TEXAS MEDICAID
Clinical Edit Prior Authorization
naldemedine (SYMPROIC)

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 30-day treatment trial with at least 1 preferred agent (including gastrointestinal (GI) motility over the counter (OTC) products) 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 greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of opioid-induced constipation in the last 365 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have at least 14 days therapy with opioids in the last 30 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a diagnosis of gastrointestinal (GI) obstruction in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a claim for a strong CYP3A4 inhibitor in the last 90 days?

   Examples of strong CYP3A4 inhibitors include clarithromycin, diltiazem, itraconazole, ketoconazole, posaconazole (NOXAFIL), telithromycin (KETEK), TECHNIVIE, VIEKIRA, voriconazole (VFEND), and certain HIV treatments (e.g. CRIXIVAN, GENVOYA, INVIRASE, KALETRA, NORVIR, PREZCOBIX, and VIRACEPT).

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Is the quantity being requested less than or equal to (≤) 1 tablet per day?

   ☐ 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.