Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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)

This telecopy transmission contains confidential information belonging to the sender 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. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

Patient Name:	Prescriber Name:

calcium channel blocker, C) long-acting nitrate?

☐ Yes ☐ No

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?

☐ Yes ☐ No

Q10. Is this a request for ranolazine extended-release tablet?

☐ Yes ☐ No

Q11. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred antianginal agents (e.g., isosorbide mononitrate, isosorbide mononitrate extended-release, Nitro-Bid ointment, nitroglycerin transdermal patch, nitroglycerin sublingual tablet, ranolazine extended-release tablet)?

☐ Yes ☐ No

Q12. Additional Information:

Prescriber Signature

Date

Updated for 2022

This telecopy transmission contains confidential information belonging to the sender 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. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document