TEXAS MEDICAID
Clinical Edit Prior Authorization
levoketoconazole (RECORLEV)

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: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have diagnosis of endogenous Cushing's syndrome in the last 730 days?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is this a renewal request?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #3)

3. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a diagnosis cirrhosis, acute liver disease or poorly controlled chronic liver disease, recurrent symptomatic cholelithiasis, or extensive metastatic liver disease in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a prolonged QT syndrome, history of torsade de pointes, ventricular tachycardia, or ventricular fibrillation in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

TEXAS MEDICAID
Clinical Edit Prior Authorization
levoketoconazole (RECORLEV)

6. Has the client had therapy with drugs that cause QT prolongation, drugs that are sensitive substrates of CYP3A4 or CYP3A4 and P-gp, or strong CYP3A4 inhibitors or inducers in the last 90 days?

   Examples include: alfuzosin, amiodarone, amitriptyline, aripiprazole, azithromycin, BRILINTA, budesonide, buspirone, carbamazepine, clarithromycin, chlorpromazine, ciprofloxacin, clozapine, clomipramine, cyclobenzaprine, donepezil, citalopram, darifenacin, desipramine, digoxin, dofetilide, doxepin, eletriptan, eplerenone, erythromycin, escitalopram, famotidine, FANAPT, felbamate, felodipine, fexofenadine, flecainide, fluconazole, fluoxetine, galantamine, GILENYA, granisetron, hydroxychloroquine, hydroxyzine, itraconazole, JYNARQUE, LATUDA, leuprolide, levofloxacin, lovastatin, mefloquine, methadone, metronidazole, MOVANTIK, moxifloxacin, MULTAQ , NAMZARIC, NAYZILAM, nefazodone, NOXAFIL, ofloxacin, olanzapine, ondansetron, ORKAMBI, paliperidone, paroxetine, perphenazine, phenobarbital, phenytoin, pimozide, PRADAXA, primidone, prochlorperazine, promethazine, propafenone, quetiapine, ranolazine, rifampin, risperidone, SAPHRIS, sildenafil, simvastatin, sotalol, tacrolimus, tolterodine, thioridazine, tizanidine, tolvaptan, trazodone, triazolam, venlafaxine, VESICARE, voriconazole, ziprasidone, certain cancer treatments (everolimus, IMBRUVICA, sirolimus, SPRYCEL, SUTENT, tamoxifen, XTANDI, and others) and certain HIV treatments (ATRIPLA, EVOTAZ, GENVOYA, PREZISTA, STRIBILD, and others).

   ☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 3: 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.