

# Criteria Based Consultation Prescribing Program

## CRITERIA FOR DRUG COVERAGE

### Ranolazine (RANEXA®)

Non-formulary **ranolazine (RANEXA®)** will be covered on the prescription drug benefit when the following criteria are met:

- Diagnosis of stable chronic angina or stable ischemic heart disease.

– AND –

- Documented treatment failure, intolerance, or contraindication to a:
  1. beta-blocker or calcium channel blocker

– AND –

2. long-acting nitrate

Avoid use in patients:

- Receiving strong CYP3A4 inhibitors including ketoconazole, Itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir or saquinavir.
- Receiving strong CYP3A4 inducers including rifampin, rifabutin, phenobarbital, phenytoin, carbamazepine, or St. John's Wort.
- With severe hepatic impairment.

Dose modification:

- Limit dose to 500 mg BID in patients on verapamil and diltiazem.
- Down-titrate ranolazine based on response in patients on P-glycoprotein inhibitors, such as cyclosporine.