Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
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 Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ranexa (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
RANEXA ER 500 MG TABLET	RANEXA ER 1,000 MG TABLET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Does the patient have a diagnosis of chronic angina in the past 730 days? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Has the patient received greater than or equal to 30 days of therapy with a first-line agent in the past 365 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 4.

4. Does the patient have a history of greater than or equal to 90 days of therapy with ranolazine in the past 120 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a diagnosis of clinically-significant hepatic impairment in the past 365 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 6.

6. Does the patient have a history of a drug that is contraindicated with ranolazine in the past 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 7.

7. Is the request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, approved for 365 days.

8. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 9.

9. Is there a documented allergy or contraindication to preferred agents in this class? Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 10.

10. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, denied.

Comments:

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

_____ _____

Prescriber (or Authorized) Signature Date