Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Fentanyl Agents: transdermal fentanyl (DURAGESIC)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:
1. Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a six (6) day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

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

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

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

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Opioid Policy Criteria

10. Does the member have a diagnosis of ONE (1) of the following in the last 365 days?
    - Sickle cell
    - Cancer
    - Palliative care
    - Hospice care

    ◯ Yes
    (Go to #16)

    ◯ No
    (Go to #11)

11. Does the member have a total of less than or equal to (≤) seven (7) days supply of opiates in the last 60 days?

    ◯ Yes
    (Go to #12)

    ◯ No
    (Go to #15)

12. Is the days supply of the requested medication greater than (>) ten (10) days?

    ◯ Yes (Deny)
    (Go to #13)

    ◯ No
    (Go to #13)

13. Is the request for a long-acting opioid agent?

    ◯ Yes (Deny)
    (Go to #14)

    ◯ No
    (Go to #14)

14. Is the incoming request greater than (>) 90 morphine milligram equivalents (MME)?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

15. Does the member's total opiate intake exceed 90 morphine milligram equivalents (MME) per day?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Please provide the drug names, strengths, and dosing instructions of ALL opioid products the member is currently taking:
(Go to #17)

Clinical Criteria (required)

17. Does the member have a diagnosis of cancer or fibrotic lung disease in the last 730 days?

- ◯ Yes
  (Go to #22)
- ◯ No
  (Go to #18)

18. Does the member have a history of an antineoplastic agent in the last 365 days?

- ◯ Yes
  (Go to #22)
- ◯ No
  (Go to #19)

19. Does the member have less than or equal to (≤) seven (7) days of opioid therapy in the last 30 days?

- ◯ Yes
  (Go to #20)
- ◯ No
  (Go to #22)

20. Does the member have a diagnosis of Chronic Non-Malignant Pain (CNMP) in the last 365 days?

- ◯ Yes
  (Go to #22)
- ◯ No
  (Go to #21)

21. Does the member have a history of an inferring CNMP non-opioid analgesic for less than or equal to (≤) 60 days out of the last 90 days?

Examples of CNMP non-opioid analegsics include: aspirin, celecoxib (CELEBREX), diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meclofenamate, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, and others.

- ◯ Yes (Deny)
  (Go to #22)
- ◯ No
  (Go to #22)

22. Is the dose less than or equal to (≤) 25ug (mcg) per hour?

- ◯ Yes
  (Go to #25)
- ◯ No
  (Go to #23)

23. Does the member have less than or equal to (≤) 14 days of opioid therapy in the last 30 days?

- ◯ Yes (Deny)
  (Go to #24)
- ◯ No
  (Go to #24)

24. Is the dose less than or equal to (≤) 600ug (mcg) per hour?

- ◯ Yes
  (Go to #25)
- ◯ No (Deny)
  (Go to #25)

25. Does the member have a total of less than or equal to (≤) seven (7) days supply of opiates in the last 60 days?

- ◯ Yes (Approve - 1 x for incoming prescription) (opioid naïve)
  (Go to #26)
- ◯ No (Approve 180 days) (opioid experienced)
  (Go to #26)

Additional Information

26. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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