TEXAS MEDICAID
Clinical Edit Prior Authorization
ANGIOTENSIN MODULATORS

Please visit http://www.txvendordrug.com/ for Preferred Drug List

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. Is the requested medication Epaned?

   ☐ Yes (Go to #2) ☐ No (Go to #3)

2. Is the client less than or equal to (≤) 6 years of age?

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

3. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the past 180 days?

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

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

☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #5)

5. 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: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

1. Is the request for one of the following drugs/strengths?

fosinopril	10mg, 20mg
perindopril	2mg, 4mg
trandolapril	1mg, 2mg
candesartan (ATACAND)	4mg, 8mg, 16mg
irbesartan (AVAPRO)	75mg, 150mg
losartan (COZAAR)	25mg, 50mg
losartan/HCTZ (HYZAAR)	50-12.5mg
olmesartan (BENICAR)	20mg
telmisartan (MICARDIS)	20mg, 40mg

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

2. Is the request for 2 or more tablets per day?

☐ Yes (Go to #3) ☐ No (Approved – 365 days)

3. Is the client greater than or equal to 18 years of age?

☐ Yes (Go to #4) ☐ No (Approved – 365 days)

4. Is the request being submitted by phone?

☐ Yes (Approved – 365 days) ☐ No (Clinical Review Required. Please provide medical rationale for requested dose below)

Medical Rationale for 2 or more units (tablets/capsules/patches) per day:

_____

_____

_____

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.