

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Ranexa**
**Prior Authorization of Benefits (PAB) Form**
**Complete form in its entirety and fax to:**
**Prior Authorization of Benefits Center at 1-844-474-3341**
**1. PATIENT INFORMATION**
**2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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**3. MEDICATION**
**4. STRENGTH**
**5. DIRECTIONS**
**6. QUANTITY PER 30 DAYS**

Ranexa	<input type="checkbox"/> 500mg tablet <input type="checkbox"/> 1000mg tablet	_____ _____	Specify: _____
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**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**
**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis of chronic angina in the past 730 days
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has received greater than or equal to 30 days of therapy with a first-line agent in the past 365 days
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a history of greater than or equal to 90 days of therapy with ranolazine in the past 120 days
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis of clinically-significant hepatic impairment in the past 365 days
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a history of a drug that is contraindicated with ranolazine in the past 30 days

**9. PHYSICIAN SIGNATURE**

_____ Prescriber or Authorized Signature	_____ Date
<small>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.          Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.	

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

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