



TEXAS MEDICAID Clinical Edit Prior Authorization zileuton (ZYFLO)

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: <input type="checkbox"/> STAR / STAR KIDS client (Go to Step 3 - PDL PA Criteria Applies) OR <input type="checkbox"/> CHIP / PERINATE client (Go to Step 4)	
STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT	
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2)	
2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3)	
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Deny)	



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a history of zileuton (ZYFLO) in the last 60 days?

- Yes (Approve - 365 days) No (Go to #2)

2. Does the client have a diagnosis of asthma in the last 730 days?

- Yes (Go to #3) No (Deny)

3. Is the client less than (<) 12 years of age?

- Yes (Deny) No (Go to #4)

4. Does the client have one (1) claim for an inhaled corticosteroid (ICS) or a long-acting beta agonist (LABA)/ICS combination product in the last 365 days?

ICS examples include: ALVESCO, ARMONAIR RESPICLICK, ARNUITY ELLIPTA, ASMANEX TWISTHALER, budesonide (PULMICORT), FLOVENT, and QVAR REDHALER.

LABA/ICS examples include: fluticasone-salmeterol (ADVAIR), BREO ELLIPTA, DULERA, and SYMBICORT.

- 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.