

Prior Authorization Form

CAREFIRST VA EXCHANGE
Ranexa Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Ranexa Step Therapy.

Drug Name (select from list of drugs shown)

Ranexa (ranolazine ER)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for chronic angina? Y N

2. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to a beta blocker used in combination with either a calcium channel blocker or long-acting nitrate? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is

available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date