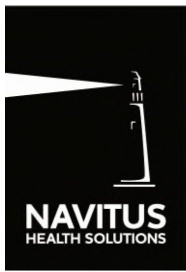


TEXAS MEDICAID
Clinical Edit Prior Authorization
ramelteon (ROZEREM)

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 failed a 14-day treatment trial with at least 1 preferred agent in the last 180 days?

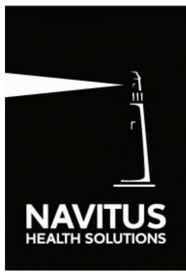
   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

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. Does the client have a history of the requested agent for 90 days in the last 150 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #2)

2. Is the incoming request for less than or equal to (≤) 1 day supply?

   ☐ Yes (Go to #3) ☐ No (Go to #4)

3. Is the incoming request for less than or equal to (≤) 5 units per day?

   ☐ Yes (Approve – 1 day) ☐ No (Go to #4)

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

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a diagnosis of chronic sleep disorder in the last 730 days?

   ☐ Yes (Go to #8) ☐ No (Go to #6)

6. Does the client have a diagnosis of drug abuse in the last 730 days?

   ☐ Yes (Go to #7) ☐ No (Go to #8)

7. Does the client have a history of a sedative/hypnotic agent for 30 days in the last 60 days?

   Examples of sedative/hypnotic agents include zolpidem (AMBIEN), zolpidem ER (AMBIEN CR, INTERMEZZO), BELSOMRA, zolpidem SL (EDLUAR), estazolam, eszopiclone (LUNESTA), temazepam (RESTORIL), triazolam, and zaleplon (SONATA)

   ☐ Yes (Deny) ☐ No (Approve – 30 days)

8. Does the client have a diagnosis of chronic sleep disorder in the last 365 days?

   ☐ Yes (Go to #9) ☐ No (Go to #7)

9. Does the client have a history of a sedative/hypnotic agent for 90 days in the last 120 days?

   Examples of sedative/hypnotic agents include zolpidem (AMBIEN), zolpidem ER (AMBIEN CR, INTERMEZZO), BELSOMRA, zolpidem SL (EDLUAR), estazolam, eszopiclone (LUNESTA), temazepam (RESTORIL), triazolam, and zaleplon (SONATA)

   ☐ Yes (Deny) ☐ No (Approve – 90 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.