TEXAS MEDICAID
Clinical Edit Prior Authorization
Antipsychotics

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 been stable on ONE (1) non-preferred agent for 30-days in the last 180 days?

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

2. 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 #3)

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

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

4. 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?

aripiprazole (ABILIFY)	5mg, 10mg, 15mg
ABILIFY MYCITE	5mg, 10mg, 15mg
olanzapine (ZYPREXA)	2.5mg, 5mg, 7.5mg, 10mg
olanzapine ODT (ZYPREXA ZYDIS)	5mg, 10mg
risperidone	0.25mg
risperidone (RISPERAL)	0.5mg, 1mg, 2mg
risperidone ODT	0.5mg, 1mg, 2mg

☐ Yes (Go to #2) ☐ No (Go to Step 5, Question 1)

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

☐ Yes (Go to #3) ☐ No (Go to Step 5, Question 1)

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

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

4. Is the request being submitted by phone?

☐ Yes (Go to Step 5, Question 1) ☐ No (Clinical Review Required. Please provide medical rationale for requested dose below then go to Step 5, Question 1)

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

_____

_____

_____

STEP 5: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the incoming claim for a first generation antipsychotic?

   Examples include amitriptyline/perphenazine, chlorpromazine, fluphenazine, haloperidol, loxapine, molindone, perphenazine, pimozide (ORAP), thioridazine, thiothixene, and trifluoperazine.

   ☐ Yes (Go to #5) ☐ No (Go to #2)

2. Is the client less than (<) 3 years of age?

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Is the client greater than (>) 5 years of age?

   ☐ Yes (Go to #5) ☐ No (Go to #4)

4. Is the incoming request for aripiprazole (ABILIFY) or risperidone (RISPERDAL)?

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have two (2) or more active claims for different antipsychotic agents (HIC4) in the last 30 days (excluding the incoming request)?

   ☐ Yes (Deny) ☐ No (Approve - 365 Days)

STEP 6: 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.