

TEXAS MEDICAID

Clinical Edit Prior Authorization

gabapentin extended release (GRALISE)

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 10-day treatment trial with at least 1 preferred agent in the last 180 days?

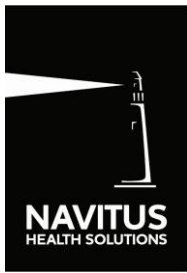
Yes (Go to Step 4 Question 1) No (Go to #2)

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: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client less than (<) 18 years of age?

Yes (Deny)

No (Go to #2)

2. Is the incoming request for a dose less than or equal to (\leq) 1,800 mg per day?

Yes (Go to #3)

No (Deny)

3. Does the client have a diagnosis of postherpetic neuralgia in the last 730 days?

Yes (Go to #4)

No (Deny)

4. Does the client have a diagnosis of severe renal impairment or hemodialysis in the last 365 days?

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.