TEXAS MEDICAID
Preferred Drug List (PDL) Criteria for Non-Preferred Drugs (NPD or NAP): Macrolides/Ketolides (PDL)

Please visit http://www.txvendordrug.com/ for Preferred Drug List

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: _____

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

1. Does the client have a diagnosis of gastroparesis or gastroesophageal reflux disease (GERD) associated with gastrostomy in the last 365 days?
   - ☐ Yes (Approve – 90 days)
   - ☐ No (Go to #2)

2. Has the client failed a 7-day treatment trial with at least one preferred agent in the last 180 days? (Exception may apply when a preferred drug requires less than a 7-day treatment trial)
   - ☐ Yes (Approve – 30 days)
   - ☐ No (Go to #3)

3. Is there a documented allergy or contraindication to preferred agents in this class?
   - ☐ Yes (Approve – 30 days)
   - ☐ No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
   - ☐ Yes (Approve – 30 days)
   - ☐ No (Deny)

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.
For questions, please call Navitus Customer Care at 1-877-908-6023.