



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Antianginal Agents

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for ranolazine extended-release tablet or Ranexa?

Yes No

Q2. Does the patient have a history of a contraindication to Ranexa (ranolazine)?

Yes No

Q3. Is this a request for a renewal of authorization?

Yes No

Q4. Does the patient have a documented improvement of chronic angina symptoms?

Yes No

Q5. Does the patient have documented electrocardiogram (EKG) monitoring?

Yes No

Q6. Is Ranexa (ranolazine) being prescribed for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (US FDA) approved package labeling OR a medically accepted indication?

Yes No

Q7. Does the patient have documentation of baseline electrocardiogram (EKG) results?

Yes No

Q8. Does the patient have a documented history of therapeutic failure of ONE of the following: A) beta blocker, B)

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calcium channel blocker, C) long-acting nitrate?
Q9. Does the patient have a documented history of intolerance or contraindication to ALL of the following: A) beta blocker, B) calcium channel blocker, C) long-acting nitrate?
Q10. Is this a request for ranolazine extended-release tablet?
Q11. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred antianginal agents...
Q12. Additional Information:

Prescriber Signature

Date

Updated for 2020