TEXAS MEDICAID
Clinical Edit Prior Authorization
Cough and Cold Medications - Table A

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: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

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

1. Has the clients failed a 3-day treatment trial with at least 1 preferred agent in the last 180 days?

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

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

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

3. 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. Is the client greater than or equal to (≥) 2 years* and less than (<) 4 years of age?

☐ Yes (Deny) ☐ No (Approve - 30 days)

**** Claims for cough and cold products for clients less than 2 years of age are not covered by Texas Medicaid. Claims for cough and cold products containing acetaminophen or ibuprofen are not covered by Texas Medicaid for ages ≥ 2 to < 6 years of age. Cough and cold products containing opioids are not covered by Texas Medicaid for ages < 18. Prior authorization for these agents will not be accepted.***

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.

Table A	
The listed products may not indicate formulary coverage. To check current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search	
Label Name	**GCN**
ALA-HIST PE TABLET	28379
APRODINE TABLET	96445
BROTAPP LIQUID	12933
CHEST CONGESTION RELIEF PE	97358
CHEST CONGESTION RELIEF TABLET	18906
CHL MUCINEX CHEST CONGEST LIQ	2512
CHLD MUCINEX STUFFY NOSE-COLD	99069
CHLO TUSS LIQUID	35393
COUGH SYRUP 200 MG/10 ML	2512
DECONEX IR TABLET	42022
DIMAPHEN ELIXIR	27207
ED BRON GP LIQUID	54250
ED CHLORPED D PEDIATRIC DROPS	30033
ED-A-HIST PSE TABLET	96445
GUAIFENESIN 100 MG/5 ML SYRUP	2512
HISTEX-PE SYRUP	29581
IOPHEN NR LIQUID	2512
KID'S MUCINEX MINI-MELTS PACK	97123
LODRANE D CAPSULE	30766
LORTUSS LQ LIQUID	29564
MAXIPHEN TABLET	97358
MUCUS RELIEF 400 MG TABLET	18906
MUCUS RELIEF SINUS TABLET	97358
NOSE DROPS	34186
ORGAN-I NR 200 MG TABLET	2482
POLY-HIST PD LIQUID	34839
POLY-VENT IR TABLET	34787
PROMETHAZINE VC SYRUP	13977
Q-TUSSIN 100 MG/5 ML SOLUTION	2512
RESCON-GG LIQUID	54250
RESPAIRE-30 CAPSULE	13255
ROBAFEN 100 MG/5 ML SYRUP	2512
RU-HIST D 10-4 MG TABLET	96609
RYNEX PE LIQUID	27207
RYNEX PSE LIQUID	12933
SILTUSSIN SA 100 MG/5 ML SYR	2512
STAHIST AD LIQUID	31771
STAHIST AD TABLET	31036
TUSSIN 100 MG/5 ML SYRUP	2512