



TEXAS MEDICAID Clinical Edit Prior Authorization glipizide XL (GLUCOTROL XL)

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: _____

STEP 3: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

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

glipizide XL (GLUCOTROL XL)

2.5mg, 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 4: 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.