contraindication(s): Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature

Date