TEXAS MEDICAID
Drug Clinical Review
Compound Drugs over $200

STEP 1: DEMOGRAPHIC INFORMATION PLEASE CLEARLY PRINT AND COMPLETE ALL SECTIONS 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: PROVIDE INDICATION FOR USE AND INGREDIENTS USED IN COMPOUND

(REQUIRED)

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

***Note: The compounded medication MUST be used for a medically accepted indication.**

Medically accepted indications are uses supported by resources such as Thomson Micromedex, American Hospital Formulary Service, Clinical Pharmacology, physician supported guidelines, and/or current primary (peer reviewed) literature. If prescribed outside FDA-approval, please provide references or documentation to support the use of the requested medication for the primary diagnosis listed above.

Drug/Ingredient Name *Note: All ingredients must be covered on formulary or pharmacy must accept non-payment for non-formulary ingredients. Bulk compounding powders are not covered by the Texas Medicaid formulary.	**Strength/Dose**	**Indication**

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STEP 3: PROVIDE DETAILS REGARDING ALL FORMULARY ALTERNATIVES TRIED

Formulary Medication	Max Dose Used	Frequency of Dosing	Start & End Dates of Use	Describe significant side effects and reasons for ineffectiveness

STEP 4: PROVIDE CLINICAL INFORMATION TO SUPPORT NEED FOR COMPOUNDED DRUG (ATTACH CHART DOCUMENTATION AND/OR ADDITIONAL PAGES AS NECESSARY)

1. Is the client 12 years of age or younger with difficulty swallowing oral medications? (Applies only to compounded oral medications.)

2. Does the client have an allergy to the commercially prepared products available to treat this condition? Describe allergies and reactions or refer to Step 3 above.

3. Does the client have a medical need for a different dosage, dosage form, or strength of medication than what is commercially available? Please provide details/rationale to support medical need.

4. If the requested product is similar to a commercially available product that has been approved by the FDA, is the FDA-approved product unavailable or in short supply?

   Is the limited availability due to the product being removed or withdrawn from the market due to safety concerns?

STEP 5: SIGN AND FAX TO: NAVITUS CLINICAL REVIEW AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation and clinical references with form citing complex medical circumstances and supporting medical necessity for the requested compound prescription.

For questions, please call Navitus Customer Care at 1-877-908-6023.