

Request Form for (ranolazine [Ranexa®])

Physician Information

Name: _____

License: _____ Physician specialty: _____

Address: _____

Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____ Date of Birth: _____

Sex: M F Weight (kg): _____ Member ID: _____

Address: _____

Medical Information

Please answer the following questions:

1) Please document patient diagnosis: _____

2) Does the patient have hepatic impairment?

a. Please specify

Please provide any medical information which may support approval: (optional)

Physician signature:

Date: