



TEXAS MEDICAID Clinical Edit Prior Authorization Lipotropics (Statins)

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: _____

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

- Has the client failed at least 2 preferred agent(s) for a total of 120 days in the last 180 days?
 Yes (Go to Step 4, Question 1) No (Go to #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)
- 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: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

1. Is the request for one of the following drugs/strengths?

atorvastatin tablet (LIPITOR)	10mg, 20mg, 40mg
fluvastatin capsule	20mg, 40mg
lovastatin tablet	10mg, 20mg
pravastatin tablet (PRAVACHOL)	20mg, 40mg
rosuvastatin tablet (CRESTOR)	5mg, 10mg, 20mg
simvastatin tablet	5mg
simvastatin tablet (ZOCOR)	10mg, 20mg, 40mg

Yes (Go to #2) No (Approved – 365 days)

2. Is the request for 2 or more capsules/tablets per day?

Yes (Go to #3) No (Approved – 365 days)

3. Is the client greater than or equal to 18 years of age?

Yes (Go to #4) No (Approved – 365 days)

4. Is the request being submitted by phone?

Yes (Approved – 365 days) No (Clinical Review Required. Please provide medical rationale for requested dose below)

Medical Rationale for 2 or more units (tablets/capsules/patches) per day:

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.