



TEXAS MEDICAID Clinical Edit Prior Authorization Calcium Channel Blockers

Please visit <http://www.txvendordrug.com/> for Preferred Drug List

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

- 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)
- Is there a documented allergy or contraindication to preferred agents in this class?
 Yes (Go to Step 4, Question 1) No (Go to #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: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

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

amlodipine tablet (NORVASC)	2.5mg, 5mg
felodipine ER tablet	2.5mg, 5mg
nifedipine ER (ADALAT CC)	30mg
nifedipine ER (PROCARDIA XL)	30mg
verapamil ER capsule (VERELAN)	100mg

Yes (Go to #2)

No (Approved – 365 days)

2. Is the request for 2 or more tablets/capsules 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. 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.