



# 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: _____	

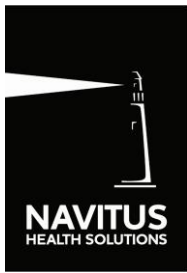
Please indicate ONE (1) of the following:

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
  - Palliative care
  - Cancer
  - 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 ( $\leq$ ) 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?

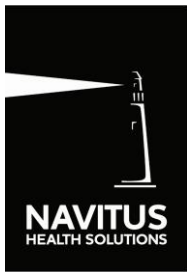
- Yes (Deny)       No (Go to #2)

2. Is the client greater than or equal to ( $\geq$ ) 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)



<p>4. Has the client tried an alternative skeletal muscle relaxant in the last 30 days?</p> <p>Examples of skeletal muscle relaxants include cyclobenzaprine (AMRIX ER, FEXMID), chlorzoxazone (LORZONE), metaxalone (SKELAXIN), methocarbamol (ROBAXIN), and orphenadrine ER.</p> <p><input type="checkbox"/> Yes (Go to #5) <input type="checkbox"/> No (Deny)</p>
<p>5. Does the client have a history of carisoprodol-containing agents prescribed by more than (&gt;) 2 prescribers in the last 90 days?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #6)</p>
<p>6. Does the client have a claim for a carisoprodol-containing agent in the last 90 days?</p> <p><input type="checkbox"/> Yes (Go to #7) <input type="checkbox"/> No (Go to #8)</p>
<p>7. Is the combined days supply for all carisoprodol-containing agents greater than (&gt;) 42 in the last 90 days?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #8)</p>
<p>8. Is the request for less than or equal to (<math>\leq</math>) 4 tablets per day (for carisoprodol single agent products) or less than or equal to (<math>\leq</math>) 8 tablets per day (for carisoprodol compound products)?</p> <p><input type="checkbox"/> Yes (Go to #9) <input type="checkbox"/> No (Deny)</p>
<p>9. Does the client have a total of less than or equal to (<math>\leq</math>) 7 days supply of opiates in the last 60 days?</p> <p><input type="checkbox"/> Yes (Approve – 1 x for incoming prescription) (opioid naïve) <input type="checkbox"/> No (Approve – 21 days) (opioid experienced)</p>
<p><b>STEP 6: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553</b></p>
<p><b>Prescriber Signature:</b> _____ <b>Date:</b> _____</p>

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.