



TEXAS MEDICAID

Clinical Edit Prior Authorization

Topical Acne Agents

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**)

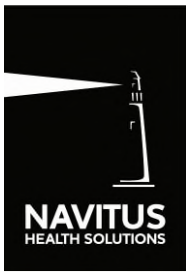
STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-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. Does the client have a diagnosis of rosacea or actinic keratosis in the last 730 days?

Yes (Approve - 365 Days)

No (Go to #2)

2. Does the client have 1 claim for a 30 day trial of a topical retinoid product in the last 730 days?

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.