TEXAS MEDICAID
Clinical Edit Prior Authorization
Opioid Policy
Fentanyl Agents: oral transmucosal fentanyl citrate (ACTIQ)

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: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 6-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: OPIOID POLICY CRITERIA

1. Does the client have a diagnosis of ONE (1) of the following in the last 365 days?
   - Sickle cell
   - Cancer
   - Palliative care
   - Hospice care

   ☐ Yes (Go to Step 5 Question 1) ☐ No (Go to #2)

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

   ☐ Yes (Go to #3) ☐ No (Go to #6)

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

   ☐ Yes (Deny) ☐ No (Go to #4)

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

   ☐ Yes (Deny) ☐ No (Go to #5)

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

   ☐ Yes (Deny) ☐ No (Go to Step 5 Question 1)

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

   ☐ Yes (Deny) ☐ No (Go to Step 5 Question 1)

STEP 5: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client less than (<) 16 years of age?

   ☐ Yes (Deny) ☐ No (Go to #2)

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

   ☐ Yes (Go to #5) ☐ No (Go to #3)

3. Does the client have a history of antineoplastic therapy in the last 365 days?

   ☐ Yes (Go to #5) ☐ No (Go to #4)

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

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have less than or equal to (≤) 7 days of opioid therapy in the last 30 days? ☐ Yes (Deny) ☐ No (Go to #6)
6. Does the client 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) ☐ No (Go to #7)
7. Is the request for transmucosal fentanyl (ACTIQ) 200mcg? ☐ Yes (Go to #10) ☐ No (Go to #8)
8. Is the request for transmucosal fentanyl (ACTIQ) greater than or equal to (≥) 400mcg? ☐ Yes (Go to #9) ☐ No (Deny)
9. Does the client 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 #10) ☐ No (Deny)
10. Is the request for less than or equal to (≤) 4 units per day? ☐ Yes (Go to #11) ☐ No (Deny)
11. Does the client have a total of less than or equal to (≤) 7 days supply of opiates in the last 60 days? ☐ Yes (Approve – 1 x for incoming prescription) (opioid naïve) ☐ No (Approve – 180 days) (opioid experienced)

STEP 6: 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.