



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.

Last Name	First Name
VH ID number	Date of Birth

Medication:	Diagnosis:
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1. Is the indication for the treatment of chronic angina?
2. Will Ranexa be used in combination with other antianginal drugs (isosorbide or nitroglycerin products), Norvasc (amlodipine), or beta-blockers (propranolol, nadolol, atenolol, labetalol, metoprolol, bisoprolol, or Coreg (carvedilol)? If yes, please specify which medication(s).
3. Is the patient currently taking drugs that prolong the QTc interval (includes quinidine, procainamide, disopyramide, amiodarone, sotalol, dofetilide (Tikosyn®) or antipsychotics, e.g., thioridazine and ziprasidone (Geodon®)? If yes, please specify which medication(s).
4. Is the patient currently taking diltiazem or verapamil?
5. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

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