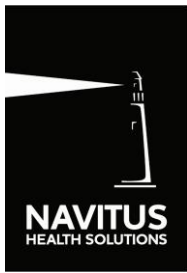




# TEXAS MEDICAID

## Vitamin and Mineral Prior Authorization: Iron (Oral)

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 <a href="http://www.txvendordrug.com">www.txvendordrug.com</a> ) <input type="checkbox"/> Non-Preferred Drug ( <b>NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies</b> ) <b>OR</b> <input type="checkbox"/> Preferred Drug ( <b>Go to Step 4</b> ) <b>OR</b> <input type="checkbox"/> No Status, Drug is not in a Market Basket ( <b>Go to Step 4</b> )	
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: VITAMIN AND MINERAL POLICY CRITERIA**

1. Is the client less than or equal to 20 years of age?

Yes (Go to #2)

No (Deny)

2. Is the prescribed product for a medically-accepted indication according to the current Vitamin and Mineral policy chapter within the *Texas Vendor Drug Program Pharmacy Provider Procedure Manual*? Please see <https://www.txvendordrug.com/about/manual/pharmacy> for complete list.

Accepted indications for use of iron products include: Disorders of iron metabolism, Iron deficiency anemia, Sideroachrestic anemia.

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.