



TEXAS MEDICAID
Clinical Edit Prior Authorization
Attention Deficit Disorder (ADD) / Attention Deficit
Hyperactivity Disorder (ADHD): clonidine ER

| 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: <input type="checkbox"/> STAR / STAR KIDS client (Go to Step 3 - PDL PA Criteria Applies) OR <input type="checkbox"/> 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? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2) | |
| 2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3) | |
| 3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Deny) | |



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client less than (<) 6 years of age?

Yes (Deny)

No (Go to #2)

2. Is the request for greater than (>) 4 units per day?

Yes (Deny)

No (Go to #3)

3. Is the client greater than or equal to (\geq) 19 years of age?

Yes (Go to #4)

No (Approve – 365 days)

4. Does the client have a diagnosis of ADD/ADHD 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.