Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Ranexa (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Ranexa (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Ranexa (ranolazine)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Does member have a diagnosis of Chronic Angina? Y N

   [If no, then no further questions.]

2. Has the member experienced an inadequate treatment response to one formulary agent from each of the following 3 drug classes: A) Beta blockers, B) Calcium channel blockers, C) Long acting nitrates? Y N

   List medications tried:

   _____

   [If yes, then skip to question 4.]

3. Does the member have a documented contraindication or intolerance to beta-blockers, calcium channel blockers AND long-acting nitrates? Y N

   If yes, please specify contraindication(s):

   _____

   [If no, then no further questions.]

4. Is the member 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**