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

TEXAS MEDICAID

Drug Prior Authorization
Antipsychotics

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 #11)

   No Status, Drug is not in a Market Basket
   (Go to #11)

   N/A as this request is for a CHIP/PERINATE member
   (Go to #11)

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

7. Has the member been stable on ONE (1) non-preferred agent for 30-days in the last 180 days?

   Yes
   (Go to #11)

   No
   (Go to #8)

8. Has the member failed a 14-day treatment trial with at least ONE (1) preferred agent in the past 180 days?

   Yes
   (Go to #11)

   No
   (Go to #9)

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

   Yes
   (Go to #11)

   No
   (Go to #10)

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

    Yes
    (Go to #11)

    No (Deny)
    (Go to #11)

Clinical Criteria (required)

11. Is the incoming claim for a first generation antipsychotic?

    Examples of first generation antipsychotics include: amitriptyline/perphenazine, chlorpromazine, fluphenazine, haloperidol, loxapine, molindone, perphenazine, pimozide (ORAP), thioridazine, thiothixene, and trifluoperazine.

    Yes
    (Go to #16)

    No
    (Go to #12)

12. Is the member less than (<) three (3) years of age?

    Yes (Deny)
    (Go to #13)

    No
    (Go to #13)

13. Is the member greater than (>) five (5) years of age?

    Yes - And the request is for an agent other than Rexulti
    (Go to #16)

    Yes - And the request is for Rexulti
    (Go to #14)

    No
    (Go to #15)

14. Is the member greater than or equal to (≥) 13 years of age?

    Yes
    (Go to #16)

    No (Deny)
    (Go to #16)

15. Is the incoming request for aripiprazole (ABILIFY) or risperidone (RISPERDAL) (excluding long-acting preparations)?

    Yes
    (Go to #16)

    No (Deny)
    (Go to #16)

16. Does the member have two (2) or more active claims for different antipsychotic agents (HIC4) in the last 30 days (excluding the incoming request)?

    Yes (Deny)
    (Go to #17)

    No (Approve - 365 Days)
    (Go to #17)

Additional Information

17. 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.
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