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
   - Cancer
   - Palliative care
   - Hospice care

   ☐ Yes (Go to #7) ☐ No (Go to #2)

2. Does the client have a total of less than or equal to (≤) 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 (≥) 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 (≤) 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.