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

TEXAS MEDICAID

Drug Prior Authorization
Opioid Policy: Cough & Cold Products – Table E

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)

- ◯ 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 3-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)

Opioid Policy Criteria

10. Does the member have a diagnosis of ONE (1) of the following in the last 365 days?
    - Cancer
    - Hospice Care
    - Palliative Care
    - Sickle Cell

    ◯ Yes
    (Go to #16)

    ◯ No
    (Go to #11)

11. Does the member have a total of less than or equal to (≤) seven (7) days supply of opiates in the last 60 days?

    ◯ Yes
    (Go to #12)

    ◯ No
    (Go to #15)

12. Is the days supply of the requested medication greater than (>) ten (10) days?

    ◯ Yes (Deny)
    (Go to #13)

    ◯ No
    (Go to #13)

13. Is the request for a long-acting opioid agent?

    ◯ Yes (Deny)
    (Go to #14)

    ◯ No
    (Go to #14)

14. Is the incoming request greater than (>) 90 morphine milligram equivalents (MME)?

- ◯ Yes (Deny)
  (Go to #15)
- ◯ No
  (Go to #16)

15. Does the member's total opiate intake exceed 90 morphine milligram equivalents (MME) per day?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Please provide the drug names, strengths, and dosing instructions of ALL opioid products the member is currently taking:
(Go to #17)

Clinical Criteria (required)

17. Is the member greater than or equal to (≥) 18 years of age*?

*In January 2018, the FDA issued a safety announcement requiring labeling changes for prescription cough and cold products containing codeine or hydrocodone to limit the use of these products to adults aged 18 years and older. Cough and cold products containing opioids are not covered by Texas Medicaid for ages less than (<) 18. Prior authorization for these agents will not be accepted.

- ◯ Yes (Approve - 180 days)
  (Go to #18)
- ◯ No (Deny)
  (Go to #18)

Additional Information

18. 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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