



TEXAS MEDICAID Clinical Edit Prior Authorization imiquimod 3.75 % cream (ZYCLARA)

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: COMPLETE REQUIRED CRITERIA

Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have a diagnosis of genital or perianal warts in the last 60 days?
 Yes (Go to #2) No (Go to #3)

2. Is the client greater than or equal to (\geq) 12 years of age?
 Yes (Approve - 56 days/8 weeks) No (Deny)

3. Is the client greater than or equal to (\geq) 18 years of age?
 Yes (Go to #4) No (Deny)

4. Does the client have a diagnosis of actinic keratosis in the last 60 days?
 Yes (Approve - 56 days/8 weeks) No (Deny)

STEP 3: 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.