GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
RANOLAZINE PA SUMMARY

Preferred	Non-Preferred
Ranolazine extended-release tablets generic*	Aspruzyo Sprinkle (ranolazine extended-release granules)

LENGTH OF AUTHORIZATION: 1 year

NOTE: Ranolazine generic is preferred but requires prior authorization.

PA CRITERIA:

Ranolazine Extended-Release Tablets Generic and Aspruzyo

- Approvable for members 18 years of age or older with a diagnosis of chronic stable angina/stable ischemic heart disease (SIHD) experiencing an inadequate response to at least one medication in two of the following anti-anginal drug classes, calcium channel blockers, beta-blockers and nitrates, or allergies, contraindications, drug-drug interactions or intolerable side effects to calcium channel blockers, beta blockers and nitrates.
- In addition for Aspruzyo, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic ranolazine, is not appropriate for the member.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.

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