



**TEXAS MEDICAID**  
**Clinical Edit Prior Authorization**  
**diclofenac 1.5% topical solution,**  
**diclofenac 2% topical solution (PENNSAID 2%**  
**PUMP)**

**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](http://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 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)



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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 ( $\geq$ ) 18 years of age?

- Yes (Go to #2)     No (Deny)

2. Does the client have a diagnosis of osteoarthritis of the knee in the last 730 days?

- Yes (Go to #3)     No (Deny)

3. Does the client have a history of a gastrointestinal (GI) bleed in the last 730 days?

- 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.