PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
ANTIANGINAL AGENTS

Proposed Effective Date: January 1, 2020

Revisions are noted with a ~~strikethrough~~ for deletions and ~~**bold and underline**~~ for additions.

I. Requirements for Prior Authorization of ~~Vasodilators, Coronary~~ **Antianginal Agents**

A. Revisions to Prescriptions That Require Prior Authorization

Prescriptions for ~~Vasodilators, Coronary~~ **Antianginal Agents** that meet any of the following conditions must be prior authorized:

1. A ~~prescription for a~~ non-preferred ~~Vasodilator, Coronary~~ **Antianginal Agent**. See the Preferred Drug List (PDL) for the list of preferred ~~Vasodilators, Coronary~~ **Antianginal Agents** at: https://papdl.com/preferred-drug-list.

2. A**n** ~~prescription for a preferred or non-preferred~~ ~~Vasodilator, Coronary~~ **Antianginal Agent** with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.

3. **A prescription for Ranexa (ranolazine).**

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an ~~a non-preferred~~ ~~Vasodilators, Coronary~~ **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 ~~Vasodilators, Coronary~~ **Antianginal Agents**; **AND**

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

   a. Is being treated for 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. ~~In addition,~~ If a prescription for an ~~Vasodilator, Coronary~~ **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 the Quantity Limits Chapter.

   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 the Quantity Limits Chapter.**

   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

~~Vasodilator, Coronary~~ **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.