



# TEXAS MEDICAID

## Clinical Edit Prior Authorization

### Benign Prostatic Hyperplasia (BPH) Agents

Please visit <http://www.txvendordrug.com/> for Preferred Drug List

#### 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: \_\_\_\_\_

Indicate the drug's formulary status: \*(Formulary available at [www.txvendordrug.com](http://www.txvendordrug.com))

- Non-Preferred Drug (**NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies**)
- OR**  Preferred Drug (**Go to Step 4**)
- OR**  No Status, Drug is not in a Market Basket (**Go to Step 4**)
- OR**  N/A as this request is for a CHIP / PERINATE client (**Go to Step 4**)

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

Indicate Primary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

1. Has the client failed a 30-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: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA**

1. Is the request for one of the following drugs/strengths?

doxazosin tablets (CARDURA)	1mg, 2mg, 4mg
terazosin tablets	1mg, 5mg

Yes (Go to #2)  No (Approved – 365 days)

2. Is the request for 2 or more tablets per day?

Yes (Go to #3)  No (Approved – 365 days)

3. Is the client greater than or equal to 18 years of age?

Yes (Go to #4)  No (Approved – 365 days)

4. Is the request being submitted by phone?

Yes (Approved – 365 days)  No (Clinical Review Required. Please provide medical rationale for requested dose below)

Medical Rationale for 2 or more units (tablets/capsules/patches) per day:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.