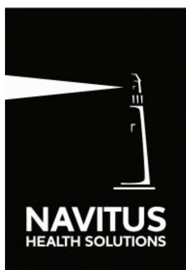

TEXAS MEDICAID
Drug Prior Authorization
Non-Preferred Diabetic Supplies

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:
Quantity Requested:	Dose Requested:
Dosing Instructions:	

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Product Requested: ____

Please note: FreeStyle, Precision, and True Test are preferred

☐ Patient is using an insulin pump

Insulin Pump Name (required): ____________________________________

AND ☐ Patient's glucose meter has connectivity with insulin pump

Glucose Meter Name (required): ____________________________________

Test Strips Name (required): ______________________________________

AND ☐ Patient utilizes the connectivity feature

STEP 3: 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
If approved, coverage allowed for 1 year (subject to formulary changes)
For questions, please call Navitus Customer Care at 1-877-908-6023