



TEXAS MEDICAID

Drug Regimen Optimization

ramipril (ALTACE), valsartan (DIOVAN)

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. Is the requested medication EPANED?

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

2. Is the client less than or equal to (\leq) 6 years of age?

- Yes (Go to Step 4, Question 1) No (Go to #3)

3. Has the client failed a 14-day treatment trial with at least one (1) preferred agent in the past 180 days?

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



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

Yes (Go to Step 4, Question 1) No (Go to #5)

5. 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: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

1. Is the request for one of the following drugs/strengths?

ramipril (ALTACE)	1.25mg, 2.5mg, 5mg
valsartan (DIOVAN)	80mg, 160mg

Yes (Go to #2) No (Approved – 365 days)

2. Is the request for 2 or more tablets per day?

Yes (Go to #3) No (Approved – 365 days)

3. Is the client greater than or equal to 18 years of age?

Yes (Go to #4) No (Approved – 365 days)

4. Does the client have a history of heart failure in the last 365 days?

Yes (Go to #5) No (Approved – 365 days)

5. Is the request being submitted by phone?

Yes (Approved – 365 days) No (Clinical Review Required. Please provide medical rationale for requested dose below)

Medical Rationale for 2 or more units (tablets/capsules/patches) per day:

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.