

PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

RANEXA
(ranolazine extended-release)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Ranexa is indicated for the treatment of chronic angina.

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

1. Ranexa [package insert]. Foster City, CA: Gilead Sciences, Inc.; January 2016.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed April 2017.
3. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed April 2017.
4. Fihn S, Gardin J, Abrams J. et al. American College of Cardiology Foundation/American Heart Association Task Force. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease. J Am Coll Cardiol, 60: 1-121. ACC Vol. 60, No. 24, December 18, 2012:2564–603. Available at: <http://content.onlinejacc.org/data/Journals/JAC/926038/07012.pdf>.