



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. 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 the caller feels 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>.