TEXAS MEDICAID
Clinical Edit Prior Authorization
ranolazine (RANEXA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have a diagnosis of chronic angina in the past 730 days?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Has the client received greater than or equal to (≥) 30 days of therapy with a first-line agent in the past 365 days?

   Examples of first-line agents include amlodipine, atenolol, diltiazem, isosorbide, metoprolol, nifedipine, nitroglycerin, propranolol, and verapamil.

   ☐ Yes (Go to #4) ☐ No (Go to #3)

3. Does the client have a history of greater than or equal to (≥) 90 days of therapy with ranolazine (RANEXA) in the past 120 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a diagnosis of clinically-significant hepatic impairment in the past 365 days?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a history of a drug that is contraindicated with ranolazine (RANEXA) in the past 30 days?

   Examples contraindicated drugs includes buprenorphine/naloxone (BUNAVAIL, SUBOXONE), carbamazepine (CARBATROL, EQUETRO, TEGRETOL), clarithromycin, erythromycin, itraconazole, ketoconazole, phenobarbital, phenytoin (DILANTIN), posaconazole (NOXAFIL), rifabutin, rifampin, telithromycin (KETEK), voriconazole (VFEND) and certain HIV treatments (e.g. CRIXIVAN, GENVOYA, INVIRASE, KALETRA, NORVIR, PREZCOBIX, VIRACEPT).

☐ Yes (Deny) ☐ No (Approve – 365 Days)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.