

## **Clinical Policy: Ranolazine (Ranexa)**

Reference Number: CP.PMN.34

Effective Date: 08.01.09

Last Review Date: 02.18

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Ranolazine (Ranexa®) is an antianginal agent.

### **FDA Approved Indication(s)**

Ranexa is indicated for the treatment of chronic angina.

### **Policy/Criteria**

*Provider must submit documentation (including 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 Centene Corporation<sup>®</sup> that Ranexa is **medically necessary** when the following criteria are met:

## **I. Initial Approval Criteria**

### **A. Chronic Angina** (must meet all):

1. Diagnosis of chronic angina;
2. Prescribed by or in consultation with a cardiologist;
3. Age  $\geq$  18 years;
4. Member meets one of the following (a, b, or c):
  - a. Failure of concurrent use of a beta-blocker and long-acting nitrate at therapeutic doses for  $\geq$  30 days within the previous 6 months;
  - b. Failure of concurrent use of a calcium channel blocker and long-acting nitrate at therapeutic doses for  $\geq$  30 days within the previous 6 months;
  - c. Member experienced clinically significant adverse effects or has contraindications to both calcium channel blockers and beta blockers, or long-acting nitrates.
5. Does not exceed 2000 mg/day (2 tablets/day).

**Approval duration: 12 months**

### **B. Other diagnoses/indications**

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

## **II. Continued Therapy**

### **A. Chronic Angina** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;

## CLINICAL POLICY

### Ranolazine

- If request is for a dose increase, new dose does not exceed 2000 mg/day (2 tablets/day).

**Approval duration: 12 months**

#### B. Other diagnoses/indications (must meet 1 or 2):

- Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 12 months (whichever is less); or**

- Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

### III. Diagnoses/Indications for which coverage is NOT authorized:

- Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

### IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Beta Blockers</i>		
Acebutolol (Sectral)	≥ 400 mg per day	
Atenolol (Tenormin)	≥ 50 mg per day	
Betaxolol (Kerlone)	≥ 5 mg per day	
Bisoprolol (Zebeta)	≥ 5 mg per day	
Carvedilol (Coreg)	≥ 50 mg per day	
Labetalol (Trandate)	≥ 200 mg per day	
Metoprolol ( Lopresor, Lopressor, Toprol XL)	Regular-release: ≥ 100 mg per day Extended-release: ≥ 100 mg per day	
Nadolol (Corgard)	≥ 40 mg per day	
Nebivolol (Bystolic)	≥ 5 mg per day	
Pindolol (Visken)	≥15 mg per day	
Propranolol (Inderal LA, Innopran XL)	Immediate-release: ≥ 20 mg per day Extended-release: ≥ 80 mg per day	
Sotalol (Betapace)	≥ 120 mg per day	
Timolol (Blocadren)	≥ 10 mg per day	
<i>Long Acting Nitrates</i>		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Isosorbide Dinitrate (Isordil)	≥ 40 mg per day	480 mg/day IR 160mg/day SR
Isosorbide Mononitrate (Imdur)	≥ 30 mg per day	240 mg/day
Transdermal Nitroglycerin (Minitran, Nitro-Dur)	1 transdermal patch (0.1 to 0.8 mg/hour) per day	0.8 mg/hour per day
<i>Calcium Channel Blockers</i>		
Amlodipine (Norvasc)	≥ 5 mg per day	10 mg per day
Diltiazem (Cardizem, Cartia XT, Matzim LA)	Regular-release: ≥ 120 mg per day Extended release once-daily capsules: ≥ 120 mg per day Extended release once-daily tablets: ≥ 180 mg per day	Regular-release; 360 mg/day Extended release once-daily capsules: 480 to 450 mg/day Extended release once-daily tablets: 420 mg/day
Felodipine (Plendil)	≥ 5 mg per day	10 mg/day
Isradipine (DynaCirc)	≥ 7.5 mg per day	22.5 mg/day
Nicardipine (Cardene, Cardene SR)	≥ 60 mg per day	120 mg/day
Nifedipine (Procardia, Adalat)	Immediate release: ≥ 30 mg per day Extended release: ≥ 30 mg per day	180mg/day IR 90 mg/day ER
Nisoldipine (Sular)	≥ 8.5 mg per day	34 mg/day
Verapamil (Calan, Isoptin SR Verelan)	Regular-release: ≥ 240 mg per day	480 mg/day

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

## V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Chronic Angina	500 mg twice daily	1000mg twice daily

## VI. Product Availability

Extended-release tablets: 500 mg, 1000 mg.

## VII. References

1. Ranexa Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; January 2016. Available at: <https://www.ranexa.com/>. Accessed December 12, 2017.
2. Fihn SD, Gardin JM, Abrams J, Berra K, Blankenship JC, Dallas AP, et al. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS guideline for the diagnosis and management of patients with stable ischemic heart disease: a report of the American College of Cardiology Foundation/American Heart Association task force on practice guidelines, and the American College of Physicians, American Association for Thoracic Surgery, Preventive

## CLINICAL POLICY

### Ranolazine

Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons. *Circulation* 2012; 126:e354.

- Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2016. Available at: <http://www.clinicalpharmacology-ip.com/>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added language to criteria to include calcium channel blockers plus long acting nitrate therapy as an “OR” statement. References updated	08.12	08.12
References updated	08.14	08.14
Converted to new template Added appropriate age for use to approval criteria	08.15	08.15
Criteria: Updated to include intolerance to first line agents; Modified criteria to require $\geq 30$ day trial of first line agents within the previous 6 months; added requirement that dosing frequency does not exceed BID in accordance with FDA dosing guidelines; modified specific max quantity limit to generalized FDA max recommended dose and health plan approved QL statement; Updated references to reflect current literature search	05.16	08.16
Converted to new integrated template. Initial: removed age requirement per new template and added prescriber specialty; modified trial and failure criteria to require use of beta-blocker and long-acting nitrate or calcium channel blocker and long-acting nitrate at therapeutic doses; modified generalized FDA maximum recommended dose and health plan approved daily QL to specific max dose and QL statement; removed requirement related to twice daily dosing since criteria modified to include specific QL of 2 tablets/day. Re-auth: added positive response to therapy requirement; modified generalized FDA maximum recommended dose and health plan approved daily QL to specific max dose and QL statement; removed requirement related to twice daily dosing since criteria modified to include specific QL of 2 tablets/day. Updated references.	12.16	02.17
1Q18 annual review: - Policies combined for Medicaid and commercial No significant clinical changes from previously approved corporate policy - Commercial: added the requirement of first line generic agent trial	12.12.17	02.18

## CLINICAL POLICY

### Ranolazine

Reviews, Revisions, and Approvals	Date	P&T Approval Date
-Age added -References reviewed and updated.		

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

**CLINICAL POLICY**  
Ranolazine

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

©2009 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene<sup>®</sup> and Centene Corporation<sup>®</sup> are registered trademarks exclusively owned by Centene Corporation.