

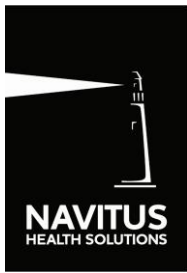


TEXAS MEDICAID Clinical Edit Prior Authorization

DPP-4 Inhibitors:

alogliptin-metformin (KAZANO), alogliptin-pioglitazone (OSENI), GLYXAMBI, JANUMET (XR), JENTADUETO (XR), KOMBIGLYZE XR, QTERN, STEGLUJAN

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) <input type="checkbox"/> Non-Preferred Drug (NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies) OR <input type="checkbox"/> Preferred Drug (Go to Step 4) OR <input type="checkbox"/> No Status, Drug is not in a Market Basket (Go to Step 4) OR <input type="checkbox"/> 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? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2)	
2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3)	
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> 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 Type II Diabetes in the past 730 days?

Yes (Go to #3)

No (Deny)

3. Does the client have a diagnosis of severe renal failure or End-Stage Renal Disease (ESRD) in the last 730 days?

Yes (Deny)

No (Approve – 365 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.