



TEXAS MEDICAID Clinical Edit Prior Authorization Opioid Policy Promethazine-Codeine Syrup

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 a diagnosis of ONE (1) of the following in the last 365 days?

- Sickle cell
 - Palliative care
 - Cancer
 - Hospice care
- Yes (Go to #7) 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?

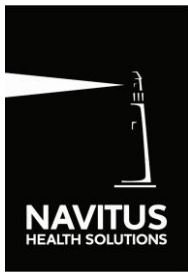
- Yes (Deny) No (Go to #5)

5. Is the incoming request greater than ($>$) 90 morphine milligram equivalents (MME)?

- Yes (Deny) No (Go to #7)

6. Does the client's total opiate intake exceed 90 morphine milligram equivalents (MME) per day?

- Yes (Deny) No (Go to #7)



7. Is the client greater than or equal to (\geq) 2 years of age?

Yes (Go to #8)

No (Deny)

*** Cough and cold products containing opioids are not covered by Texas Medicaid for ages less than (<) 18. Prior authorization for these agents will not be accepted.**

8. Does the client have a total of less than or equal to (\leq) 7 days supply of opiates in the last 60 days?

Yes (Approve – 1 x for incoming prescription) (opioid naïve)

No (Approve – 180 days) (opioid experienced)

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.