



Fax completed form to Navitus at: 855-668-8553  
 For questions, please call: 877-908-6023

**TEXAS MEDICAID**

**Drug Prior Authorization  
 Sedatives-Hypnotics: Adults**

**Request Information (required)**

This request is:

- Expedited\* (Urgent)**
- Standard (Non-Urgent)**

\*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

**Member Information (required)**

**Prescriber Information (required)**

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

**Please fill out the following information:**

1. Medication Requested (Name):  
 (Go to #2)

2. **Quantity Requested:**  
(Go to #3)

3. **Dose Requested (Strength):**  
(Go to #4)

4. **Dosing Instructions:**  
(Go to #5)

**Required Criteria**

5. **Provide primary diagnosis including ICD-10 code(s):**  
(Go to #6)

6. Please indicate the requested drug's formulary status: \*(Formulary available at [www.txvendordrug.com](http://www.txvendordrug.com))

Non-Preferred Drug (NPD or NAP)  
(Go to #7)

Preferred Drug (PDL)  
(Go to #10)

No Status, Drug is not in a Market Basket  
(Go to #10)

N/A as this request is for a CHIP/PERINATE member  
(Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 14-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes  
(Go to #10)

No  
(Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

Yes  
(Go to #10)

No  
(Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes  
(Go to #10)

No (Deny)  
(Go to #10)

Clinical Criteria (required)

10. Is the incoming request for less than or equal to ( $\leq$ ) five (5) units?

Yes (Approve - 1 day)  
(Go to #15)

No  
(Go to #11)

11. Does the member have a diagnosis of insomnia in the last 365 days?

Yes  
(Go to #12)

No (Deny)  
(Go to #12)

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

Yes  
(Go to #13)

No (Deny)  
(Go to #13)

13. Does the member have a diagnosis of drug abuse/dependence in the last 365 days?

Yes (Deny)  
(Go to #14)

No  
(Go to #14)

14. Is the incoming request for greater than ( $>$ ) one (1) unit/day?

Yes (Deny)  
(Go to #15)

No (Approve - 180 days)  
(Go to #15)

Additional Information

15. Please provide any additional information we should consider (or attach any supporting documents):  
(END)

**Submission Information (required)**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* PLEASE FAX COMPLETED FORM TO: 855-668-8553 \*\***

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
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