



TEXAS MEDICAID Vitamin and Mineral Prior Authorization

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: _____	
STEP 3: VITAMIN AND MINERAL POLICY CRITERIA	
1. Is the client less than or equal to 20 years of age? <input type="checkbox"/> Yes (Go to #2) <input type="checkbox"/> No (Deny)	
2. Is the prescribed product for a medically-accepted indication according to the current Vitamin and Mineral policy chapter within the <i>Texas Vendor Drug Program Pharmacy Provider Procedure Manual</i> ? Accepted indications for use vary by the product requested. Please see https://www.txvendordrug.com/about/manual/pharmacy for a complete list. <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)	
STEP 4: 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.