PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

RANEXA
(ranolazine extended-release)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Ranexa may be used with beta-blockers, nitrates, calcium channel blockers, anti-platelet therapy, lipid-lowering therapy, ACE inhibitors, and angiotensin receptor blockers.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

• The requested drug is being prescribed for chronic angina
AND
• The patient has tried, failed and/or been intolerant (continues to have angina) to a trial of therapy with a nitrate plus a beta-blocker or calcium channel blocker

REFERENCES