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

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)**

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 (<) 12 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 D

*****The listed products may not indicate formulary coverage. To check current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search***

Label Name	GCN
DELSYM COUGH + CHEST CONGST DM LQ	53497
GUAIFENESIN ER 1,200 MG TABLET	98863
GUAIFENESIN/PSE ER 600-60 MG	54980
MUCINEX D ER 1,200-120 MG TABLET	89731
MUCINEX D ER 600-60 MG TABLET	54980
MUCINEX DM ER 1,200-60 MG TAB	93677
MUCINEX DM ER 600-30 MG TABLET	53550
MUCINEX ER 1,200 MG TABLET	98863
MUCINEX ER 600 MG TABLET	35905
MUCINEX FAST-MAX CONGEST-COUGH	36254
MUCINEX FAST-MAX DM MAX LIQUID	53497
RESCON TABLET	31879
ROBAFEN COUGH 15 MG LIQUIDGEL	17770
SUDOGEST SINUS & ALLERGY TAB	44023