



# TEXAS MEDICAID Preferred Drug List (PDL) Criteria for Non-Preferred Drugs (NPD or NAP): TOPICAL ANTIFUNGALS

Please visit <http://www.txvendordrug.com/> for Preferred Drug List

## 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: \_\_\_\_\_

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

1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the last 180 days?  
 Yes (Approve – 365 days)  No (Go to #2)
2. Is there a documented allergy or contraindication to preferred agents in this class?  
 Yes (Approve – 365 days)  No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?  
 Yes (Approve – 365 days)  No (Deny)

## STEP 4: 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.