



TEXAS MEDICAID Clinical Edit Prior Authorization Sedatives/Hypnotics - Adults

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 14-day treatment trial with at least 1 preferred agent in the last 180 days?

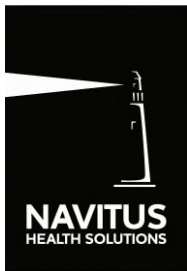
- Yes (Go to Step 4 Question 1) No (Go to #2)

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)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the incoming request for less than or equal to (\leq) 1 day supply?
 Yes (Go to #2) No (Go to #3)

2. Is the incoming request for less than or equal to (\leq) 5 units per day?
 Yes (Approve – 1 day) No (Go to #4)

3. Does the client have a diagnosis of insomnia in the last 365 days?
 Yes (Go to #4) No (Deny)

4. Is the client greater than or equal to (\geq) 18 years of age?
 Yes (Go to #5) No (Deny)

5. Does the client have a diagnosis of drug abuse/dependence in the last 365 days?
 Yes (Deny) No (Go to #6)

6. Is the incoming request for greater than ($>$) 1 unit/day?
 Yes (Deny) No (Approve – 180 days)

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.