



# TEXAS MEDICAID Clinical Edit Prior Authorization imiquimod 5% cream (ALDARA)

## 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: COMPLETE REQUIRED CRITERIA

Indicate Primary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

1. Does the client have a diagnosis of genital or perianal warts in the last 60 days?

Yes (Go to #2)

No (Go to #3)

2. Is the client greater than or equal to ( $\geq$ ) 12 years of age?

Yes (Approve - 112 days/16 weeks)

No (Deny)

3. Is the client greater than or equal to ( $\geq$ ) 18 years of age?

Yes (Go to #4)

No (Deny)

4. Does the client have a diagnosis of actinic keratosis or basal cell carcinoma in the last 60 days?

Yes (Approve - 112 days/16 weeks)

No (Deny)

## STEP 3: 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.