TEXAS MEDICAID
Clinical Edit Prior Authorization
300mg Aliskiren-Containing Agents
(Excluding VALTURNA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 6 years of age?

   ☐ Yes (Go to # 2) ☐ No (Deny)

2. Does the client have a diagnosis of hypertension in the last 365 days?

   ☐ Yes (Go to # 3) ☐ No (Deny)

3. Does the client have a diagnosis of pregnancy in the last 310 days?

   ☐ Yes (Go to # 4) ☐ No (Go to # 5)

4. Does the client have a diagnosis to negate the pregnancy diagnosis in the last 310 days?

   ☐ Yes (Go to # 5) ☐ No (Deny)

5. Does the client have a diagnosis of renal artery stenosis in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to # 6)

6. Does the client have a history of a cyclosporine (GENGRAF, NEORAL, SANDIMMUNE) or an itraconazole (SPORANOX) agent in the last 30 days?

   ☐ Yes (Deny) ☐ No (Go to # 7)

7. Does the client have a diagnosis of diabetes mellitus in the last 730 days?

   ☐ Yes (Go to # 8) ☐ No (Go to # 9)

8. Does the client have a history of an Angiotensin Converting Enzyme Inhibitor (ACEI) or Angiotensin II Receptor Blocker (ARB) agent in the last 30 days?

   ☐ Yes (Deny) ☐ No (Go to # 9)

9. Is the requested dose less than or equal to (≤) 1 tablet per day?

   ☐ Yes (Approve – 365 Days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.