



TEXAS MEDICAID

Clinical Edit Prior Authorization

chlordiazepoxide, meprobamate, oxazepam

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 client failed a 30-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. Does the client have a history of a chlordiazepoxide (CLD), meprobamate (MePB), or oxazepam (OXAZ) agent for 90 days in the last 150 days?

Yes (Approve - 365 days) No (Go to #2)

2. Is the incoming request for less than or equal to (\leq) 1 day supply?

Yes (Go to #3) No (Go to #4)

3. Is the incoming request for less than or equal to (\leq) 5 units per day?

Yes (Approve - 1 day) No (Go to #4)

4. Does the client have a diagnosis of anxiety disorder in the last 730 days?

Yes (Go to #6) No (Go to #5)

5. Does the client have a diagnosis of drug abuse in the last 730 days?

Yes (Deny) No (Go to #6)

6. Is the client less than ($<$) 6 years of age?

Yes (Deny) No (Go to #7)

7. Is the client greater than or equal to (\geq) 6 years of age and less than or equal to (\leq) 18 years of age?

Yes (Go to #8) No (Go to #11)

8. Does the client have a diagnosis of anxiety disorder in the last 730 days?

Yes (Go to #9) No (Go to #10)

9. Does the client have a history of an anxiolytic agent for 60 days in the last 90 days?

Examples of anxiolytic agents include alprazolam (XANAX), buspirone, chlordiazepoxide, clorazepate (TRANXENE), clonazepam (KLONOPIN), diazepam, lorazepam, meprobamate, and oxazepam.

Yes (Deny) No (Approve - 60 days)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

10. Does the client have a history of an anxiolytic agent for 30 days in the last 60 days?

Examples of anxiolytic agents include alprazolam (XANAX), buspirone, chlordiazepoxide, clorazepate (TRANXENE), clonazepam (KLONOPIN), diazepam, lorazepam, meprobamate, and oxazepam.

Yes (Deny)

No (Approve - 30 days)

11. Does the client have a diagnosis of anxiety disorder in the last 730 days?

Yes (Go to #12)

No (Go to #13)

12. Does the client have a history of an anxiolytic agent for 180 days in the last 200 days?

Examples of anxiolytic agents include alprazolam (XANAX), buspirone, chlordiazepoxide, clorazepate (TRANXENE), clonazepam (KLONOPIN), diazepam, lorazepam, meprobamate, and oxazepam.

Yes (Deny)

No (Approve - 180 days)

13. Does the client have a history of an anxiolytic agent for 60 days in the last 90 days?

Examples of anxiolytic agents include alprazolam (XANAX), buspirone, chlordiazepoxide, clorazepate (TRANXENE), clonazepam (KLONOPIN), diazepam, lorazepam, meprobamate, and oxazepam.

Yes (Deny)

No (Approve - 60 days)

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.