



TEXAS MEDICAID Preferred Drug List (PDL) Criteria for Non-Preferred Drugs (NPD or NAP): Benign Prostatic Hyperplasia (BPH) Agents

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: _____

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

Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

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

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

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

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Approved – 365 days) No (Deny)

STEP 4: 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.