TEXAS MEDICAID
Clinical Edit Prior Authorization
Growth Hormones:
somatropin (SEROSTIM)

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 been stable on one (1) non-preferred agent for 30-days in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

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

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #4)

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4. 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: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 17 years of age?

☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Human Immunodeficiency Virus (HIV) in the last 3 years?

☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of cachexia in the last 365 days?

☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have claims for greater than or equal to (≥) 2 single ingredient antiretroviral agents or a claim for a combination ingredient antiretroviral agent in the last 90 days?

Examples of single ingredient antiretroviral agents include abacavir (ZIAGEN), APTIVUS, CRIXIVAN, didanosine DR (VIDEX), EDURANT, EMTRIVA, FUZEON, INTELENCE, INVIRASE, ISENTRESS, lamivudine (EPIVIR), LEXIVA, nevirapine (VIRAMUNE), NORVIR, PREZISTA, RESCRIPTOR, REYATAZ, SELZENTRY, stavudine (ZERIT), SUSTIVA, TIVICAY, TYBOST, VIRACEPT, VIREAD, and zidovudine (RETROVIR).

Examples of combination ingredient antiretroviral agents include abacavir/lamivudine (EPZICOM), abacavir/lamivudine/zidovudine (TRIZIVIR), ATRIPLA, COMPLERA, DESCOVY, EVOTAZ, GENVOYA, KALETRA, lamivudine/zidovudine (COMBIVIR), ODEFSEY, PREZCOBIX, STRIBILD, TRIUMEQ, and TRUVADA.

☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a diagnosis of active malignancy in the last 180 days?

☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a history of chemotherapy/radiation (CPTs) in the last 180 days?

☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a diagnosis of active proliferative or severe non-proliferative diabetic retinopathy in the last 365 days?

☐ Yes (Deny) ☐ No (Approve – 48 weeks)

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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.