TEXAS MEDICAID
Clinical Edit Prior Authorization
Inhaled Antibiotics

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 28-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)

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STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of cystic fibrosis in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Go to #2)

2. Does the client have a diagnosis of non-cystic fibrosis bronchiectasis (NCFB) colonized with *Pseudomonas aeruginosa*? [Manual Step]

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the request for BETHKIS, KITABIS, TOBI, TOBI PODHALER, or inhaled tobramycin?

   ☐ Yes (Go to #4) ☐ No (Go to #5)

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

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

5. Is the request for CAYSTON?

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Is the client greater than or equal to (≥) 7 years of age?

   ☐ 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.