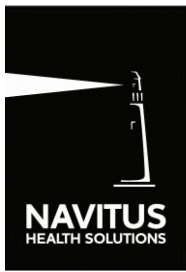


TEXAS MEDICAID
Clinical Edit Prior Authorization
Long-Acting Injectable Antipsychotics

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 1 non-preferred agent for 30-days in the last 180 days?

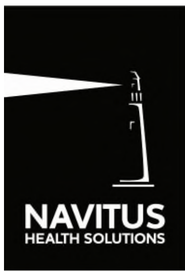
   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Has the client failed a 30-day treatment trial with at least 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?

RISPERDAL CONSTA	25mg

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

2. Is the request for more than 2 injections per month (1 injection per 14 days)?

   ☐ 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 injections per month:

   ____

   ____

   ____

STEP 5: CLINICAL PRIOR AUTHORIZATION CRITERIA

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

   Examples include fluphenazine decanoate and haloperidol decanoate (HALDOL DECANOATE).

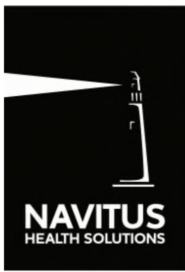
   ☐ Yes (Go to #5) ☐ No (Go to #2)

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 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.