TEXAS MEDICAID – Cook Children's Health Plan Only
Clinical Edit Prior Authorization
Enzymes

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:

STEP 3: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Please indicate the medication that is being requested:
   - ☐ laronidase [ALDURAZYME] (Go to #2)
   - ☐ protein C concentrate (human) [CEPROTIN] (Go to #3)
   - ☐ idursulfase [ELAPRASE*] (Go to #4)
   - ☐ agalsidase beta [FABRAZYME] (Go to #5)
   - ☐ alglucosidase alfa [LUMIZYME] (Go to #7)
   - ☐ galsulfase [NAGLAZYME] (Go to #8)
   - ☐ nitisinone [NITYR / ORFADIN] (Go to #10)
   - ☐ elapegademase-lvlr [REVCOVI] (Go to #11)
   - ☐ elosulfase alfa [VIMIZIM*] (Go to #13)

2. Does the client have a diagnosis of mucopolysaccharidosis I (also called MPS I and/or Hurler-Scheie syndrome) in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
3. Does the client have a diagnosis of severe congenital protein C deficiency in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
4. Does the client have a diagnosis of mucopolysaccharidosis II (Hunter syndrome) in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
5. Is the client less than (<) 2 years of age? ☐ Yes (Deny) ☐ No (Go to #6)
6. Does the client have a diagnosis of Fabry disease in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
7. Does the client have a diagnosis of Pompe disease in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
8. Is the client less than (<) 5 years of age? ☐ Yes (Deny) ☐ No (Go to #9)
9. Does the client have a diagnosis of mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome) in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
10. Does the client have a diagnosis of hereditary tyrosinemia type 1 (HT-1) in the past 730 days? ☐ Yes (Approve – 365 days) ☐ No (Deny)
11. Does the client have a diagnosis of adenosine deaminase severe combined immunodeficiency disease (ADA-SCID) in the last 730 days? ☐ Yes (Go to #12) ☐ No (Deny)
12. Does the client have a diagnosis of thrombocytopenia in the last 365 days? ☐ Yes (Deny) ☐ No (Approve – 365 days)

13. Is the client greater than or equal to (≥) 5 years of age?

☐ Yes (Go to #14) ☐ No (Deny)

14. Does the client have a diagnosis of mucopolysaccharidosis IVA (also called Morquio A syndrome) in the past 730 days?

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: 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.

*Elaprase and Vimizim must be filled by Cook Children's Home Health Pharmacy (Phone: 682-303-2230, Fax: 682-885-2499).