Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.217	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Antianginal Agents	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q1 2022 annual review: no changes.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Antianginal Agents

Reference Number: PHW.PDL.217
Effective Date: 01/01/2020
Last Review Date: 10/2021

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that Antianginal Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antianginal Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Antianginal Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Antianginal Agent.

2. An Antianginal Agent with a prescribed quantity that exceeds the quantity limit.

3. A prescription for Ranexa (ranolazine).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antianginal Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antianginal Agent, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Antianginal Agents; **AND**

2. For Ranexa (ranolazine), **all** of the following:

   a. Is prescribed Ranexa (ranolazine) for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

   b. Does not have a history of a contraindication to Ranexa (ranolazine),

   c. Has documentation of baseline EKG results,

   d. **One** of the following:

i. Has a documented history of therapeutic failure of **one** of the following:

a) Beta blocker,
b) Calcium channel blocker,
c) Long-acting nitrate,

ii. Has a documented history of intolerance or contraindication to **all** of the following:

a) Beta blocker,
b) Calcium channel blocker,
c) Long-acting nitrate;

AND

3. If a prescription for an Antianginal Agent is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRESCRIPTIONS FOR RANEXA (ranolazine): The determination of medical necessity of a request for renewal of a prior authorization for Ranexa (ranolazine) that was previously approved will take into account whether the beneficiary:

1. Has a documented improvement of chronic angina symptoms; **AND**

2. Does not have a contraindication to Ranexa (ranolazine); **AND**

3. Has documented EKG monitoring; **AND**

4. If a prescription for Ranexa (ranolazine) is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antianginal Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	10/2021