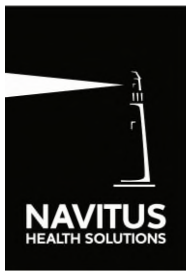



# TEXAS MEDICAID
# Clinical Edit Prior Authorization
# carvedilol ER (COREG CR) capsules

**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: ___________

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 14-day treatment trial with at least 1 preferred agent in the last 180 days?

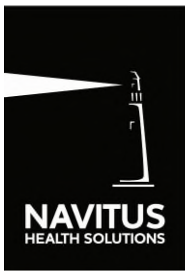
   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

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)



## STEP 4: DRUG REGIMEN OPTIMIZATION (DRO) PRIOR AUTHORIZATION CRITERIA

1. Is the request for one of the following drugs/strengths?

| carvedilol ER capsules (COREG CR) | 10mg, 20mg, 40mg |
|---|---|

☐ Yes (Go to #2) ☐ No (Approved – 365 days)

2. Is the request for 2 or more capsules per day?

☐ Yes (Go to #3) ☐ No (Approved – 365 days)

3. Is the client greater than or equal to 18 years of age?

☐ Yes (Go to #4) ☐ No (Approved – 365 days)

4. Is the request being submitted by phone?

☐ Yes (Approved – 365 days) ☐ No (Clinical Review Required. Please provide medical rationale for requested dose below)

Medical Rationale for 2 or more units (tablets/capsules/patches) per day:

____________________________________________________________

____________________________________________________________

____________________________________________________________

## 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.