

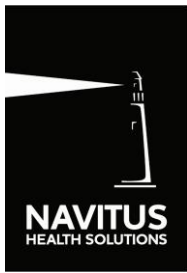


# TEXAS MEDICAID

## 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 <a href="http://www.txvendordrug.com">www.txvendordrug.com</a> ) <input type="checkbox"/> Non-Preferred Drug (NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies) <b>OR</b> <input type="checkbox"/> Preferred Drug (Go to Step 4) <b>OR</b> <input type="checkbox"/> 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? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2)	
2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3)	
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> 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](http://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