TEXAS MEDICAID
Clinical Edit Prior Authorization
Opioid Policy

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 ☐ No Status, Drug is not in a Market Basket **(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. Has the client failed a 6-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

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

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

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

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

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STEP 4: OPIOID POLICY CRITERIA

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

   ☐ Yes (Approve – 180 days) ☐ No (Go to #2)

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

   ☐ Yes (Go to #3) ☐ No (Go to #6)

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

   ☐ Yes (Deny) ☐ No (Go to #4)

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

   ☐ Yes (Deny) ☐ No (Go to #5)

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

   ☐ Yes (Deny) ☐ No (Approved x 1 for incoming prescription)

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

   ☐ Yes (Deny) ☐ No (Approve – 180 days)

7. Please provide the drug names, strengths, and dosing instructions of ALL opioid products the patient is currently taking:

   _____

   _____

   _____

   _____

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.