BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Ranolazine ER

Policy Number: 9.608
Version Number: 2
Version Effective Date: 3/1/2022

Product Applicability ☐ **All Plan+ Products**

Well Sense Health Plan
☐ New Hampshire Medicaid

Boston Medical Center HealthNet Plan
☒ MassHealth - MCO
☒ MassHealth - ACO
☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Ranolazine ER**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	• Liver cirrhosis • Concurrent use of ketoconazole, clarithromycin, nelfinavir, rifampin, phenobarbital, St. John’s wort.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Required Medical Information	1. A diagnosis of angina; AND 2. An inadequate response, intolerance, or a contraindication to *all* of the therapies listed below (alone or in combination): • Calcium channel blocker • Beta-blocker • Long-acting Nitrate therapy
Age Restriction	None
Prescriber Restriction	None
Coverage Duration	Initial and Reauthorization: 24 months
Other criteria	Reauthorization: 1. Member continues to meet initial criteria AND 2. Attestation of continued efficacy, monitoring and appropriateness of therapy.

Clinical Background Information and References

1. Product Information. Ranexa, ranolazine extended release tablets.

   Gilead Sciences, Inc. Foster City, CA 94404. January 2016.

2. Scirica BM, Morrow DA, Hod H, et al. Effect of ranolazine, an antianginal agent with novel electrophysiological properties, on the incidence of arrhythmias in patients with non-ST-segment-elevation acute coronary syndrome. *Circulation* 2007; 116:1647—52.

3. Simmons M., Laham RJ. New therapies for angina pectoris. UptoDate, Inc. Accessed April 2014

4. Fihn SD, Gardin JM, Abrams J et. al. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and management of patients with stable ischemic heart disease: executive summary. Circulation. 2012 Dec 18;126(25):3097-137

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	9.121 Ranexa policy retired, new policy created. Renamed to Ranolazine	1/1/2021	P&T Committee
11/11/2021	Annual review: no changes.	3/1/2022	P&T Committee

Next Review Date

11/2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.