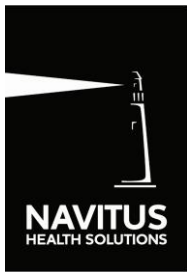




TEXAS MEDICAID

Vitamin and Mineral Prior Authorization: Pediatric Vitamin Preparations

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) <input type="checkbox"/> Non-Preferred Drug (NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies) OR <input type="checkbox"/> Preferred Drug (Go to Step 4) OR <input type="checkbox"/> No Status, Drug is not in a Market Basket (Go to Step 4)	
STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT	
1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <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 (Go to Step 4 Question 1) <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 (Go to Step 4 Question 1) <input type="checkbox"/> No (Deny)	



STEP 4: VITAMIN AND MINERAL POLICY CRITERIA

1. Is the client less than or equal to 20 years of age?

Yes (Go to #2)

No (Deny)

2. Is the prescribed product for a medically-accepted indication according to the current Vitamin and Mineral policy chapter within the *Texas Vendor Drug Program Pharmacy Provider Procedure Manual*? Please see <https://www.txvendordrug.com/about/manual/pharmacy> for complete list.

Accepted indications for use of pediatric multi-vitamin products include: Cystic fibrosis, Other and unspecified protein-calorie malnutrition.

Yes (Approve – 180 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.