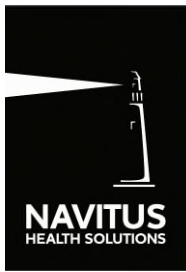


TEXAS MEDICAID
Clinical Edit Prior Authorization
pimavanserin (NUPLAZID)

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: ___________

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client been stable on one (1) non-preferred agent for 30-days in the last 180 days?

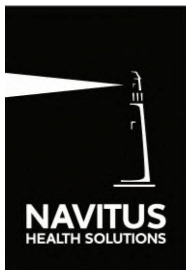
   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Has the client failed a 14-day treatment trial with at least one (1) preferred agent in the past 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is there documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #4)



4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of Parkinson's disease **AND** psychosis with hallucinations and/or delusions in the last 730 days?

☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a claim for a drug that increases the QT interval in the last 90 days?

Examples of drugs that increase the QT interval include some antipsychotic and antidepressant drugs (amitriptyline, aripiprazole, citalopram, clozapine, doxepin, escitalopram, FANAPT, fluoxetine, olanzapine, paliperidone, quetiapine, risperidone, SAPHRIS, trazodone, venlafaxine, ziprasidone), antibiotics and antifungals (azithromycin, ciprofloxacin, clarithromycin, erythromycin, fluconazole, itraconazole, levofloxacin, metronidazole, voriconazole), dementia-related drugs (donepezil, galantamine, NAMZARIC), anti-nausea drugs (granisetron, ondansetron, promethazine, prochlorperazine), muscle relaxants (cyclobenzaprine, tizanidine), and other drugs such as amiodarone, hydroxyzine, methadone, tacrolimus (PROGRAF).

☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a diagnosis of hepatic impairment in the last 730 days?

☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a claim for a strong CYP3A4 inhibitor in the last 90 days?

Examples of strong CYP3A4 inhibitors include clarithromycin, telithromycin (KETEK), ketoconazole, itraconazole, posaconazole (NOXAFIL), voriconazole (VFEND), diltiazem, TECHNIVIE, VIEKIRA, or certain HIV treatments (e.g., GENVOYA, NORVIR, KALETRA, CRIXIVAN, INVIRASE, PREZCOBIX, or VIRACEPT).

☐ Yes (Go to #5) ☐ No (Approve – 365 days)

5. Is the request for less than or equal to (≤) 1 tablet per day?

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

STEP 5: 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.