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

TEXAS MEDICAID

Drug Prior Authorization
Long-Acting Injectable 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 30-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 include fluphenazine decanoate and haloperidol decanoate (HALDOL DECANOATE).

    Yes
    (Go to #15)

    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
    (Go to #15)

    No
    (Go to #14)

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

    Yes
    (Go to #15)

    No (Deny)
    (Go to #15)

15. 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 #16)

No (Approve - 365 Days)
(Go to #16)

Additional Information

16. 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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