Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Fentanyl Agents: oral transmucosal fentanyl (ACTIQ)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a six (6) day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Opioid Policy Criteria

10. Does the member have a diagnosis of ONE (1) of the following in the last 365 days?
    - Cancer
    - Hospice Care
    - Palliative Care
    - Sickle Cell

    ◯ Yes
    (Go to #16)

    ◯ No
    (Go to #11)

11. Does the member have a total of less than or equal to (≤) seven (7) days supply of opiates in the last 60 days?

    ◯ Yes
    (Go to #12)

    ◯ No
    (Go to #15)

12. Is the days supply of the requested medication greater than (>) ten (10) days?

    ◯ Yes (Deny)
    (Go to #13)

    ◯ No
    (Go to #13)

13. Is the request for a long-acting opioid agent?

    ◯ Yes (Deny)
    (Go to #14)

    ◯ No
    (Go to #14)

14. Is the incoming request greater than (>) 90 morphine milligram equivalents (MME)?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

15. Does the member's total opiate intake exceed 90 morphine milligram equivalents (MME) per day?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Please provide the drug names, strengths, and dosing instructions of ALL opioid products the member is currently taking:
(Go to #17)

Clinical Criteria (required)

17. Is the member less than (<) 16 years of age?

- ◯ Yes (Deny)
  (Go to #18)
- ◯ No
  (Go to #18)

18. Does the member have a diagnosis of cancer or fibrotic lung disease in the last 730 days?

- ◯ Yes
  (Go to #21)
- ◯ No
  (Go to #19)

19. Does the member have a history of antineoplastic therapy in the last 365 days?

- ◯ Yes
  (Go to #21)
- ◯ No
  (Go to #20)

20. Does the member have a diagnosis of Chronic Non-Malignant Pain (CNMP) in the last 365 days?

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

21. Does the member have less than or equal to (≤) 7 days of opioid therapy in the last 30 days?

- ◯ Yes (Deny)
  (Go to #22)
- ◯ No
  (Go to #22)

22. Does the member have a claim for a monoamine oxidase inhibitor (MAOI) or a strong/moderate CYP3A4 inhibitor in the last 30 days?

Examples of MAOIs include: AZILECT, linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), selegiline (EMSAM, ZELAPAR), and tranylcypromine (PARNATE).

Examples of CYP3A4 inhibitors include: aprepitant (EMEND), AKYNZEO, BUNAVAIL/SUBOXONE, clarithromycin, COPIKTRA, CRESEMBA, diltiazem (CARDIZEM, CARDIZEM CD, CARTIA XT, DILT XR, MATZIM LA, TAZTIA XT, TIAZAC ER), erythromycin, fluconazole (DIFLUCAN), GLEEVEC, itraconazole (SPORANOX, TOLSURA), KETEK, ketoconazole, KISQALI, KORLYM, MULTAQ, nefazodone, NOXAFIL, PREVYMIS, TASIGNA, TECHNIVIE, verapamil (CALAN, VERELAN), VICTRELIS, VIEKIRA, voriconazole (VFEND), ZYDELIG, and certain HIV treatments (e.g. atazanavir (REYATAZ), CRIXIVAN, EVOTAZ, GENVOYA, INVIRASE, KALETRA, fosamprenavir (LEXIVA), PREZCOBIX, PREZISTA, ritonavir (NORVIR), VIRACEPT, STRIBILD, SYMTUZA, TYBOST, and VIRACEPT).

- ◯ Yes (Deny)
  (Go to #23)
- ◯ No
  (Go to #23)

23. Is the request for transmucosal fentanyl (ACTIQ) 200mcg?

- ◯ Yes
  (Go to #26)
- ◯ No
  (Go to #24)

24. Is the request for transmucosal fentanyl (ACTIQ) greater than or equal to (≥) 400mcg?

- ◯ Yes
  (Go to #25)
- ◯ No (Deny)
  (Go to #25)

25. Does the member have a history of transmucosal fentanyl (ACTIQ) therapy in the last 30 days with the dose greater than or equal to (≥) 200mcg?

- ◯ Yes
  (Go to #26)
- ◯ No (Deny)
  (Go to #26)

26. Is the request for less than or equal to (≤) four (4) units per day?

- ◯ Yes
  (Go to #27)
- ◯ No (Deny)
  (Go to #27)

27. Does the member have a total of less than or equal to (≤) seven (7) days supply of opiates in the last 60 days?

- ◯ Yes (Approve - 1 x for incoming prescription) (opioid naïve)
  (Go to #28)
- ◯ No (Approve 180 days) (opioid experienced)
  (Go to #28)

Additional Information

28. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Customer Care at 877-908-6023

For questions, please call Navitus Customer Care at 1-877-908-6023.