



TEXAS MEDICAID Preferred Drug List (PDL) Criteria for Non-Preferred Drugs (NPD or NAP): TOPICAL STEROIDS

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 | |
| 1. Has the client failed a 7-day treatment trial with at least 1 preferred agent in the last 180 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Go to #2) | |
| 2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Go to #3) | |
| 3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> 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.