TEXAS MEDICAID
Clinical Edit Prior Authorization
meloxicam 7.5mg (MOBIC)

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: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

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

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the last 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: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

1. Is the request for one of the following drugs/strengths?

meloxicam tablet (MOBIC)	7.5mg

☐ Yes (Go to #2) ☐ No (Go to Step 5, Question 1)

2. Is the request for 2 or more tablets per day?

☐ Yes (Go to #3) ☐ No (Go to Step 5, Question 1)

3. Is the client greater than or equal to 18 years of age?

☐ Yes (Go to #4) ☐ No (Go to Step 5, Question 1)

4. Is the request being submitted by phone?

☐ Yes (Go to Step 5, Question 1) ☐ No (Clinical Review Required. Please provide medical rationale for requested dose below, then go to Step 5, Question 1)

Medical Rationale for 2 or more units (tablets/capsules/patches) per day:

_____

_____

_____

STEP 5: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client younger than 2 years of age?

☐ Yes (Deny) ☐ No (Go to #2)

2. Is the client older than 60 years of age?

☐ Yes (Approve – 365 days) ☐ No (Go to #3)

3. Does the client have a history of Peptic Ulcer Disease (PUD) or Gastrointestinal (GI) Bleed in the last 730 days?

☐ Yes (Approve – 365 days) ☐ No (Go to #4)

4. Does the client have a history of warfarin therapy for 30 days in the last 45 days?

☐ Yes (Approve – 365 days) ☐ No (Go to #5)

5. Does the client have corticosteroid therapy for greater than or equal to (≥) 35 days in the last 90 days?

☐ Yes (Approve – 365 days) ☐ No (Go to #6)

6. Has the client taken high dose Non-Steroidal Anti-Inflammatory Drug (NSAID) therapy for 30 days in the last 45 days?

☐ Yes (Approve – 365 days) ☐ No (Go to #7)

7. Does the client have a diagnosis of Rheumatoid Arthritis, Juvenile Rheumatoid Arthritis, or Osteoarthritis in the last 730 days?

☐ Yes (Approve – 365 days) ☐ No (Go to #8)

8. Does the client have a history of a Disease-Modifying Antirheumatic Drug (DMARD) agent for 30 days in the last 60 days?

Examples include azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, ENBREL, HUMIRA, and KINERET.

☐ Yes (Approve – 365 days) ☐ No (Go to #9)

9. Does the client have a history of 2 or more NSAID agents for 30 days in the last 180 days?

☐ Yes (Approve - 365 days) ☐ No (Deny)

STEP 6: 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.