NHS Calderdale Clinical Commissioning Group

West and South Yorkshire and Bassetlaw Commissioning Support Unit

Commissioning Statement

Treatment	**Ranolazine** (Ranexa®; Menarini)
For the treatment of	For the treatment of **stable angina**
Commissioning position	**The Calderdale CCG commissions the use of ranolazine for the treatment of stable angina if the following conditions apply:** **As monotherapy if beta blockers and/or calcium channel blockers are not tolerated or are contraindicated** **OR** **As add-on therapy where beta blocker or calcium channel blocker monotherapy is sub-optimal and the other option (beta blocker or calcium channel blocker) is unsuitable or contra-indicated** **WHEN** **A long-acting nitrate, ivabradine and nicorandil have been found to be unsuitable, contra-indicated or ineffective** The specialist should prescribe ranolazine until: 1. It has been titrated to the optimum effective dose **AND** 2. Improved symptom control has been demonstrated. North Kirklees CCG / Greater Huddersfield CCG / Wakefield CCG / Calderdale CCG
Date effective from	26th September 2013
Policy to be reviewed by	June 2015
Background information	NICE CG126 Stable angina (issued Jul 2011, updated Dec 2012) Stable angina is a chronic medical condition associated with a low but appreciable incidence of acute coronary events and increased mortality. The aim of management is to improve quality of life by stopping or minimising symptoms and reducing long-term morbidity and mortality. Ranolazine is licensed for adults as add-on therapy for the symptomatic treatment of patients with stable angina pectoris who are inadequately controlled or intolerant to

	first-line antianginal therapies (such as beta-blockers and/or calcium antagonists). The mechanism of action of ranolazine is largely unknown. Ranolazine may have some antianginal effects by inhibition of the late sodium current in cardiac cells. This reduces intracellular sodium accumulation and consequently decreases intracellular calcium overload. The reduction in cellular calcium overload is expected to improve myocardial relaxation and thereby decrease left ventricular diastolic stiffness.
Summary of evidence/rationale	For full rationale in relation to decision, see NICE CG126 Stable angina (issued Jul 2011, updated Dec 2012). NICE CG126 recommendation 1.4.11: If the person cannot tolerate beta-blockers and calcium-channel blockers or both are contraindicated, consider monotherapy with 1 of the following drugs: • a long-acting nitrate **or** • ivabradine **or** • nicorandil **or** • ranolazine. NICE CG126 recommendation 1.4.12: For people on beta-blocker or calcium-channel blocker monotherapy whose symptoms are not controlled and the other option (calcium-channel blocker or beta-blocker) is contraindicated or not tolerated, consider 1 of the following as an additional drug: • a long-acting nitrate **or** • ivabradine **or** • nicorandil **or** • ranolazine. NICE states: “Decide which drug based on comorbidities, contraindications, person’s preference and drug costs”. “The national resource impact is not considered to be significant”. NICE did not carry out any cost effectiveness analysis for ranolazine as part of the CG126 guideline development process.
Contact for this policy	North Kirklees CCG / Gt Huddersfield CCG: Eric Power Wakefield CCG: Joanne Fitzpatrick Calderdale CCG: Helen Foster

*Drug costs/month (Drug Tariff April 2013):
Isosorbide mononitrate (60mg bd) £8.86-£10.50

Ivabradine	£40.17
Nicorandil (20mg bd)	£9.21
Ranolazine	£45.71