

**RANEXA**  
**PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for Ranexa, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Ranexa (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information

**For Additional Information:** Coordinator Name: \_\_\_\_\_ PA#: \_\_\_\_\_

Number of Pages in this Request: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ & Phone: (\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

**Ranexa Strength & Directions:**  500 mg BID     1000 mg BID     Other: \_\_\_\_\_ mg \_\_\_\_\_ time(s) per day

**Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_ (required)

1. Does the Recipient have a diagnosis of chronic angina?     Yes – submit documentation     No
2. Which of the following standard anti-anginal agents has the Recipient tried and failed (submit documentation of the drugs, dosages and therapy duration)?  
 Beta Blockers       Calcium Channel Blockers       Long-Acting Nitrates
3. Does the Recipient have contraindications or intolerances to any of the agents listed in question (2)?  
 Yes – submit documentation     No
4. Does the Recipient have a diagnosis of liver cirrhosis?     Yes – submit documentation     No
5. Has a complete listing of Recipient's current medications been submitted?     Yes – submit list     No
6. Does the Recipient have a documented baseline EKG?     Yes – submit documentation     No
7. Renewal Requests: Has the Recipient experienced an improvement in symptoms while on Ranexa?  
 Yes – submit documentation     No

**PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_