TEXAS MEDICAID
Clinical Edit Prior Authorization
Opioid Policy
Carisoprodol-Aspirin-Codeine

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. Does the client have a diagnosis of substance abuse in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #2)

2. Is the client greater than or equal to (≥) 16 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the incoming request for greater than (>) a 21 days supply?

   ☐ Yes (Go to #4) ☐ No (Go to #5)

4. Has the client tried an alternative skeletal muscle relaxant in the last 30 days?

   Examples of skeletal muscle relaxants include cyclobenzaprine (AMRIX ER, FEXMID), chlorzoxazone (LORZONE), metaxalone (SKELAXIN), methocarbamol (ROBAXIN), and orphenadrine ER.

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a history of carisoprodol-containing agents prescribed by more than (>) 2 prescribers in the last 90 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a claim for a carisoprodol-containing agent in the last 90 days?

   ☐ Yes (Go to #7) ☐ No (Go to #8)

7. Is the combined days supply for all carisoprodol-containing agents greater than (>) 42 in the last 90 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Is the request for less than or equal to (≤) 4 tablets per day (for carisoprodol single agent products) or less than or equal to (≤) 8 tablets per day (for carisoprodol compound products)?

   ☐ Yes (Go to #9) ☐ No (Deny)

9. 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 – 21 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.