Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Multiple Sclerosis (MS) Agents: cladribine (MAVENCLAD)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

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

- ◯ Yes
(Go to #7)
- ◯ No (Deny)
(Go to #7)

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

- ◯ Yes
  (Go to #8)
- ◯ No (Deny)
  (Go to #8)

8. Is the member currently pregnant?

- ◯ Yes (Deny)
  (Go to #9)
- ◯ No
  (Go to #9)

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

   Examples of disease modifying therapies for MS include: AUBAGIO, AVONEX, BAFIERTAM DR, BETASERON, dimethyl fumarate (TECFIDERA), EXTAVIA, GILENYA, glatiramer & glatopa (COPAXONE), KESIMPTA, MAYZENT, mitoxantrone, PLEGRIDY, PONVORY, REBIF, VUMERITY, and ZEPOSIA.

- ◯ Yes (Deny)
  (Go to #10)
- ◯ No
  (Go to #10)

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

- ◯ Yes (Deny)
  (Go to #11)
- ◯ No
  (Go to #11)

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

- ◯ Yes (Approve - 365 days)
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

Additional Information

12. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

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If criteria not met, submit chart documentation with form citing complex medical circumstances.
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