Ranexa Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341

1. Patient Information	**2. Physician Information**
Patient Name: ______	Prescribing Physician: ______
Patient ID #: ______	Physician Address: ______
Patient DOB: ______	Physician Phone #: ______
Date of Rx: ______	Physician Fax #: ______
Patient Phone #: ______	Physician Specialty: ______
Patient Email Address: ______	Physician DEA: ______
	Physician NPI #: ______
	Physician Email Address: ______

3. Medication	**4. Strength**	**5. Directions**	**Quantity Per 30 Days**
Ranexa	☐ 500mg tablet ☐ 1000mg tablet	______	Specify: ______

7. Diagnosis ______

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes	☐ No	Patient has a diagnosis of chronic angina in the past 730 days
☐ Yes	☐ No	Patient has received greater than or equal to 30 days of therapy with a first-line agent in the past 365 days
☐ Yes	☐ No	Patient has a history of greater than or equal to 90 days of therapy with ranolazine in the past 120 days
☐ Yes	☐ No	Patient has a diagnosis of clinically-significant hepatic impairment in the past 365 days
☐ Yes	☐ No	Patient has a history of a drug that is contraindicated with ranolazine in the past 30 days

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

TXWP-CD-043420-23 | November 2023

9. Physician Signature

Prescriber or Authorized Signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.
If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.
If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.