Texas – DELL CHILDREN'S HEALTH PLAN
Clinical Edit Prior Authorization
Contraceptives

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: COMPLETE REQUIRED CRITERIA

Please Note: Contraceptives prescribed for the prevention of pregnancy will not be approved

☐ Contraceptive is medically necessary and prescribed for a medical diagnosis other than the prevention of pregnancy

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

STEP 3: INDICATE MEDICATION REQUESTED

Medication Name: _____

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
If approved, coverage allowed for 1 year (subject to formulary changes)
For questions, please call Navitus Customer Care at 1-877-908-6023