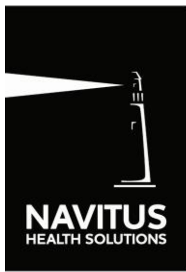


TEXAS MEDICAID
Clinical Edit Prior Authorization
rosiglitazone (AVANDIA)

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: ___________

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ 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?

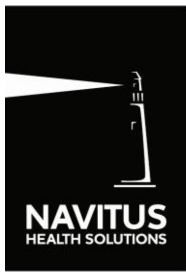
   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

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 heart failure in the last 365 days?

   ☐ Yes (Go to # 2) ☐ No (Go to #3)

2. Does the client have a history of two (2) heart failure drugs for 30 days in the last 90 days?

   Examples of heart failure drugs include BIDIL, bumetanide (BUMEX), CORLANOR, digoxin (LANOXIN), ENTRESTO, eplerenone (INSPRA), ethacrynic acid, furosemide (LASIX), and torsemide.

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a diagnosis of Type II Diabetes in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a history of a metformin-containing agent for 30 days in the last 730 days?

   ☐ Yes (Go to #6) ☐ No (Go to #5)

5. Does the client have a diagnosis of renal failure in the last 730 days?

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Does the client have a history of insulin therapy in the last 30 days?

   ☐ Yes (Deny) ☐ No (Approve - 365 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.