



# TEXAS MEDICAID Clinical Edit Prior Authorization Dopamine Agonists

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

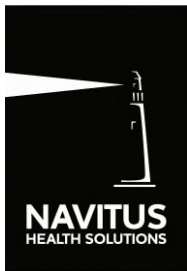
Yes (Go to Step 4, Question 1)  No (Go to #2)

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. 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 Parkinson's disease in the last 730 days?

Yes (Go to #3)

No (Deny)

3. Does the client have a claim for a 5HT<sub>3</sub> antagonist in the last 30 days?

Examples include AKYNZEO, alosetron (LOTRONEX), granisetron (SANCUSO), ondansetron (ZUPLENZ)

Yes (Deny)

No (Go to #4)

4. Is the request for less than or equal to ( $\leq$ ) the United States Food and Drug Administration (FDA) recommended dose?

KYNMOBI:

- Maximum single dose is 30mg
- No more than 5 doses 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.