TEXAS MEDICAID
Clinical Edit Prior Authorization
cladribine (MAVENCLAD)

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: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of multiple sclerosis (MS) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the client currently pregnant?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Is the medication being prescribed concurrently with other disease modifying therapies for MS?

   Examples of disease modifying therapies include AUBAGIO, AVONEX PEN, BAFIERTAM DR, BETASERON, glatiramer (COPAXONE), dimethyl fumarate (TECFIDERA), EXTAVIA, GILENYA, GLATOPA, KESIMPTA, MAYZENT, mitoxantrone, PLEGRIDY, REBIF, REBIF REBIDOSE, VUMERITY, and ZEPOSIA

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a diagnosis of clinically isolated syndrome, current malignancy, human immunodeficiency virus (HIV) infection or active chronic infection?

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Is the requested dose less than or equal to (≤) 100mg (10 tablets) per cycle?

☐ 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.