



TEXAS MEDICAID Clinical Edit Prior Authorization propylthiouracil

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: COMPLETE REQUIRED CRITERIA

Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have a diagnosis of pregnancy in the last 120 days?

Yes (Approve – 90 days)

No (Go to #2)

2. Does the client have an allergy to methimazole in the last 180 days? [Manual Step]

Yes (Approve – 90 days)

No (Deny)

STEP 3: 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.