TEXAS MEDICAID
Clinical Edit Prior Authorization
imiquimod 3.75 % cream

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 (≥) 12 years of age?

   ☐ Yes (Approve - 56 days/8 weeks) ☐ No (Deny)

3. Is the client greater than or equal to (≥) 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.