Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Oxycodone Extended-Release Agents: High Dose

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a six (6) day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

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

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Opioid Policy Criteria

10. Does the member have a diagnosis of ONE (1) of the following in the last 365 days?
    - Cancer
    - Hospice Care
    - Palliative Care
    - Sickle Cell

    ◯ Yes
    (Go to #16)

    ◯ No
    (Go to #11)

11. Does the member have a total of less than or equal to (≤) seven (7) days supply of opiates in the last 60 days?

    ◯ Yes
    (Go to #12)

    ◯ No
    (Go to #15)

12. Is the days supply of the requested medication greater than (>) ten (10) days?

    ◯ Yes (Deny)
    (Go to #13)

    ◯ No
    (Go to #13)

13. Is the request for a long-acting opioid agent?

    ◯ Yes (Deny)
    (Go to #14)

    ◯ No
    (Go to #14)

14. Is the incoming request greater than (>) 90 morphine milligram equivalents (MME)?

- ◯ Yes (Deny)
  (Go to #15)
- ◯ No
  (Go to #16)

15. Does the member's total opiate intake exceed 90 morphine milligram equivalents (MME) per day?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Please provide the drug names, strengths, and dosing instructions of ALL opioid products the member is currently taking:
(Go to #17)

Clinical Criteria (required)

17. Does the member have a diagnosis of malignant cancer in the last 730 days?

- ◯ Yes
  (Go to #20)
- ◯ No
  (Go to #18)

18. Does the member have a history of an antineoplastic agent in the last 365 days?

Examples of an antineoplastic agent include the following: ALKERAN, anastrozole (ARIMIDEX), azacitidine, bicalutamide (CASODEX), BICNU, BOSULIF, capecitabine (XELODA), CAPRELSA, COMETRIQ, COSMEGEN, cyclophosphamide, CYTARABINE, EFUDEX, EMCYT, ERIVEDGE, erlotinib (TARCEVA), etoposide, exemestane (AROMASIN), FARYDAK, fluorouracil, flutamide, GLEEVEC, GLEOSTINE, HEXALEN, HYCAMTIN, hydroxyurea (DROXIA), IBRANCE, ICLUSIG, IMBRUVICA, INLYTA, IRESSA, JAKAFI, KISQALI, LENVIMA, letrozole (FEMARA), LEUKERAN, LYSODREN, MATULANE, megestrol acetate (MEGACE), MEKINIST, mercaptopurine (PURIXAN), methotrexate (RHEUMATREX, TREXALL), mitomycin, mitoxantrone, MYLERAN, NEXAVAR, NILANDRON, OFEV, ONCASPAR, raloxifene (EVISTA), SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TABLOID, tamoxifen (SOLTAMOX), TARGRETIN, TASIGNA, temozolomide (TEMODAR), teniposide, toremifene (FARESTON), TYKERB, vinblastine, VOTRIENT, XALKORI, XTANDI, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA, and ZYTIGA.

- ◯ Yes
  (Go to #20)
- ◯ No
  (Go to #19)

19. Does the member have a diagnosis of Chronic Non-malignant Pain (CNMP) in the last 365 days?

- ◯ Yes
  (Go to #20)
- ◯ No (Deny)
  (Go to #20)

20. Does the member have less than (<) 14 days of opioid therapy in the last 30 days?

- ◯ Yes
  (Go to #21)
- ◯ No
  (Go to #25)

21. Manual step - Has the member tried other pain management therapies?

- ◯ Yes
  (Go to #22)
- ◯ No (Deny)
  (Go to #22)

22. Manual step - Has the prescriber provided medical justification for the use of a higher strength?

- ◯ Yes
  (Go to #23)
- ◯ No (Deny)
  (Go to #23)

23. Manual step - Does the member have a pain management agreement with the prescriber?

- ◯ Yes
  (Go to #24)
- ◯ No (Deny)
  (Go to #24)

24. Is the requested quantity less than or equal to (≤) three (3) tablets per day?

- ◯ Yes
  (Go to #25)
- ◯ No (Deny)
  (Go to #25)

25. Does the member have a total of less than or equal to (<) seven (7) days supply of opiates in the last 60 days?

- ◯ Yes (Approve - 1x for incoming prescription) (opioid naïve)
  (Go to #26)
- ◯ No (Approve - 180 days) (opioid experienced)
  (Go to #26)

Additional Information

26. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

** PLEASE FAX COMPLETED FORM TO: 855-668-8553 **

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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