



**Ranexa**  
(ranolazine)

**Express Scripts**  
**Prior Authorization**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

**Please have the information below ready when calling in the authorization.**

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
-------------	------------

1. **Is the indication for the treatment of chronic angina?**
2. **Is the patient currently taking drugs that prolong the QTc interval (includes quinidine, procainamide, disopyramide, amiodarone, sotalol, dofetilide (Tikosyn®) or antipsychotics, e.g., thioridazine, ziprasidone (Geodon®)? If yes, please specify which medication(s).**
3. **Is the patient currently taking CYP3A Inhibitors, such as ketoconazole, itraconazole, diltiazem or verapamil?**
4. **Are there any other comments, diagnoses, symptoms, and/or any other information important to this review?**

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination is 72 hours.** View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.