TEXAS MEDICAID
Clinical Edit Prior Authorization
Opioid Policy: Oxycodone Extended Release (ER) - High Dose oxycodone (OXYCONTIN) 60mg & 80mg

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:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the last 180 days?

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

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

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. 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: OPIOID POLICY CRITERIA

1. Does the client have a diagnosis of ONE (1) of the following in the last 365 days?
   - Sickle cell
   - Cancer
   - Palliative care
   - Hospice care

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

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

   ☐ Yes (Go to #3) ☐ No (Go to #6)

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

   ☐ Yes (Deny) ☐ No (Go to #4)

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

   ☐ Yes (Deny) ☐ No (Go to #5)

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

   ☐ Yes (Deny) ☐ No (Go to Step 5 Question 1)

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

   ☐ Yes (Deny) ☐ No (Go to Step 5 Question 1)

STEP 5: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of malignant cancer in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Go to #2)

2. Does the client have a history of an antineoplastic agent in the last 365 days?

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

   ☐ Yes (Go to #4) ☐ No (Go to #3)

3. Does the client have a diagnosis of Chronic Non-Malignant Pain (CNMP) in the last 365 days?

☐ Yes (Go to #4) ☐ No (Deny)

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

☐ Yes (Go to #5) ☐ No (Go to #9)

5. Has the client tried other pain management therapies? [Manual Step]

☐ Yes (Go to #6) ☐ No (Deny)

6. Has the prescriber provided medical justification for the use of a higher strength? [Manual Step]

☐ Yes (Go to #7) ☐ No (Deny)

7. Does the client have a pain management agreement with the prescriber? [Manual Step]

☐ Yes (Go to #8) ☐ No (Deny)

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

☐ Yes (Go to #9) ☐ No (Deny)

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

☐ Yes (Approve – 1 x for incoming prescription) (opioid naïve) ☐ No (Approve – 180 days) (opioid experienced)

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.