TEXAS MEDICAID
Clinical Edit Prior Authorization
Phosphate Binders

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 ☐ 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. Does the client have a diagnosis of End-Stage Renal Disease (ESRD) in the past 180 days?

   ☐ Yes (Go to #2) ☐ No (Go to #11)

2. Does the client have a diagnosis of hyperphosphatemia in the past 180 days?

   ☐ Yes (Go to #3) ☐ No (Go to #11)

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

   ☐ Yes (Go to #5) ☐ No (Go to #4)

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

☐ Yes (Go to #5) ☐ No (Go to #11)

5. Does the client have a diagnosis of hypercalcemia in the past 180 days?

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #6)

6. Does the client have a history of a corrected calcium lab value greater than (>) 10.2 in the past 180 days?

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #7)

7. Does the client have a history of consecutive parathyroid hormone (PTH) lab values less than (<) 150 in the past 180 days?

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #8)

8. Does the client have a diagnosis of dialysis in the past 180 days?

☐ Yes (Go to #9) ☐ No (Go to #11)

9. Does the client have a history of common procedural technology (CPT) codes for dialysis in the past 180 days?

☐ Yes (Go to #10) ☐ No (Go to #11)

10. Does the client have a history of vascular or soft tissue calcification in the past 180 days?

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #11)

11. 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 diagnosis of end stage renal disease (ESRD) in the last 730 days?

☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of hyperphosphatemia in the last 180 days?

☐ Yes (And the request is for Renvela or generic Renvela, go to #4)
☐ Yes (And the request is for an agent other than Renvela or generic Renvela, go to #5)
☐ No (And the request is for Auryxia, go to #3)
☐ No (And the request is for an agent other than Auryxia, deny)

3. Does the client have a diagnosis of iron deficiency anemia in the last 180 days? ☐ Yes (Go to #5) ☐ No (Deny)
4. Is the client greater than or equal to (≥) 6 years of age? ☐ Yes (Approve – 365 days) ☐ No (Deny)
5. Is the client greater than or equal to (≥) 18 years of age? ☐ Yes (Approve – 365 days) ☐ No (Deny)
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.